

CIT Training: Recommendations for Effective Implementation of Policies and Procedures

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CIT Training: Recommendations for Effective Implementation of Policies and Procedures

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## **Abstract**

CIT Training: Recommendations for Effective Implementation of Policies and Procedures.

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### **Statement of Problem**

Crisis Intervention Training (CIT) involves a significant collaboration between law enforcement and local mental health services. However the CIT program and subsequent research has not specifically identified the factors related to effective policy implementation at the local law enforcement level. The practice of the CIT model seems promising, but the full effectiveness of CIT may be reduced if structured policy implementation is not in place for law enforcement and their partnerships with mental health facilities. Identifying what factors are associated with effective CIT for police officers will improve implementation of effective policy and procedures related to a system wide approach for responding to mentally ill subjects in crisis.

### **Method of Approach**

Secondary data as well as a review of empirical data has been used to research the methods of CIT. In addition, the CIT 40 hour police officer training has been reviewed to gather additional information on the direct approach taken to train law enforcement officers to better respond to consumers in crisis. Additionally this research includes descriptions of implementation processes used to address a system wide approach to using a CIT method to respond to consumers.

**Results of Study**

Although promising, the CIT program is not without shortcomings. The literature relative to CIT highlights the limiting factor that no empirical research exists that shows the program is actually effective. Additionally, some police administrators have expressed concern about creating a specialty unit to address common place calls for service with consumers and the fiscal concerns that a 40- hour training may present. However, studies have shown that officers support the training the 40- hour CIT training. Officers indicate that the training provides for greater understanding of mental illness, assists in the destigmatizing of mental illness, and offers education concerning the skills that are essential to successfully handling calls for service with consumers (Lord et al., 2011). Additionally, the CIT concept operates on the premise that CIT trained officers will have the ability to more safely manage calls for service with consumers experiencing a mental health crisis. The core elements of the CIT program, consisting of ongoing, operational, and sustaining elements, provide law enforcement administrators with a guideline for implementing an all encompassing CIT program. Police administrators have the ability to carefully study the information presented in this paper to identify the factors that will improve effective implementation of policy and procedure as it relates to successfully responding to consumers.

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**Section I: Introduction****Introduction**

Through the course of their required duties law enforcement officers often encounter individuals suffering from mental illness (hereafter referred to as “consumers”). These encounters vary from consumers being considered witnesses, to being crime victims, and/or suspects involved in calls for police service. A variety of researchers have estimated that between 6-16% of the total public contacts involving law enforcement officers are with consumers (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003; Lord, Bjerregaard, Blevins, & Whisman, 2011). Calls for service with consumers present difficult challenges for law enforcement officers due to the fact that consumers do not respond well to traditional police tactics (Lord et al., 2011). However police officers are expected to reach a traditional outcome, for example an informal resolution or arrest, regardless of these challenges (Lord et al., 2011).

The historical perspective related to increased police contact with consumers dates back nearly 50 years with the deinstitutionalize movement (Wells & Schafer, 2006). In the 1960’s state psychiatric hospitals across the nation began to deinstitutionalize the mentally ill, placing them back into the community, and at the same time stricter legal restrictions were put in place to commit or confine persons believed to be suffering from a mental illness. Proponents for deinstitutionalization believed that consumers were better served through treatment programs that were community-based versus institutionally based (Wells & Schafer, 2006). However, police contact with consumers increased while training police on how to effectively handle situations with consumers did not. As a result growing numbers of consumers were incarcerated and entered a criminal justice system that was unable to sufficiently provide mental health services. To emphasize this concern, a recent estimate showed that each year nearly one million

consumers are booked into jail, which is 1.5 times greater than the number of consumers that are hospitalized for psychiatric disorders (Fisher & Grudzinskas Jr., 2010).

To address the challenges associated with effectively dealing with consumers the Crisis Intervention Training (CIT) program was developed. The impetus for the creation of CIT came on the heels of the tragic fatal shooting of a consumer, who suffered from major psychiatric and substance abuse problems, by the Memphis, Tennessee Police Department in 1988 (Fisher & Grudzinskas Jr., 2010). After this tragic event, community leaders united to develop a program that allowed the community to effectively respond to the needs of the mentally ill. CIT was formulated with the input of the Memphis Police Department, the University of Tennessee Psychology Department, representatives from the University of Memphis, the National Alliance for the Mentally Ill, mental health facility managers within Memphis, and local citizens (BJA, 2000). The result was a CIT program with the mission of building partnerships between law enforcement and mental health facilities. The most advantageous CIT program is one that includes specialized officer training to include officers working all shifts; a close partnership between law enforcement and mental health facilities; and improved emergency psychiatric services that include a mobile crisis team that can assist officers in the field, and/or a 24/7 no refusal mental health drop-off facility (Lord et al., 2011).

Over the past two decades the CIT model has multiplied across the nation with over 1,000 programs in operation throughout United States as well as some other countries (Lord et al., 2011). However, currently there is a lack of evidence-based research that confirms the factors that are most effective when implementing CIT within a community utilizing a system wide approach. Although the CIT concept shows tremendous potential and has produced data showing reduction in the practice of incarcerating consumers, questions still remain such as:

what factors relating to collaboration are the most effective at reducing criminalization of the mentally ill and providing them with the appropriate services and what factors need to be present for law enforcement agencies to effectively implement policy and procedure related to CIT?

### **Statement of Problem**

CIT involves a significant collaboration between law enforcement and local mental health services. However the CIT program and subsequent research has not specifically identified the factors related to effective policy implementation at the law enforcement level. The practice of the CIT model seems promising but the full effectiveness of CIT may be reduced if structured policy implementation is not in place for law enforcement and mental health facilities.

Identifying what factors are associated with CIT for police officers will improve implementation of effective policy and procedures related to a system wide approach for responding to mentally ill subjects in crisis.

### **Purpose of the Study**

Police officers are considered the first responders to those consumers who are experiencing a mental health crisis. Therefore, it is imperative that law enforcement leaders across the nation have access to the most comprehensive information available associated with the factors that produce an effective CIT response. Identifying these factors will allow law enforcement leaders to understand the importance of having officers who truly understand the most effective way to communicate and relate to consumers, so consumers can receive the assistance they need and law enforcement officers can effectively address the needs of the community. By identifying these factors, law enforcement leaders will be able to produce and implement effective policy. It is the anticipation of this writer to identify factors that law

enforcement policymakers can use to define and structure comprehensive procedures for their law enforcement department to use when implementing CIT. This writer anticipates that the direction of this seminar research project will encourage other researchers to develop studies that identify factors that will assist in the system wide community approach to full implementation of policy and procedure associated with CIT.

### **Significance and Implication**

Within the mental health advocacy community a notion has developed that the criminalization of behavior exhibited by the mentally ill is an indication of poor police training and inadequate or inaccessible mental health services (Fisher & Grudzinskas Jr., 2010). Additionally, studies have identified that consumers are exceptionally vulnerable to systemic criminalization. Furthermore as previously noted the criminal justice system does not have the ability to provide proper services for consumers. Due to the lack of adequate mental health services within the criminal justice system consumers are at risk of the recurrence of the symptoms that caused them to have police contact, therefore the cycle of recidivism likely will occur (Lord et al., 2011). The frontline personnel within the criminal justice system and law enforcement who have the initial contact with consumers who are in crisis must have the proper policies, procedures, and training in place to make a positive and accurate impact on consumers who are typically in need of mental health services and not the throws of the criminal justice system.

