Dealing with individuals who have mental illness: the Crisis Intervention Team (CIT) in law enforcement

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Abstract

Purpose – *The current paper seeks to outline the Crisis Intervention Team (CIT) and review extant research regarding its efficacy in reducing criminalization of people with mental illness, as well as improving interactions between this population and law enforcement officers.*

Design/methodology/approach – *The CIT model and theoretical underpinnings are discussed and an evaluative review of the current literature is presented.*

Findings – *Research on the CIT model has generally shown improved officer and community safety; better mental healthcare for those in need; and decreased criminalization of those with mental illness. Methodologies have included the use of records reviews and officer surveys, primarily.*

Practical implications – *Implications in the practice of law enforcement and psychology include decreasing criminalization of those with mental illness; reducing the frequency of police use of force; minimizing injury to consumers and law enforcement officers; and connecting people with mental illness to needed psychological/psychiatric resources.*

Social implications – *Success of CIT has wider social implications, such as decreasing stigma regarding mental illness and fear of involving police in mental health related crises.*

Originality/value – *The authors provide a summary of the CIT model in the context of law enforcement's response to people with mental illness; highlight important research to date; discuss implications of the programme; and suggest directions for future research in the area of CIT.*

Keywords *Crisis intervention, Mental illness, Police, Law enforcement, Psychology*

Paper type *Research paper*

In the 1960s, deinstitutionalization in the USA sought to eradicate large state psychiatric hospitals. The goal of this movement was to federally fund outpatient mental health centers (CMHCs) that would be able to service the needs of those diagnosed with mental illness within the community. Ideally, these communities would gradually take over funding of CMHCs. However, many communities did not have the funds to take on the CMHC plan, subsequently lost funding, and were forced to close them. The CMHCs that remained were typically only equipped for acute and outpatient care. Therefore, more people with a chronic mental illness were released into the community without needed services. This trend resulted in greater interaction between individuals with mental illness and law enforcement (Pogrebin and Poole, 1987). Unfortunately, LEOs generally receive little formal training in de-escalation of individuals in crisis who have a mental illness (Engel and Silver, 2001; Vickers, 2000). For example, usually only a small portion of police academy instruction is devoted to dealing with mental health issues. Such insufficient training has led to negative outcomes of encounters between LEOs and people with mental illness, including: increased injuries of officers and people with mental health issues, more frequent use of force with individuals having a mental illness, criminalization of individuals with mental illness, and a failure to provide adequate care leading to repeat calls for service and/or re-arrest(s).

As the behavior of individuals with mental illness in crisis, and where they are not successfully maintained on medication, can be erratic, LEOs have frequently interpreted it

as dangerous and aggressive (Engel and Silver, 2001; Finn and Stalans, 2002). For example, such individuals in crisis may suffer from hallucinations and delusions. This may cause them to respond unpredictably to police, and can even cause them to react to internal auditory or visual stimuli that are not present to others. Finn and Stalans (2002) observed that, in the context of domestic violence calls, police viewed suspects with mental illness as significantly more dangerous, less in control of their actions, less likely to be acting in self defense, and less credible than suspects without mental illness. Therefore, it is not surprising that officers often utilize force to gain control of individuals with mental health problems in arrest or detainment situations. In fact, Engel and Silver (2001) reported that LEOs used force with such suspects 1.4-4.5 times as often as with suspects who did not have a mental illness.

Once LEOs gain control or compliance from an individual with mental illness, they have to decide where to take him/her. Officers have a limited number of options in these situations. They can resolve the situation formally (through hospitalization or arrest) or informally (through advice or recommendations at the scene; Teplin, 2000). Often, the decision to hospitalize is made difficult by stringent admission criteria set by hospital emergency departments and by the prolonged period of time the officers must remain out of service. Hospitals are hesitant to admit individuals with mental health problems with co-occurring disorders, especially substance abuse/dependence. Further, the criteria that are most common to individuals referred to treatment by police (e.g. danger to self and/or others) are frequently the very reasons hospitals refuse to admit them.

