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

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As persons with mental illnesses and law enforcement become increasingly intertwined, 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. The article will discuss the key elements of the CIT model, implementation and its related challenges, and variations of the model. Although this model has not undergone sufficient 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 available in their communities or it may serve as a springboard for the development of CIT programs where they do not currently exist.

Keywords: best practice; crisis intervention team; law enforcement; mental health

Introduction

Over the past few decades, the disproportionate involvement of persons with severe mental illness (SMI) 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 SMI into the front door of the criminal justice system, and for those who do enter the system, provide effective intervention in the hope 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, & Watson, 2011).

Although there has not been enough research to date to declare CIT an evidence-based practice, it 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). This article describes the CIT model and emerging evidence of its effectiveness, as well as the role of mental health practitioners in working with law enforcement and, more specifically, CIT programs to improve the overall response to individuals experiencing mental health crises.

The Nature of the Problem

The most recent available data, although they are now over a decade old, suggest that approximately 10 percent of all police contacts with the public involve persons with SMI (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 SMI in U.S. jails are 14.5 percent for males and 31 percent for females (Steadman, Osher, Robbins, Case, & Samuels, 2009), suggesting that police are arresting sizable numbers of people with SMI. Data on the number of people with SMI that police are directing to services or for whom they are providing informal disposition (e.g., resolving on the scene with no formal intervention) is limited. However, as mental health budgets are slashed, the role of police 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, & Appelbaum, 2005; Wells & Schafer, 2006). Officers perceive mental-health-related calls as very unpredictable and dangerous, which without adequate training, can cause them to inadvertently approach in a manner that escalates the situation (Ruiz, 1993; Ruiz & Miller, 2004). As media reports confirm, on rare occasions, mental-health-related calls end in tragedies in which officers or persons with mental illness are seriously or fatally wounded.
The CIT Model

It was a tragedy that spurred the collaboration among stakeholders to develop the original CIT program in Memphis, Tennessee. 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 comprising law enforcement, mental health and addiction professionals, and mental health advocates cooperated 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, to divert persons with mental illnesses from the criminal justice system to mental health treatment.

Although the centerpiece of the model is forty hours of specialized training for a select group of officers who volunteer to become CIT officers, proponents stress that CIT is more than just training (CIT International, 2012b). The crisis intervention team 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 forty hours of training provided by mental health clinicians, client 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. The CIT curriculum 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 illness as well as site visits to agencies in the community (Compton et al., 2011).

Call dispatchers are trained to identify mental disturbance calls and to assign these calls to CIT officers. The CIT officers are trained to use de-escalation techniques if necessary and to determine whether 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 to return to other duties in a timely manner. Additionally, during and after training, CIT officers familiarize themselves with a variety of community mental health services 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. As the model has proliferated, policy and program guidance documents have been developed and a professional organization, CIT International, has formed. Current estimates suggest that there are more than 3,000 CIT programs being implemented worldwide (CIT International, 2012a). CIT International, as indicated in its brochure (2012b), is a membership organization “whose primary purpose is to facilitate understanding, development and
implementation of Crisis Intervention Team (CIT) training programs throughout the United States and in other nations worldwide.” Its board of directors and membership comprise law enforcement, mental health providers, and advocates. The organization maintains a website (http://www.citinternational.org), newsletter, and annual conference.

Dupont et al. (2007) have published a description of the core elements of the CIT model on the University of Memphis’s CIT Center website. Additionally, this site 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). The 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.

As there are innumerable variations in police jurisdictions, so are there many 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, 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 prioritizes police transports so that officers can return to the street within fifteen to thirty minutes. In larger jurisdictions, a central drop-off is not practical (Compton et al., 2011). For example, in Chicago, the police department maintains memoranda of understanding (MOUs) with designated emergency facilities across the city for each police district. These MOUs provide for officer transports to be given priority. Philadelphia has crisis centers that police can utilize for emergency transports. These 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 forty-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 officers and limits the success of CIT programs.

Another key component of the Memphis CIT model is that officers volunteer to become CIT officers so 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 who volunteer and are accepted into the program may have a particular disposition for and interest in handling mental health calls. This better prepares them to use CIT training to respond effectively to mental health crisis calls. As a
result of CIT training, officers gain additional skills and are designated for dispatch on mental-health-related calls.