**Method of Approach**

Secondary data as well as a review of empirical data will be used to research the methods of Crisis Intervention Training. In addition the CIT 40 hour police officer training will be reviewed to gather additional information on the direct approach taken to train law enforcement officers to better respond to consumers in crisis. Additionally this research will include descriptions of implementation processes that attempted to address a system wide approach to using a CIT method to respond to consumers.

## **Section II: Literature Review**

The following literature review is divided into eleven sections starting with an explanation of the deinstitutionalization movement. The review continues with research focusing on the improvement in response to those with mental illness including law enforcement, the courts, corrections and the impact of information sharing. Additionally the description of pre and post-booking diversionary programs is provided along with an explanation of the development of the Crisis Intervention Team (CIT) concept.

### **Law Enforcement and the Mentally Ill**

Law enforcement officers have frequent contact with consumers who have a mental illness. It is estimated that nearly 6% percent of individuals that law enforcement agencies consider suspects have mental illness (Morabito, Kerr, Watson, Draine, Ottati, & Angell, 2010). Additionally, Morabito et al., (2010) report that many police officers feel that encounters with the mentally ill are outside of their proficiency and they believe that they are unprepared to properly deal with these situations. Furthermore, officers often lack knowledge associated with the services that are available for consumers experiencing a mental health crisis (Lord et al., 2011). Lastly, calls for service involving consumers have had a propensity for the use of force due to officers responding to consumers with the same tactics that they would use for any other encounter (Morabito et al., 2010). At times these tactics do not gain the desired response from consumers and officers escalate their level of force to gain compliance, which can result in injury or death (Morabito et al., 2010). Due to these circumstances, consumers with mental illness are often times arrested and face criminal charges when what they could have utilized were mental

health services to address their mental health condition (Borum, Williams, Deane, Steadman, & Morrissey, 1998).

To address the mounting issues of law enforcement responding to consumers with mental illness the criminal justice and mental health services profession have collaborated to improve responses to the mentally ill (Wells & Schafer, 2005). Strategies have developed that have brought mental health service providers to the scene of a consumer in crisis. Other programs have developed where a crisis team works in conjunction with law enforcement officers. One of the most notable programs that have emerged in the field of improving response to those with mental illness is the Crisis Intervention Team concept. This concept is a system wide approach to effectively deal with consumers who are experiencing a mental health crisis and law enforcement has been called upon to respond to the scene. The goal of the CIT program is to better officers' interactions with those with mental illness and to improve the safety of all individuals involved (Ellis, 2011). The development of CIT is the result of nearly a half century of circumstances that have placed law enforcement and consumers at the heart of an important societal issue that needed to improve.

### **Deinstitutionalization of Consumers with Mental Illnesses**

While studying law enforcement responses to consumers with mental illnesses it becomes imperative to possess a firm understanding of the historical perspectives that relate to how police officers have responded to these consumers in crisis. Thompson, Reuland, and Souweine, (2003) indicate that increasing numbers of consumers with mental illnesses have come in contact with the criminal justice system over the past several decades. To understand why requires insight in the major change in mental health policy that occurred in late 1950's and early 1960's.

During a special message to congress in February of 1963, President John F. Kennedy presented a plan for a national community health program. The plan, the Community Mental Health Centers Act of 1963, called for a 50% or more reduction of the number of mental health patients within custodial care within 10 to 20 years (Mechani & Rochefort, 1990). A premise behind this congressional act was that the proposed redirection of mental health patients into the community would symbolize scientific and humanitarian progress, doing away with institutional confinement (Mechani & Rochefort, 1990). With this, the deinstitutionalization movement began, and over the next four decades the population of U.S. state mental hospitals went from 559,000 patients in 1955 to less than 80,000 patients in 1995. This reduction in custodial mental health patients occurred in part due to a shift in the strategy of how to best treat those with mental illness. The concept of providing these patients with the least restrictive placement and community based support, instead of institutional care and isolation became the mission of the mental health care profession.

However, this mental healthcare strategy came with the inherent consequence of more consumers having contact with the criminal justice system. For community based support to be productive and successful for consumers, the support has to be readily accessible. According to Mechanic and Rochefort (1990) this seemed to be the case in the late 1960's and early 1970's with the expanse of social welfare options such as Medicaid, housing programs, food stamps and Supplement Security Income. In time, these programs have undergone reductions while the number of consumers with mental illnesses continued to grow (Mechanic & Rochefort, 1990). Thus, the lack of community based resources and the reduced ease of obtaining these resources led consumers with mental illnesses to become an even more vulnerable part of the population leading to increased contact with the criminal justice system.

The deinstitutionalization movement was controversial in part due to the difficulty that mental health patients had integrating into society (Ellis, 2011). State hospitals released mental health patients without providing them with transition skills to adapt to life outside of a mental health facility (Douglas & Lurigio, 2010). The lack of adaptation skills left many mental health patients unfit to conform to the norms of society. These patients were now in need of case management, social work, and psychiatric services (Ellis, 2011).

The deinstitutionalization movement had a simple goal of creating opportunities for mental health patients that integrated them into communities while providing them with care and resources. According to Draine, Wilson, and Pogorzelski (2007) this idea failed to take into account the changes to budgetary and demographic circumstances that come with moving large numbers of people into the community. Consumers with mental illness experienced difficulties in actually receiving the services that they needed. With this gap in treatment access young consumers took on a greater risk for a mental health break down and their first criminal arrest (Draine, Wilson, & Pogorzelski, 2007). Whereas prior to decriminalization these individuals may have been institutionalized, thus limiting their exposure to the criminal justice system during these formative and vulnerable years.

Researches cited homelessness as being a circumstance of the reduced public assistance available to consumers with mental illnesses. Subsequently research has shown that nearly 20-25% of the single adult homeless population endures severe and/or continual mental illness (Thompson et al., 2003). Thus disruptive behavior by homeless individuals often times requires the response of law enforcement services. Additionally, according to Thompson et al., (2003) a recent increase in the enforcement of quality of life infractions such as possession of illegal

narcotics have earned many consumers, specifically those with substance disorders, a place within the criminal justice system.

The increased likelihood of consumers having contact with law enforcement correlates to consumers having an increased chance of entering into the criminal justice system; a system that is ill-equipped to effectively provide the proper services that consumers need (Thompson et al., 2003). According to Thompson et al., (2003) consumers' mental illness can deteriorate and lead to additional misbehavior that lengthens their time within the criminal justice system. Without proper mental health services and acceptable transition planning, recidivism among consumers is likely. In some jurisdictions the recidivism rate for inmates with mental illness has topped 70% (Thompson et al., 2003). With community based support being the primary mechanism to treat and assist consumers, the criminal justice and the mental health systems are tasked to collaborate and find better ways to address situations related to those with a mental illness.

### **Improving Responses to People with Mental Illness**

Acknowledging the need to improve responses to consumers with mental illnesses, the Council of State Governments formed the Criminal Justice/Mental Health Consensus Project (Thompson et al., 2003). Between 2000 and 2002 the Council of State Governments partnered with numerous associations within the criminal justice and mental health professions to develop policy suggestions to improve the response to consumers who are in contact or at a risk of being in contact with the criminal justice system (Thompson et al., 2003).