Thus, the lack of appropriate treatment facilities (or facilities that will accept police referrals) has limited officers' options when detaining an individual who presents with serious mental illness, and who is committing only a minor violation, or is endangering him/herself and/or others while not committing a legal violation (Teplin and Pruett, 1992). The relative ease of and familiarity with the arrest option, in conjunction with officers' tendency to overestimate dangerousness of such individuals, can lead to using arrest as a default method of handling mental health emergency calls. Individuals with mental illness are commonly arrested, prosecuted, and/or incarcerated because hospital services are unavailable or too difficult to obtain. One study found that such suspects were arrested in 46.7 per cent of cases, compared to only 27.9 per cent of cases involving suspects with no mental illness (Teplin and Pruett, 1992). The criminalization of mental illness is further elucidated by Bureau of Justice Statistics estimating that 16 per cent of incarcerated cases meet clinical criteria for a major mental illness, which is three to four times the rate of mental illness in the general population (Ditton, 1999).

Additionally, there is little to no follow-up mental healthcare once an individual with mental illness is released from jail/prison. However, it is important to note that when mentally disordered status is based on officer perceptions, officers are significantly less likely to arrest those whom they perceive to be mentally disordered (Engel and Silver, 2001). Thus, there is some evidence that the disproportionate number of individuals with mental illness in prisons could be reduced by training officers to more accurately recognize the signs and symptoms of mental illness.

These negative outcomes have challenged law enforcement agencies to consider novel approaches to dealing with such individuals in crisis. Three primary types of specialized responses have emerged in recent years:

1. mental health-based mental health responses;
2. police-based specialized mental health responses; and
3. police-based police responses (Deane *et al.*, 1999; Hails and Borum, 2003).

The first response is a model in which mental health emergency calls are diverted from police to a mental health crisis facility or agency, such as an on-call mobile crisis unit. These units handle the emergency without police involvement, if possible, and direct the consumer to the appropriate resources. The police-based mental health response model also uses non-sworn mental health personnel; however, they are employed by the police agency and

respond to mental health crises instead of sworn officers. In the third model, police officers are specially trained to handle mental health crises and respond to police call-outs to ensure that the individual receives proper care and treatment, when possible. This model, referred to as the Crisis Intervention Team (CIT), has been the focus of increased investigative attention which has yielded considerable empirical support in recent years.

The Crisis Intervention Team

The CIT, a type of police-based specialized police response, involves collaborations between mental health and law enforcement, specialized training for LEOs in mental health issues, crisis intervention/de-escalation, and service user-friendly mental health resources (Du Pont and Cochran, 2000; Vickers, 2000). CIT was created in Memphis, Tennessee, in 1988 (Vickers, 2000). That year, the Memphis Police Department responded to a call regarding an individual who was suicidal and had a diagnosis of schizophrenia. Although the man was known by many other officers to have mental health difficulties, the officers who responded were new and unfamiliar with him. The young man became upset when officers confronted him and demanded that he drop his knife; he made a sudden move toward the officers. They were forced to shoot him, as they had been trained to do in such situations. The young man died as a result of these injuries.

Collaborative framework

Following this tragedy, the community demanded a response in which training in the use of less lethal strategies was made available to law enforcement for the purpose of, at least, providing options in volatile situations and encounters. Collaborations between policy-makers, law enforcement, the National Alliance for the Mentally Ill, mental health consumers, and others from the community began to take shape. One example was the formation of a single-location mental healthcare facility for police drop-offs, called ''the Med'' (Vickers, 2000). This facility adopted a no-refusal policy for police referrals, and streamlined the intake process to allow officers to admit an individual with mental illness, and to then get back on patrol within about 30 minutes. All ''Memphis model'' CIT programs currently utilize such a facility. The no-refusal policy has meant that individuals with existing mental health and substance use/abuse issues, as well as those who are violent toward themselves or others, can be admitted. Because these sites are housed within a fully staffed hospital, they are also able to provide follow-up referrals for individuals brought in by police. The no-refusal, single-point-of-entry component of CIT has been credited as instrumental in the program's success (Steadman *et al.*, 2001). Data from two different communities with similar facilities reveal that officers:

- were not deterred from taking individuals with mental illness to the hospital;
- had a better perception of program efficacy in their department; and
- were able to return to patrol duties quickly after mental health emergency calls.

CIT training components

CIT training was designed as a 40-hour course (five days, eight hours per day), and most programs maintain this length of training. The curriculum includes recognition and understanding of the signs/symptoms of mental illnesses, pharmacological interventions and their side effects, crisis intervention and de-escalation skills, and knowledge of the user-friendly mental health resources available to the mental health consumers that CIT officers encounter (Du Pont *et al.*, 2007; Table I). Mental health professionals from the community teach the majority of the course components. Mental health service users and their families also participate in educating officers about mental health issues to add perspective.