Initially, the Memphis team suggested that 20 to 25 percent of the police force be CIT trained to ensure 24/7 availability (Dupont et al., 2007). However, according to Major Sam Cochran (Ret.), founding coordinator of the Memphis Police Crisis Services, maximizing the percentage of officers who are CIT trained is less important than selecting the most appropriate officers for training (personal communication, August 22, 2012). Other departments have taken a different approach and are requiring all of their patrol officers to 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 respond effectively. 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 poses a problem for many CIT programs (Compton et al., 2011). Emergency communications (911/dispatch) is generally a separate agency or department that is not run by the police department. Thus, some CIT programs have not fully implemented dispatch protocols and training of dispatch personnel. Programs that have implemented dispatch training have used varied approaches. For example, in some jurisdictions, dispatch personnel participate in 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 who have repeated police contacts (Rosenbaum, 2010). Thus, although 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 catalog these variations or to 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 arrest rates of persons with mental illnesses (Steadman, Dean, Borum, & Morrissey, 2000), as well as increases in the number of mental-health-related calls identified, increases in hospital transports by CIT officers for psychiatric evaluation, and increases in the proportion of voluntary transports (Teller, Munetz, Gil, & Ritter, 2006). In
Chicago, no difference was found in arrest rates between CIT and non-CIT-trained officers. However, CIT officers were more likely than their non-CIT colleagues to direct persons with mental illnesses to mental health treatment and less likely to resolve mental-health-related calls with contact only (no action taken). This effect was most pronounced in districts with greater availability of mental health services (Watson, Ottati, Draine, & Morabito, 2011). Only one study examined outcomes for persons with mental illnesses beyond the immediate CIT encounter. Broner, Lattimore, Cowell, and Schlenger (2004) found that diversion from arrest by prebooking programs, such as CIT, increased mental health service utilization in the subsequent twelve months for persons with SMI.

Several studies suggest that CIT improves safety outcomes. Dupont and 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 and Bibeau (2008) found that CIT officers used force in only 15 percent of encounters rated as high-violence risk, and that when they did use force, they generally relied on low-lethal methods. A study of Chicago’s CIT program (Morabito, Kerr, Watson, Draine, Angell, 2012) found that CIT officers used less force than non-CIT-trained officers as subject resistance increased. No correlation was found between CIT implementation and injuries (Kerr, Morabito, & Watson, 2010), perhaps due to the low frequency of reported injuries overall. However, in a qualitative study (Hanafi, Bahora, Demir, & Compton, 2008), officers reported that application of their CIT skills reduces the risk of injury to both officers and persons with mental illness.

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

Research to date has been limited to nonexperimental and quasi-experimental designs. Although a randomized controlled trial of CIT would allow more rigorous testing of the model’s effectiveness, researchers have struggled with devising a feasible approach and the resources to conduct the trial (Watson, 2010). Instead, studies have examined attitudes and knowledge before and after CIT training, compared call data before and after CIT implementation and 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 criminal justice system. Thus, although there is insufficient support for CIT to be considered an evidence-
based practice, at this juncture, it is considered a best practice in law enforcement (Thompson & Borum, 2006).

**The Role of Mental Health Clinicians in the Success of the Model**

Mental health agencies often serve individuals who have contacts with the police and, at times, roles of clinicians and officers intersect with regard to client needs. 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 to 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, each group frequently relies on the other for assistance. However, collaboration between groups is often fraught with difficulties, mistrust, and misunderstandings about the constraints faced by members of the other group (Hatcher, Mohandie, Turner, & Gelles, 1998).

Early in the task force meetings that eventually led to the development of the CIT model in Memphis, it became 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 transported people 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 perspectives of the other groups, 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 intended to improve the response of police, mental health services, and communities to mental health crises. 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 are 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 curriculum and include providers on panels to share their perspectives 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

Although 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. As a minimum, clinicians should understand the CIT model, know whether their community has such a program, and if so, know how to utilize CIT officers when situations require police involvement. Going beyond the minimum to improve services to the populations they serve, clinicians can become involved in CIT and related cross-system initiatives. Clinicians can also stay abreast of the research evidence on CIT, and if indicated, assist with modifying strategies to maximize program success.

References