As a result of this consensus project, numerous policy statements were developed that were presented to service organizations and policy makers who have an impact on how organizations respond to consumers (Thompson et al., 2003). Interestingly, the Criminal Justice/Mental Health Consensus Project identified that from a consumers first involvement with

mental health professionals, to their initial contact with law enforcement, to the court process, incarceration, and reentry into society, numerous opportunities exist for improvement to how the mental health and criminal justice systems responded and reacted to those individuals whose mental illness facilitated their path into the criminal justice system. Additionally, this project developed recommendations for each entity involved in responding to consumers: the mental health system, law enforcement, the court system, and corrections.

The efforts of the mental health system to better improve their response to their clients takes on a varied approach as identified by the Criminal Justice/Mental Health Consensus. The primary focus of the mental health system is to not only provide effective and inclusive services but also to make them highly available to consumers. Thus, improvements in this area of mental health services may assist consumers in the avoidance of contact with the criminal justice system. Thompson et al (2003) indicated that recommendations related to mental health services include developing programs for consumers who were incarcerated and are reentering the community, and recognizing that these services may need to be specialized and may need to last as long as necessary.

**Table 1. Mental Health Policy Statements**

<b>Event/Issue</b>	<b>Policy Statement Number</b>	<b>Policy Statement</b>
Access to effective health services	1	Improve availability of and access to comprehensive, mental individualized services when and where they are most needed to enable persons with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement
Maintaining contact between individual mental health system	23	Ensure that people with mental illness who are no longer under supervision of the criminal justice system maintain contact with mental health services and supports for as long as is necessary

*Note.* Mental Health Policy Statements. Adapted from “Criminal Justice/Mental Health

Consensus: Improving Responses to People with Mental Illness,” by Michael D. Thompson and

Melissa Reuland and Daniel Souweine, 2003, *Crime & Delinquency*, Vol 49, p. 36. Copyright 2003 by Sage Publications.

Research has suggested that historically law enforcement agencies have done little in the way of collaborating with mental health service providers to improve responses with consumers (Wells & Schafer, 2006). Since the mental health system factors prominently in the disposition of calls for service involving consumers, contingencies such as poor relationships between mental health service providers and law enforcement, inadequate mental health services, or inaccessibility of mental health services are all aspects that are a detriment to proper services being provided to the mentally ill (Wells & Schafer, 2006). Additionally, police agencies may feel that the community based options that are available do not properly address the issues being faced by consumers and thus the calls for service continue to occur. Lastly, options put in place by mental health and police collaborations can sometimes be time consuming and carry the perception of being ineffective (Wells & Schafer, 2006).

The Criminal Justice/Mental Health Consensus results revealed that law enforcements contact with consumers typically occurs in five basic situations: as a crime victim, as a subject of a nuisance call, as a witness to an incident, as an offender, or as a danger to themselves (Thompson et al., 2003). The policy statements related to law enforcement stress the high importance of the safety for all individuals involved in calls for service that include a consumer, the consumer's family members, bystanders, and law enforcement officials. The conclusion to a call for service with a consumer should include resolving the problem by treating those with mental illness fairly and with dignity.

**Law Enforcement Approaches to Dealing with Consumers**

The Criminal Justice/Mental Health Consensus report identified four universal approaches that could be utilized when a law enforcement officer responds to a call for service involving a consumer. The first approach involves a crisis intervention team concept where officers are specifically trained to handle the circumstances resulting in the call. Additionally this concept would be built around partnerships with other resources within the mental health field. The second approach identified involves mental health professionals riding along with on duty officers and responding to calls involving consumers as a team. This approach could also include a system where mental health professionals respond when they are notified after the scene is deemed safe. The third approach consisted of a mandatory 40-hour training course for all officers within the department that consists of instruction on how to effectively handle calls for service that involve a consumer experiencing a mental health crisis. The fourth approach called for a county-wide mobile crisis response team that would respond when requested and would assist officers in determining if the consumer met the requirements for a mental health detention (Thompson et al., 2003). These recommendations represent options for police administrators to consider when developing policies for officers to follow when responding to calls involving mental health crisis.

**Table 2. Law Enforcement Policy Statements**

<b>Event/Issue</b>	<b>Policy Statement Number</b>	<b>Policy Statement</b>
Request for police service	2	Provide dispatchers with tools to determine whether mental illness may be a factor in call for service and to use that information to dispatch the call to the appropriate responder
On-scene assessment	3	Develop procedures that require officers to determine whether mental illness is a factor in the incident and whether a serious crime has been committed – while ensuring the safety of all parties involved
On-scene response	4	Establish written protocols that enable officers to implement an appropriate response based on the nature of the incident, the behavior of the person with mental illness, and available resources
Incident documentation	5	Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery
Police response evaluation	6	Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement

*Note.* Mental Health Policy Statements. Adapted from “Criminal Justice/Mental Health

Consensus: Improving Responses to People with Mental Illness,” by Michael D. Thompson and Melissa Reuland and Daniel Souweine, 2003, *Crime & Delinquency*, Vol 49, p. 37. Copyright 2003 by Sage Publications.

### **The Courts, Corrections, and Information Sharing**

During a call for service involving a consumer, the initial response by law enforcement officers substantially factors into the success of the outcome. However, consumers may find themselves involved in the court system and facing charges based on an arrest by law enforcement. The court system often has a substantial impact on services, or the lack there of, that are provided to the consumer. The Criminal Justice/Mental Health Consensus reported that information sharing is a vitally important component for judges, prosecutors, and defense attorneys when consumers are immersed in the criminal justice court system. As stated by the Criminal Justice/Mental Health Consensus, without the proper information explaining a

defendant's mental illness, prosecutors may not be able to consider recommendations that may assist the defendant in prospering in a mental health diversion program (Thompson et al., 2003).

**Table 3. Courts Policy Statements**

<b>Event/Issue</b>	<b>Policy Statement Number</b>	<b>Policy Statement</b>
Appointment of counsel	7	Defense attorneys should be aware of (a) the mental health condition, history, and needs of their clients as early as possible in the court process; (b) the current availability of quality mental health resources in the community; and (c) current legislation and case law that might affect the use of mental health information in the resolution of their clients' cases
Consultation with victim	8	Educate individuals who have been victimized by a defendant with a mental illness, or their survivors, about mental illness and how the criminal justice system deals with defendants with mental illness
Prosecutorial review of charges	9	Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases
Modification of pretrial diversion conditions	10	Assist defendants with mental illness in complying with conditions of pretrial diversion
Pretrial release/detention hearing	11	Maximize the use of pretrial release options in appropriate cases of defendants with mental illness so that no person is detained pretrial solely for the lack of information or options to address the person's mental illness
Modification of pretrial release conditions	12	Assist defendants with mental illness who are released pretrial in complying with conditions of pretrial release
Intake at county/municipal detention facility	13	Ensure that the mechanisms are in place to provide for screening and identification of mental illness, crisis intervention and short-term treatment, and discharge planning for defendants with mental illness who are held in jail pending the adjudication of their cases
Adjudication	14	Maximize the availability and use of dispositional alternatives in appropriate cases of persons with mental illness
Sentencing	15	Maximize the use of sentencing options in appropriate cases for offenders with mental illness

*Note.* Mental Health Policy Statements. Adapted from "Criminal Justice/Mental Health

Consensus: Improving Responses to People with Mental Illness," by Michael D. Thompson and

Melissa Reuland and Daniel Souweine, 2003, *Crime & Delinquency*, Vol 49, p. 40. Copyright 2003 by Sage Publications.