Officers begin with didactic lectures that help them learn to recognize severe mental illness and how different psychiatric disorders are likely to be manifested in those they encounter. Some of the topics covered in these didactics include: medications and their side effects, alcohol and drug assessment, comorbid disorders, developmental disorders, family/

Table I Some CIT core components and their implications

CIT component	*Implication(s)*
Training	
Signs/symptoms of mental illness	Officers accurately identifyindividuals with mental illness Officers have some idea of what type of behavior to expect
Psychiatric drugs and uses	Officers are aware of what medications are used to treat certain disorders Officers are aware some side effects of medication use/withdrawal
De-escalation skills	Officers can resolve mental health crises more safely Reduced violence and force in police-person with mental illness encounters Fewer injuries to mental health consumers and LEOs
Collaborative framework	
Single point of entry, no-refusal treatment facility	Officers have effective alternative to incarceration of individuals with mental illness in crisis Officers more likely to use facility due to ease and efficiency Mental health consumers receive the treatment and/or referrals they need Reduced criminalization of individuals with mental illness
Legal provisions for detention in place	Officers are not hesitant to transport individuals with mental illness to treatment facility Treatment facility is able to accept all police referrals more easily

consumer perspectives, suicide prevention, consumer rights/civil commitment laws, post-traumatic stress, personality disorders, and community resources (Du Pont *et al.*, 2007).

Further, participating officers learn tactics for verbally de-escalating crises and practice these skills via role play scenarios. Officers are instructed in basic and advanced strategies of verbal de-escalation, which emphasize active listening skills, display of empathy, and the building of rapport. The information regarding mental illness, resources for mental health consumers, and de-escalation skills are integrated in complex role play scenarios in which the officers must demonstrate their ability to apply these concepts.

In addition to classroom didactics and applied role play assessments, CIT officers also visit local mental health treatment/receiving facilities and resource sites. During these visits, they are exposed to the function and mission of each of these facilities. They also hear the experiences of mental health consumers and their families to gain perspective on situations that involve police interactions with people with mental illness.

At the end of the course, officers graduate with CIT certification and receive a pin to wear on their uniform, identifying them as CIT officers. This allows service users to recognize CIT officers when they are in crisis, and also serves as a source of pride for the officers (Vickers, 2000). CIT training programs that have subsequently been carried out in other parts of the United States have generally conformed to the Memphis model, including statewide CIT programs, such as one in Georgia (Oliva and Compton, 2008).

Theory, goals, and implications

Watson and Angell (2007) asserted that the manner in which police officers initially approach and interact with individuals with mental illness can have a significant impact on the subsequent interaction. They reported that the reason for this was based in procedural justice theory, which postulates that people have a desire to be heard and to be treated fairly by authority figures. CIT training, with its focus on active listening skills, teaches officers to listen to complaints, and to display empathy toward such individuals. When those with mental illness perceive that officers are concerned with what they have to say, they are more likely to respond positively to requests and suggestions from police officers. Active listening skills have long been at the foundation of displaying empathy and establishing rapport in

counseling and crisis intervention (Evans *et al.*, 1989; Hersen and van Hasselt, 1998). These theoretical underpinnings allow CIT to accomplish the goals it was intended to achieve.

Consistent with the training and services provided through CIT, program goals have been to:

- improve interactions between police and those who have mental illness;
- decrease criminalization of individuals with mental illness; and
- provide better and more effective mental health services in the community.

Specifically, Du Pont and Cochran (2000) and Vickers (2000) reported that CIT has sought to improve encounters between individuals with mental illness and LEOs by reducing the violence/uses-of-force involved in them through de-escalation and crisis intervention skills taught to CIT officers. CIT has also attempted to divert individuals with mental illness from being continuously re-entered into the criminal justice system, and provide them with appropriate follow-up mental healthcare, post-crisis.

The implications of successful realization of these goals are numerous and extend to law enforcement, individuals with mental health difficulties, their families, and the community. For example, if officers are able to resolve a crisis situation involving an individual with a mental illness, and which is effecting the interaction, by verbal de-escalation, rather than by force, risk of injury decreases for both. In addition, officers and (by extension) police departments would incur fewer lawsuits that arise due to force-related injuries.