The release of medical information, specifically mental health information, to the courts system comes with unique challenges. From a defense attorney's perspective, it may not seem beneficial to have a client's mental health information provided to the courts. Depending on the circumstances of what brought the consumer to the courts, he/she may not consent to releasing their mental health records to a criminal court where open records laws apply. It becomes vitally important that judges, prosecutors, and defense attorneys are accustomed with mental illness, available mental health services, and applicable case law (Thompson et al., 2003).

Mental Health Courts have also been developed to aid in the response to the mentally ill that have found themselves in the criminal justice system. Mann (2011) conducted research related to the 196 mental health courts that were listed in the Criminal Justice/Mental Health Consensus database. Mann (2011) reported that these courts are structured in that they seek to understand where criminal responsibility is eclipsed by a consumer's mental instability. Mental health courts provide for an innovative intervention for consumers however mental illness and treatment options are complicated and these courts differ substantially from drug and OWI courts where recidivism and sobriety are a prominent focus (Mann, 2011). Nevertheless mental health courts hold promise and as their development continues they may prove to be a very functional aspect of the system wide response to consumers with mental illness.

The corrections area of the criminal justice system plays a vital role in responding to consumers with mental illnesses. As noted by Thompson et al., (2003) it has been difficult for the corrections system to specifically identify the exact number of people in prison or on supervision who are experiencing a mental illness. However, information from the Criminal

Justice/Mental Health Consensus indicates that community-based mental health services should be included in the corrections aspect of the criminal justice system (Thompson et al., 2003).

This partnership would include services to those not only on extended supervision but also to those who are in custody.

**Table 4. Corrections Policy Statements**

Event/Issue	Policy Statement Number	Policy Statement
Receiving and intake of sentenced inmates	17	Develop a consistent-approach uniform method to screen sentenced inmates for mental illness on admission to state prison or jail facilities and make referrals, as appropriate, for the follow-up assessment and for evaluation
Development of treatment plans, assignment to programs, and classification/housing decisions	18	Use the results of the mental health assessment and evaluation to develop an individualized treatment, housing, and programming plan, and ensure that this information follows the inmate whenever he or she is transferred to another facility
Subsequent referral for screening and mental health evaluation	19	Identify individuals who—despite not raising any flags during the screening and assessment process— show symptoms of mental illness after their intake into the facility, and ensure that appropriate action is taken
Release decision	20	Ensure that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release
Development of transition plan	21	Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community
Modification of conditions of supervised release	22	Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release

*Note.* Mental Health Policy Statements. Adapted from “Criminal Justice/Mental Health

Consensus: Improving Responses to People with Mental Illness,” by Michael D. Thompson and Melissa Reuland and Daniel Souweine, 2003, *Crime & Delinquency*, Vol 49, p. 41. Copyright 2003 by Sage Publications.

For the criminal justice system to improve responses to those with mental illness, many factors and components are involved for the different entities that make up the criminal justice system. Specifically, information from the Criminal Justice/Mental Health Consensus included the following areas to be of high importance: collaboration, training, and an effective mental health system. A multitude of promising programs have developed that address services for consumers with mental illnesses that become involved in the criminal justice system.

### **Pre-Booking and Post-Booking Diversion Programs for the Mentally Ill**

Many strategies have been recommended for handling individuals with mental illnesses that are involved in the criminal justice system. The percentage of jail inmates that have serious mental illness hovers between 6%-16% compared to the general adult population at 7.3% (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003). When adding substance abuse to these percentages, almost 75% of those incarcerated with serious mental illness have alcohol and/or drug use problems. Comparatively, out of the general adult population that has serious mental illness, about 25% have a co-occurring substance abuse problem. This disparity highlights the need for diversionary programming. Strategies that have been developed to address the issue of mental illness coupled with substance abuse have consisted of pre-booking and post-booking diversion programs.

Diversionary programs are structured endeavors that seek to distinguish individuals with serious mental illness, as well as those with substance abuse issues, and divert them from the conventional criminal justice conduit to mental health and substance abuse services (Lattimore et al., 2003). In pre-booking diversion programs, police officers who respond to a call for service for an individual with a mental illness must use their discretion on how to properly deal with the individual. The police officers may have the support of a collaborative system of mental health

services that can be called upon to provide the individual with the proper system of care without having them further involved in the criminal justice system. However, it is important to note that not all jurisdictions have these available services. In contrast, post-booking diversion systems occur when an individual has been arrested and booked. These individuals are typically screened and assessed and then discussions begin between diversion program personnel and criminal justice staff where the development of a mental health treatment disposition occurs (Lattimore et al., 2003). Although a wide variety of pre and post-booking diversionary programs exist the objective of these programs is to identify consumers with serious mental illness and provide them needed services (Lattimore et al., 2003).

### **Section III: Crisis Intervention Team Program**

The following section explains the development of the CIT program. This section includes factors that influence CIT development along with factors which influence the use of force when officers deal with consumers. Additionally, this section includes information concerning the importance of emergency dispatchers, the need for law enforcement training, officer safety, and factors influencing mental health service provider response. Lastly the CIT program is examined, followed by information concerning the limitations of the current research and alternatives to CIT.

In the fall of 1987, officers with the Memphis, Tennessee police department responded to a call for service involving a young man with a history of mental illness. Upon arrival, officers observed that the man had self inflicted injuries and was holding a weapon in his hand. The man refused to drop the weapon after repeated verbal commands from the police officers. The man became upset and ran at a police officer with the weapon still in his hand. Fearing for his own safety, the officer fired his handgun striking and killing the individual (BJA, 2000).

This incident activated an increased effort to develop a program that provides a structured relationship between law enforcement and mental health services. The result in Memphis was collaboration between the Memphis Police Department, the University of Tennessee Psychology Department, representatives from the University of Memphis, the National Alliance for the Mentally Ill, mental health facility managers within Memphis, and local citizens (BJA, 2000). The result of this collaboration was a Crisis Intervention Team (CIT) program with the mission of building partnerships between law enforcement and mental health facilities, improve the safety of the police and community, minimize unnecessary criminal justice involvement for

those with mental illness, and increase the redirecting of individuals with mental illnesses from the criminal justice system to mental health services (Fisher & Grudzinskas Jr., 2010).

The structure and approach of a CIT program includes several elements: advanced training, officer and consumer safety, instantaneous crisis response, and the delivery of appropriate mental health care (Fisher & Grudzinskas Jr., 2010). A significantly important component to the operational elements of the Memphis CIT model is the 40-hour comprehensive training class that patrol officers receive. This training program includes de-escalation skill development, the recognition of the characteristics of mental illness, and information describing the local community mental health resources and services that officers can utilize when responding to a mental health crisis (Ritter et al., 2010). The 40-hour training class consists of didactics and lectures, on-site visits, practical skill training, questions and answers, and commencement and recognition (University of Memphis CIT Center, 2007). More specifically the 40-hour CIT training delves into specified areas of study that provide officers with specialized knowledge. The following areas are covered within the didactics and lectures (University of Memphis CIT Center, 2007):

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post Traumatic Stress Disorders
- Legal Aspects of Officer Liability
- Community Resources

The CIT training program is designed to modify officer's attitudes concerning people with mental illness and to supply these officers with the proficiency to better deal with calls for service involving consumers with mental illness (Ritter et al., 2010).

**General Overview of a CIT Program**

The most advantageous CIT program is one that includes specialized officer training to include officers working all shifts; a close partnership between law enforcement and mental health facilities; and improved emergency psychiatric services that include a mobile crisis team that can assist officers in the field, and/or a 24/7 no refusal mental health drop-off facility (Lord et al., 2011). Fisher and Grudzinskas Jr., (2010) cited Deane et al., 1999 in their explanation of the CIT model as the most visible pre-booking diversion program in the United States.

**Factors Influencing the Response of CIT**

With the advent of CIT programs, officers are being provided with a structured, systematic, multi-disciplinary approach to effectively deal with calls for service that involve a consumer experiencing a mental health crisis. The CIT program model has been praised for its potential to obtain desired intervention for consumers with reduced arrests and injury to all involved. The CIT program is thought to reduce time and costs associated with the system wide dealing of all entities involved in the criminal justice system (Lord et al., 2011).

Although the CIT program model has shown tremendous potential in the improvement of law enforcement's handling of mental health crises, many factors influence the proper implementation of the program and the dispositional decision made by officers. Organizational characteristics that effect the implementation of CIT start with the size of the agency. According to Lord et al, (2011) factors such as differences in the degree of professionalism, organizational differences, policing styles and arrest rates, police expenditures, police resources, technology and equipment, expense, travel and shift coverage related to training, diversity of personnel, and community/police relationships all factor into the proper implementation of CIT.

Additionally, dispositional factors are inherent in each and every situation where police officers deal with consumers. These factors include the characteristics of the consumer; the specifics of the reason the police were called; demographic information, such as the race and sex of the consumer; and if substance use occurred during or prior to the incident. These factors will influence whether an officer diverts, arrests, involuntarily commits, or attempts to influence a voluntary commitment, or attempts to informally handle the situation (Lord et al., 2011). Although the CIT model has shown promise when fully implemented, multiple factors are present that pose hurdles for communities that are trying to institute collaborative efforts to more effectively respond to the needs of consumers.

### **Factors influencing the Use of Force**

A founding principle of the CIT concept was to reduce violent encounters between law enforcement officers and consumers experiencing a mental health crisis. Although the use of force is a relatively uncommon event, occurring in less than 1% of incidents that law enforcement officers respond to, it receives a disproportionate amount of attention, coverage, and study (Morabito, Kerr, Watson, Draine, Ottati, & Angell, 2010). However this does not negate the importance of police use of force as it relates to consumers with mental illnesses, as previously cited, the shooting of the consumer in crisis led to the development of CIT. However, the question remains whether the utilization of the CIT program will reduce use of force encounter between law enforcement and consumers with mental illnesses.

Although no empirical study exists that measures the effect of an intervention option such as CIT on the use of force during encounters with consumers experiencing a mental health crisis, the notion that CIT training will better assist officers in recognizing the signs of a person experiencing a mental crisis is promising in reducing use of force (Morabito et al., 2010).

Situational factors play a key role in the decision making process that law enforcement officers go through when deciding if force is needed during an encounter. However, often times, consumers experiencing a mental health crisis may behave in a bizarre manner, acting hostile or nonresponsive. If, through CIT training, law enforcement officers are able to better recognize these behaviors as being related to mental illness, these encounters may result in less formal conclusions, including reduced use of force (Morabito et al., 2010).

### **Officers Perceptions of Responding to the Mentally Ill, Training, and CIT**

With law enforcement officers responding to numerous situations that involve consumers with mental illness it is increasingly important for officers to have the proper knowledge in understanding consumers and the dispositions that are made available to them. Training officers to properly respond to calls for service involving consumers experiencing mental health crisis is a critical component to providing consumers with the appropriate intervention. However, research highlights that pre service law enforcement officers do not obtain a sufficient amount of training concerning such an important area of service. According to Hails and Borum (2003) in a study of 70 police agencies with 300 or more sworn officers, the average training hours dedicated to responding to the mentally ill was 6.5 during pre service or recruit training. The same study showed that these agencies averaged one hour of in service training per year dedicated to the same topic. The authors indicate that due to the frequency of calls for service involving consumers and challenges that they pose, this amount of training is insufficient. Additionally, Hails and Borum (2003) indicated that the Police Executive Research Forum has suggested that the model police curriculum for instructing officers how to respond to consumers should be 16 hours in length.

Concerning responses to consumers with mental illness, Wells and Schafer (2006) conducted a study to measure officer perceptions to responding to these specific situations as well as perceptions toward CIT training. According to the authors' study, law enforcement officers expressed concern related to responding to consumers with mental illness in the following areas: inadequate and poorly focused training, inaccessible services, inadequate community-based referral options, and deficient relations with medical and mental health service providers. Additionally, due to these concerns a related consequence is the increased amount of time that is required by an officer to adequately respond to and handle a call for service where a mental health crisis is occurring. Due to these realities, mental health service providers, law enforcement agencies, and mental health advocates have started collaborative partnerships to better respond to the needs of the consumers experiencing crisis, like the CIT program.

An important concept related to CIT training is the response from officers who complete the training related to their knowledge and feeling of capability when responding to a consumer in a mental health crisis. Prior to receiving CIT training, officers reported that they felt unprepared and not able to properly meet the needs of consumers. After receiving the CIT training, officers overwhelmingly indicated that their preparedness level was much greater and they were better prepared to meet the needs of consumers. Additionally, officers reported that they believed they could effectively respond to a wide range of incidents involving consumers (Wells & Schafer, 2006). These training procedures are designed to provide officers with the skills to manage crisis situations in a flexible, proficient, and effective manner (Olivia, Morgan, & Compton, 2010).

The authors' note that in communities where effective mental health services exist and a strong relationship is in place between police agencies and service providers, police will

maintain a positive perspective toward providing consumers with mental illness the appropriate needed services (Wells & Schafer, 2006). Thus system wide improvements in these areas are likely to succeed. However in contrast, communities that do not share the same relationships or have accessibility to the proper services may not experience successful reforms, even if CIT training is implemented. Wells and Schafer (2006) indicate that findings suggest that CIT training has the possibility to change the characteristics related to interactions between law enforcement and consumers with mental illness. However the authors' indicate that whether this training can actually bring about system wide changes remains unseen.

### **Examination of the CIT Program**

The CIT program is a pre-booking diversion program that couples the services of law enforcement and mental health service providers (Lord et al., 2011). The CIT program consists of a wide variety of information that seeks to provide an optimal collaboration between law enforcement and mental health professionals where the appropriate needs are provided for consumers experiencing mental health crisis. According to Lord et al. (2011) a typical CIT program consists of a 40-hour training curriculum delivered to officers from all shifts who volunteer for the training, a 24 hour no-refusal drop off facility and/or a mental health mobile crisis team that assist officers during a CIT call. CIT programs are meant to enhance law enforcement training and provide officers with a better understanding of the recognition of mental illness and the dispositions that are available through a working collaboration with mental health services providers. In addition, CIT seeks to positively effect the system that is in place to respond to those suffering with mental illness (Wells & Schafer, 2006).