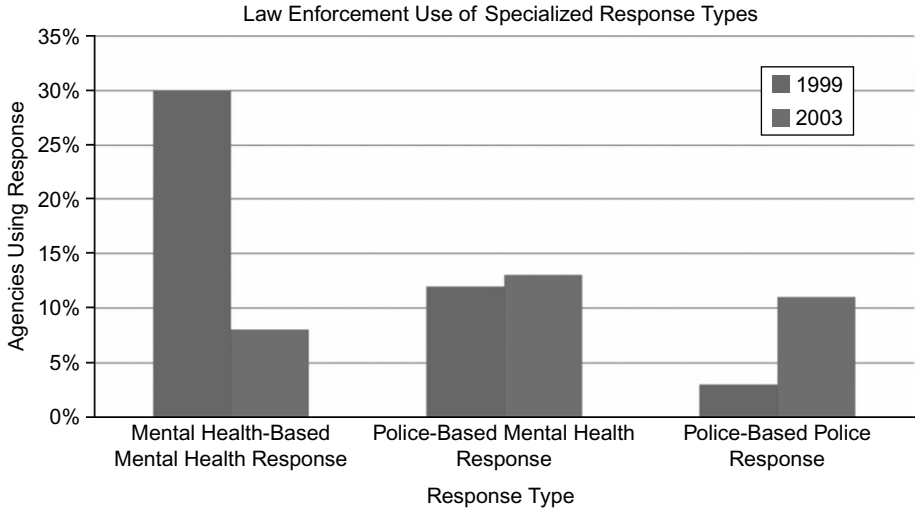
Also, success of CIT programs would mean fewer individuals with mental illness being re-arrested and prosecuted (the ''revolving door''). Officers would be provided with an effective, efficient, and user-friendly alternative to arrest when dealing with such individuals. Also, as the programme would be viewed as both effective and easy to navigate, officers would be more likely to use it. Consequently, and importantly, individuals with mental illness would receive treatment, rather than punishment. In this way, the programme would be working to help people deal with their mental illness, and law enforcement would be positively impacting the community. Further, follow-up care would be better managed within the CIT programme, because unlike in prisons, those responsible for the consumers' care maintain contact with these clients upon release/discharge. Additionally, CIT programs would connect individuals with mental illness with resources, such as psychological/psychiatric care and residential services. The potential impact of all of these outcomes on the community is considerable. Specifically, criminal justice systems would save money by reducing the number of people in jails and prisons, consumers/families would feel more comfortable calling police for assistance during mental health emergencies, and decriminalization would reduce community stigma towards mental illness.

To augment the effect of CIT in communities, it can be viewed in the context of the sequential intercept model, which conceptualizes decriminalization as strategies employed to intercept and divert individuals with mental illness at several stages during their intake to the criminal justice system (Munetz and Griffin, 2006). CIT fits into the framework of this model as a strategy to divert such individuals pre-arrest. As such, it can be used in concurrently with other diversion and recidivism-reducing strategies in communities (e.g. mental health courts, post-release connective care). In this way, many strategies can augment the effectiveness of each other in decriminalizing mental illness.

Research findings

The model has achieved some success, based on the limited research available (Compton *et al.*, 2008; Tucker *et al.*, 2008). First, CIT has been gaining in popularity and usage in communities across the USA. In 1999, 3 per cent of major police departments across the country utilized a police-based police response type such as CIT (Deane *et al.*, 1999). In 2003, the proportion of major police departments utilizing such a response type had risen to 11 per cent (Figure 1; Hails and Borum, 2003). Moreover, Du Pont and Cochran (2000) noted that special weapons and tactics (SWAT) team call-outs, officer injury rates, length of time on mental health crisis calls, and arrest rates of individuals with mental illness decreased in

Figure 1



Sources: Deane *et al.* (1999); Hails and Borum (2003)

Memphis, Tennessee after CIT was implemented. They also observed that the arrest rate of such individuals by Memphis CIT was about 2 per cent, far lower than that of other types of specialized responses to mental health emergencies. Vickers (2000) similarly found that, following implementation of CIT, violence was lower and recidivism of offenders with mental illness was less than 15 per cent on average. Other jurisdictions have reported similar findings. For example, Albuquerque, New Mexico SWAT call-outs decreased by 58 per cent, police use-of-force declined, and public confidence and support increased after CIT was instituted (Bower and Pettit, 2001). In addition, the arrest rate of individuals with mental illness was under 10 per cent.