## **Emergency Dispatchers**

In order for CIT programs to be successful it is critical for all service providers who are involved with consumers with mental illness to understand their role and how their role can be utilized. Thus, dispatchers that are sending officers to a call for service involving consumers with a mental health crisis need to have the appropriate skills to decipher the call and dispatch the proper personnel. Dispatchers are often the first line of communication in an emergency situation, hence they need to be properly trained to recognize and appropriately dispatch calls for service (Compton, Broussard, Hankerson-Dyson, Krishan, Stewart, Olivia, & Watson, 2010).

Dispatchers provide a critical link in connecting police officers with consumers. Because it is important to include dispatchers in the CIT training that is developed for jurisdictions that employ a CIT response, the CIT core elements include a training component that is specifically designed for dispatchers (Compton et al., 2010). Many circumstances have been cited for why dispatchers have not been included in the initial training that law enforcement officers have received, including staffing and awareness. However, recent trends have shown that more law enforcement agencies have been cognizant of training dispatchers and recognizing the important part they play in providing the appropriate services to the consumers (Compton et al., 2010).

## **The Need for Law Enforcement Training**

When responding to calls for service involving a consumer experiencing a mental health crisis it is imperative that law enforcement officers have a proper understanding of the needs of the consumer. This can be a difficult factor for officers to understand if they lack formalized training related to responding to mental health emergencies. Many officers report that responding to consumers is outside of their expertise and they believe they are unprepared to effectively handle the situation (Morabito et al., 2010). Officers frequently report that calls for

service involving consumers are more difficult than non-consumer calls due to the following reasons: the perception of a heightened risk to both the officer and the consumer, unpredictability, lack of training, lack of knowledge concerning available resources, and time consuming (Lord et al., 2011). The resources needed to effectively provide the services that the consumer needs may seem to be outside the traditional scope of what an officer can provide (Morabito et al., 2006).

### **Officer Safety**

Officer safety is a paramount concern when responding to consumers. Although the perception that those in mental health crisis may pose a greater threat than those who are experiencing the same type of crisis may be just that, a perception, officer safety must be understood as a critical component to improving law enforcement response to those with mental illness. Training will likely improve an officer's abilities to identify and understand a consumer experiencing a mental health crisis and this may in fact reduce use of force. However, it is observed that law enforcement officers have long been trained to place their personal safety above all other concerns (Wells & Schafer, 2006). The authors' note that this may be an impediment in improving police officer response to consumers with mental illnesses due to deep-seated mindsets that focus solely on their own safety. Although this officer safety issue may be a factor in reforming police response to consumers with mental illnesses, of greater influence may be organizational perspectives that support police officers and offer them access to improved alternatives when dealing with consumers in a mental health crisis (Wells & Schafer, 2006).

Additionally, time constraints and the availability of services for consumers can factor greatly in law enforcement's response. Mental health related calls for service can consume an excessive amount of a police officer's time when compared to other calls for service. These calls

can also create a high amount of stress (Lurgio & Watson, 2010). Furthermore if particular jurisdictions do not have access to the resources needed by the consumer, additional frustrations can occur when law enforcement attempts to effectively respond to and assist the consumer.

### **Factors Influencing Mental Health Service Provider Response**

Although numerous factors play a role in the response of law enforcement to the needs of consumers, additional factors are present that affect the response of mental health service providers to consumers experiencing crisis. Factors such as the relationship that service providers maintain with law enforcement agencies; services that mental health providers are able to provide; funding; and structured programs, for example 24/7 no refusal drop off facilities; all determine the level of response that mental health service providers are able to give. Although by no means is this an exhaustive list of factors, they are critical elements involved in providing services to consumers with mental illnesses.

One of the first steps in improving the response to consumers experiencing a mental health crisis is for mental health services provider and law enforcement agencies to have a strong working partnership. These partnerships can be structured to address the unique needs of individual communities (Thompson et al., 2003). However, according to Wells and Schafer, (2006) officers have reported disappointment in the lack of accessibility to services and the nonexistence of a coordinated law enforcement/mental health service provider response to consumers in crisis. Additionally, the authors note that these two professions have been criticized for not developing significant partnerships designed to service the needs of consumers with mental illnesses. The fact that the relationship between mental health service providers and law enforcement is so critical to the success of responding to consumers in crisis so collaborative

partnerships have been initiated with the purpose of meeting the needs of consumers and steering them away from the criminal justice system (Wells & Schafer, 2006).

The partnership between law enforcement and mental health services providers is significantly impacted by the services that are available to meet the needs of consumers with mental illnesses. As law enforcement officers respond to calls for services involving consumers who are experiencing a mental health crisis, a successful outcome may hinge on the services that are available to the consumer. During the 2003 Criminal Justice/Mental Health Consensus Project, recommendations were made for mental health service providers that included improving the availability of and access to complete services for people with mental illness so that they can maintain meaningful membership within the community (Thompson et al., 2003). Secondly, the Consensus Project produced a recommendation for mental health service providers to maintain contact with those in need of mental health services for as long as they need contact to sustain mental health (Thompson et al., 2003). The recommendations highlight the importance and need of available services for consumers experiencing mental illness.

Various sources of literature concerning CIT programming stress the importance of structured services, such as a 24/7 no refusal drop off facility for consumers (Lord et al., 2011). The 24/7 no refusal drop off facility accomplishes two very critical goals for providing services for consumer with mental illnesses. First, the availability of this drop off site allows law enforcement the ability to properly handle a situation with a consumer where the officer can obtain the suitable services for the consumer without having to make a decision that would place the consumer in the criminal justice system (Fisher & Grudzinskas, 2010). Secondly, the availability of a 24/7 drop off facility allows for the consumer to swiftly begin receiving mental health services at their time of crisis. The ability for mental health service providers to maintain

a 24/7 no refusal facility greatly impacts the mental health response for consumers that are able to benefit from the provided services.

### **Limitations and Potential in Current Research**

The CIT program was developed to enhance law enforcement's knowledge and understanding of the mental health treatment system and the availability of resources to consumers suffering mental health crisis (Ritter et al., 2010). The CIT program is designed around partnership and education, providing resources and influence to the decisions made by officers in the field. However, many researchers note that empirical evidence to support the effectiveness of CIT does not exist (Fisher & Grudzinskas, 2010; Lord et al., 2011). Furthermore, Draine et al., (2007) highlights the fact of culpability for those suffering from mental illness and what the true measure is for who receives treatment as opposed to criminal sanctions. This crossroads is mostly neglected in research related to the police response to consumers experiencing mental health crisis. Nevertheless, the CIT program was rated more positively and perceived as more successful for keeping consumers with mental illness out of the criminal justice system and keeping the community safe when compared to other types of mental health response teams (Ritter et al., 2010).

### **Alternatives to CIT**

Similar models of crisis intervention have existed however the literature has almost exclusively reported on the Memphis CIT program. According to Steadman, Deane, Borum, and Morrissey (2000 as cited in Fisher and Grudzinskas Jr. 2010), compared differing models of mental health emergency response. They identified the Memphis CIT police based specialty unit, the Birmingham, Alabama police based mental health response using non sworn officers,

and the Knoxville, Tennessee mental health based specialized mental health response team made up of mental health workers with cooperative agreements between the police agency and the mental health service agency. Although the literature did not address the specifics of the alternative methods, the study did show that the Memphis CIT model produced more referrals and less arrests. The researchers attribute this data to the fact the Memphis had a 24-hour no refusal drop off site and the other jurisdictions did not (Fisher & Grudzinskas Jr. 2010).

Additionally, Fisher and Grudzinskas Jr. (2010) revealed that some police officials are reluctant to embrace the Memphis CIT model due to the creation efforts associated to a specialized team, fiscal concerns related to training and paying officers more for being considered specialized, and labor union issues concerning officer selection. The authors cite a police official with the New York City Police Department who indicated that he would favor a more generalist approach where a sufficiently trained officer could respond to nearly all situations presented to him or her. A generalist approach would allow for more officers and a greater availability of these officers to respond. If this were the case, however, these officers would not possess the expertise that would be afforded to officers who are provided the 40-hour CIT training (Fisher & Grudzinskas Jr. 2010).

## **Conclusion**

Research has well established that law enforcement officers spent a significant amount time responding to consumers who are experiencing a mental health crisis. One such call for service in Memphis, Tennessee resulted in the consumer being shot and killed by police officers, prompting reform in the way law enforcement responds to these calls for service. The result was the development of the Crisis Intervention Team concept, a system wide approach to properly responding to consumers facing mental health crisis. Although empirical evidence does not exist

to support the effectiveness of CIT, the program has gained popularity and shows promise as an innovative approach to successfully and safely respond to consumers and provide them with the needed services.

**Section IV: Recommendations**

When requested to respond to a consumer experiencing a mental health crisis, traditionally law enforcement officers have had a lack of training and feasible non-incarceration options. Thus programs, such as CIT, which seek to improve the response to consumers, seem to be poised to have positive effects (Wells & Schafer, 2005). Law enforcement leaders are challenged to develop the best policies and procedures that allow for a system-wide response to consumers experiencing a mental health crisis. Optimally, the most advantageous policies developed by law enforcement leaders will be those that lead consumers to mental health services and away from the criminal justice system.

Within the law enforcement profession, the CIT model has gained significant popularity as a response to consumers who are experiencing a mental health crisis. However, in order for the CIT concept to be productive, a considerable collaboration must exist between three key groups: law enforcement, mental health advocates, and mental health service providers. Best practice methodology must be utilized to obtain the most desired results when law enforcement officers are called to the scene of a consumer in crisis. The Memphis model for CIT implementation has been widely recognized as the exemplar for law enforcement and mental health collaboration related to the safe management of consumers experiencing mental health crisis (Ellis, 2011). The Memphis model can be regarded as a guide to law enforcement administrators who seek to develop policy and procedure that encompasses a system wide approach to properly responding to consumers experiencing a mental health crisis.

**Core Elements**

The Memphis CIT model has identified core elements that should be included in an all encompassing CIT program. These elements provide a comprehensive outline for law enforcement and administrators that are seeking to develop or improve a CIT program. The Memphis CIT model core elements consist of ongoing elements, operational elements, and sustaining elements (University of Memphis CIT Center, 2007). The basic goals of a CIT program are to improve officer and consumer safety and to redirect consumers with mental illness from the Judicial System to the Health Care System. The implementation of the Memphis CIT model core elements is critical to achieving these goals (University of Memphis CIT Center, 2007).

**Ongoing Elements**

According to the University of Memphis CIT Center (2007) the ongoing elements of a comprehensive CIT program include partnerships, community ownership, and policies and procedures. The overarching themes of properly addressing consumers with mental illness center on collaboration, training and an effective mental health system (Thompson et al., 2003). The ongoing elements begin to create the foundation of a CIT program that can address proper collaboration, training and additional resources through the medical field that provide for effective mental health services.

Within the law enforcement community, leadership and participation is essential to the proper development of a CIT program. Law enforcement has been described as first line responders to calls for service involving consumers experiencing a mental health crisis (Compton et al., 2010). Thus, law enforcement plays a significant role in an improved response to those with mental illness. Law enforcement partnerships should exist between police and sheriff's

departments as well as other agencies within the criminal justice system to include the courts and corrections (University of Memphis CIT Center, 2007). Therefore, law enforcement policy makers must consider the importance of not only creating a CIT team but also collaborating and maintaining crucial relationships within the criminal justice community in order to create and maintain a system wide approach to consumers experiencing a mental health emergency.

### **Partnerships**

Partnerships between the law enforcement and the mental health community are an essential component to a system wide approach to addressing the needs of consumers. These partnerships with law enforcement include not only the mental health services providers but also advocacy groups and institutions that assist in seeking improvement in the response to those with mental illness (Morabito et al., 2010). To achieve success this collaboration cannot be understated. Each organization involved in a collaborative effort to maintain a proper CIT response should be represented by the agencies chief executive or designee. The involvement of the chief executive assists in providing an indicator to the rest of their agency as well as other stakeholders that they are fully committed and supportive of the CIT collaboration (Thompson et al., 2003). In addition, agencies should take steps to institutionalize the developed relationships and collaborative efforts to aid in the longevity of the partnerships and to withstand changes in personnel (Thompson et al., 2003).

### **Community Ownership**

Community ownership is another component to the successful development of a CIT program. Community ownership can be described as having people within the community that have a dedicated investment in the CIT concept, development, and deployment (University of

Memphis CIT Center, 2007). Community ownership can be developed in various ways including dedicated professionals that assist in training patrol officers at no charge. This simple example highlights an opportunity for the mental health field and the law enforcement field to collaborate and build a sense of community. Community ownership can be established through the planning, implantation, and networking stages of CIT development. Efforts at engaging stakeholders such as advocates, citizens, families, government, law enforcement, and mental health communities can assist in providing a system wide approach related to the response to those with mental illness (University of Memphis CIT Center, 2007).

### **Policies and Procedures**

According to the Memphis CIT core elements, policies and procedures are described as an ongoing element of the CIT process. Policies and procedures are necessary as they provide a course of action for law enforcement and mental health service providers to follow when responding to a CIT related call for service. Within the CIT model, policies and procedures can relate to a variety of components that make up the CIT response. Policies can encompass inter-agency agreements, the scope of the CIT program, dispatch protocol, patrol officer protocol, and mental health service provider protocol (University of Memphis CIT Center, 2007). The wide range of areas within the CIT model that require guidelines for proper response to consumers in mental health crisis highlight the need for proper and ongoing collaboration between stakeholders.

## Operational Elements

### Key Positions

The operational component of the Memphis CIT model and the training provided to law enforcement officers has received a great deal of explanation within the research literature. However, the entities that make up the operational component have not received as much attention. According to the Memphis CIT model the following positions, described in [Table 5](#), are critical to the effective operation of a CIT program: the CIT officer, dispatcher, CIT law enforcement coordinator, mental health coordinator, advocacy coordinator, and program coordinator (University of Memphis CIT Center, 2007).