Skeem and Bibeau (2008) reported that use of force by CIT officers was positively correlated with violence potential (e.g. making threats, being intoxicated, access to a weapon) of the such individuals in crisis. However, officers used force in only 15 per cent of 189 high-risk cases. In addition, the utility of CIT training in enabling police to more accurately identify individuals with mental illness in need of hospitalization has been documented (Straus *et al.*, 2005).

By contrast, Akron, Ohio CIT and non-CIT officers did not differ with regard to arrests of individuals with mental illness (Teller *et al.*, 2006). This discrepancy in findings could be due to the use of dispatch records, rather than the officers' incident/arrest reports which contain more detail. Also, the Akron CIT program had been active for only about two years at the time of the study; the Memphis program was nearly 12 years old when most of its research was conducted.

Officer perspectives

Another source of support for the efficacy of CIT comes from perspectives and feedback of police officers themselves. A survey from Australia suggests that officers who did not have CIT training felt unprepared and unsupported in dealing with mental health issues (Fry *et al.*, 2002). Similarly, officers from 35 Texas police departments identified several situations involving individuals with mental illness that they rated as being more difficult to handle than routine calls (Peck, 2003). Moreover, these officers indicated that they needed more training in behavioral cues indicative of mental illness, response strategies for mental health crises, appropriate approach techniques, and clarification of use-of-force procedures (Peck, 2003). Thus, it appears that officers recognize the shortcomings in their training relating to such individuals in crisis. Interestingly, CIT officers generally do not express these concerns.

For example, Borum *et al.* (1998) found that the Memphis CIT officers felt prepared to handle mental health crisis calls. In fact, CIT officers felt better able to maintain community safety, divert individuals with mental illness from prison, and meet their needs, than officers using other response strategies (Borum *et al.*, 1998).

Comparing officers' attitudes before and after CIT training has shown that participants gain knowledge regarding the mental health system and its resources, demonstrate more realistic and less stigmatizing attitudes toward mental illness, and have increased confidence in their ability to deal with individuals with mental illness (Compton *et al.*, 2006; Wells and Schafer, 2006).

Limitations

Although most of the research regarding CIT supports its efficacy for both the community and law enforcement, there are limitations. First, the amount of research conducted on CIT has been somewhat limited, which is most likely due to the relative newness of this approach. Further, much of the evidence collected has been anecdotal and/or descriptive, with the exception of studies of stigma reduction and attitude changes. Bahora *et al.* (2008) provide an example of such a study. Additionally, very few replications of studies have been attempted, despite replicable study designs. However, a recent review of CIT research concluded that the program is effective in connecting those who need psychiatric assistance with such services, improving officers' knowledge and attitudes regarding the mentally ill, and increasing officers' confidence when handling mental health emergencies (Compton *et al.*, 2008). Thus, there is a convergence of support attesting to CIT as the current best practice for the law enforcement response to mental health issues.

Future research is needed to focus on specific encounters and utilize control and/or comparison groups (e.g. outcomes of mental health emergency calls between CIT and non-CIT officers). In addition, investigative efforts should involve collecting data from CIT officers and their agencies concerning:

- their interactions with individuals with mental illness, before and after CIT training;
- number of officer/subject injuries;
- prison diversions; and
- rate of psychiatric hospitalizations.

Summary and conclusions

Police officers are frequently called upon to deal with situations involving individuals with mental illness. However, law enforcement professionals generally have been inadequately trained or prepared to effectively deal with these individuals (Tucker *et al.*, in press). Consequently, there have often been negative outcomes of such encounters, including increased violence, heightened criminalization and incarceration of the individuals with mental illness, and lack of adequate mental healthcare. In response, law enforcement agencies have utilized three basic types of specialized response to mental health emergency calls: mental health-based mental health responses, police-based mental health responses, and police-based police responses. CIT is an example of the latter response type. It involves collaborative relationships with local mental healthcare providers, policy makers, and mental health consumers, as well as specialized training for officers in the area of mental health issues, crisis management/intervention, and de-escalation skills. Research supporting the CIT model has generally shown improved officer and community safety, better mental healthcare for those in need, and decreased criminalization of the mentally ill. While research in this area remains in the nascent stage, preliminary evidence suggests that CIT is effective in keeping individuals with mental illness out of prison, reducing violence, decreasing injuries to both officers and individuals with mental illness, and connecting service users with mental illness to healthcare services they need.

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