Table 5. Critical Positions for Effective Operation of a CIT Program

Position	Description
CIT Officer	<ul style="list-style-type: none"> <li>• Works within the patrol division of a law enforcement department and the voluntarily apply for the CIT positions</li> <li>• Go through a selection process based on assessment of the officers accomplishments and recommendations</li> <li>• Receive specific CIT training and are designated as responder and lead officer during calls for service involving mental health crisis situations</li> </ul>
Dispatchers	<ul style="list-style-type: none"> <li>• Receive training on CIT program and their position within the CIT model</li> <li>• Need to understand how to recognize and assess a call that may involve a consumer in mental health crisis</li> <li>• Required to understand how to properly dispatch a CIT officer</li> </ul>
CIT Law Enforcement Coordinator	<ul style="list-style-type: none"> <li>• Has experience as a law enforcement officer</li> <li>• Possesses good leadership skills and have the ability to act as a liaison by maintaining partnerships with stakeholders</li> <li>• Assists in program development and training coordination as well cultivating relationships with community partners</li> </ul>
Mental Health Coordinator	<ul style="list-style-type: none"> <li>• Member of the mental health community who serves as a liaison with advocacy groups and law enforcement</li> <li>• Serves an important role in the training function of those involved in the CIT process as well as an important role in developing the function of the receiving facility that cares for consumers</li> </ul>
Advocacy Coordinator	<ul style="list-style-type: none"> <li>• Part of the advocacy community; community consists of advocates, individuals with mental illness, and families</li> <li>• Involved in training, curriculum development, and ongoing problem solving</li> </ul>

<b>Position</b>	<b>Description</b>
Program Coordinator	<ul style="list-style-type: none"> <li>• Responsible for the day to day logistics of a multi-agency CIT program</li> <li>• Assists with inter-departmental communication, data collection and management, and the scheduling of training</li> <li>• Seeks to secure resources that assist in sustaining CIT programs</li> </ul>

## **Training**

In addition to the 40-hour officer training, discussed in Section III, the operational element of the Memphis CIT model calls for dispatcher training. Currently a model is being developed that would provide dispatchers with 20 hours of training (Compton et al., 2010). This training would stress the recognition and assessment of a CIT crisis, appropriate questions for dispatchers to ask, identifying the nearest CIT trained officer to respond, and understanding the importance of policies procedures for the proper response to a call involving a consumer experiencing a mental health crisis (University of Memphis CIT Center, 2007). The development of dispatcher training effectively connects the active stakeholders that operate within the core elements of the CIT process.

## **Emergency Mental Health Receiving Facility**

A major operational component to the Memphis CIT core elements is a designated emergency mental health receiving facility. A 24 hour drop off center is considered an important facet of the CIT model. However, this is one of the features of the program that is customized to the individual locale. Some jurisdictions rely on mobile crisis response teams while some rely on hospitals and emergency departments that have access to mental health units (Lord et al., 2011). The optimal emergency medical health receiving facility would provide a minimum turnaround time for law enforcement and should accept all referrals despite the diagnosis of the consumer (University of Memphis CIT Center, 2007).

**Sustaining Elements**

The last facet of the Memphis CIT core elements is the sustaining elements which include evaluation and research, in-service training, recognition and honors, and outreach.

These components serve an important role to the longevity and success of the CIT program.

Evaluation and research will assist in measuring the impact that the CIT program is having ,in addition to exposing if the program goals are being met. In-service training will complement the CIT program well by providing staff with updates and continual education in a variety of mental health areas. Recognition and honors will provide officers with a sense of accomplishment and will build ownership within the CIT program. Through outreach, law enforcement leaders and those within mental health services have the opportunity to develop CIT programs in surrounding communities (University of Memphis CIT Center, 2007).

Beyond the core elements of the CIT program, law enforcement leaders must consider the best implementation strategies that encompass partnerships with courts and corrections.

Although many consumers need additional mental health services, they still may find themselves facing sanctions from the courts system due to their actions. The court system can have an extraordinary impact on a defendant that has mental illness (Thompson et al., 2003). Thus law enforcement leaders and other stakeholders that are seeking policy and operational changes to better respond to consumers with mental illness would be well suited to seek effective collaboration with the court system.

Additionally, mental health courts have developed to effectively address the needs of consumers with mental illness. The purpose of these courts has been to stop consumers from multiple reoccurrences within the court system impart due to their mental illness (Mann, 2011). Jurisdictions that seek to improve responses to consumers would be well positions to include

judges, prosecutors, and defense attorneys as additional stakeholders who could provide valuable wisdom for creating a system wide approach to effectively respond to consumers in mental health crisis.

Law enforcement officers will continue to respond to consumers who are experiencing mental health crisis. However, without proper leadership and an eye to innovative solutions these officers may not be poised to properly respond to these consumers with a variety of resolutions. A template for a system wide approach to consumers experiencing mental health crisis is available through the Memphis CIT core elements. Law enforcement administrators now have the ability to take the lead in creating collaborative partnerships, improved policy, and effective procedure to improve the quality of life in their community by better responding to consumers.

## Section V: Summary and Conclusion

When the deinstitutionalization movement began in the mid 1960's the criminal justice and mental health fields were not ready to effectively respond to the higher number of consumers in society. The result was two established entities working separately from one another. The criminal justice field began to criminalize consumers who were experiencing mental health crisis and the mental health field was not poised to provide proper mental health treatment. The development of the CIT program, which strived to promote collaborative relationships, improve officers interactions with consumers, enhance the safety of all individuals involved, and provide the needed mental health care to the consumer, was a revolutionary movement in properly responding to the needs of consumers experiencing mental health crisis (Ellis, 2011; Lord et al., 2011).

The Memphis model of the CIT program was developed in Memphis, Tennessee after Memphis police officers responded to a consumer experiencing a mental health crisis. During this incident the consumer did not respond to the commands of the police resulting in the police shooting and killing the consumer. This incident spurred collaboration between law enforcement, educational institutions, mental health facilities, and citizens. The culmination of this collaborative effort was the formation of a Crisis Intervention Team consisting of law enforcement officers, mental health staff, and emergency psychiatric services that sought to properly respond to consumers (Practitioner Perspectives Memphis, Tennessee, Police Department's CIT Program, 2005).

In 2007, the Crisis Intervention Team Core Elements were developed. These core elements provide law enforcement leaders with a guide for understanding the critical components for developing a CIT program. The ongoing, operational, and sustaining elements of the CIT

concept explain the factors that will improve effective implementation of policy and procedure for law enforcement agencies. This paper has highlighted important ideas related to the CIT process as well as the system wide collaboration effort that is needed to fully implement a CIT program. Law enforcement leaders, mental health professionals, and researchers have an opportunity to utilize this information to better develop policy, procedure, and empirical research to further improve and study the effectiveness of the CIT response.

Although promising, the CIT program is not without shortcomings. The literature relative to CIT highlights the limiting factor that no empirical research exists that shows the program is actually effective. Additionally, some police administrators have expressed concern about creating a specialty unit to address common place calls for service with consumers and the fiscal concerns that a 40-hour training may present. Studies have shown, however, that officers support the training, advising that it provides for greater understanding of mental illness, assists in the destigmatizing of mental illness, and offers skills and confidence essential to successfully handling calls for service with consumers (Lord et al. 2011). The CIT concept operates on the premise that CIT trained officers will have the ability to more safely manage calls for service with consumers experiencing a mental health crisis. Additional research is needed, however police administrators have the ability to carefully study the information concerning CIT. Specifically, using the core elements along with the information presented in this paper. Police administrators can develop strategies that will improve effective implementation of policies and procedures as they relate to successfully responding to consumers.

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