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Crisis Intervention Teams (CIT): Considerations for knowledge transfer

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Abstract

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The Crisis Intervention Team (CIT) model, developed by the Memphis, Tennessee Police Department, exists in nearly 100 communities. This first responder system operates on a generalist-specialist model that uses specially trained volunteer officers to respond to behavioral health crises. CIT's remarkable popularity and its wide distribution through metropolitan and medium sized police agencies demonstrate how system change can originate and be sustained by grass-roots efforts. Knowledge transfer and skill adoption of this Memphis model has occurred predominantly without external funding or mandates.

This article describes key factors contributing to the success or failure of implementing a new CIT program. Community readiness is discussed through the lens of the Transtheoretical Model of Change. Suggestions are offered for implementing and sustaining a viable program, based on the experience of Florida's twenty operating programs. A description of the "lessons learned" from these communities may be useful to other considering system reform. The authors conclude by observing that, despite extremely positive anecdotal reports of CIT's effectiveness, additional research needed to advance this "best practice" as an "evidence-based practice".

Crisis Intervention Teams (CIT): Considerations for Knowledge Transfer

Since its inception in 1987, the "Memphis Model" Crisis Intervention Team (CIT) has become one of the most popular US law enforcement initiatives of its kind. The program emerged from efforts to heal a community divided by the fatal police shooting of a person with a mental illness in Memphis, Tennessee. By forging strong community partnerships, and maintaining steadfast commitment, the Memphis community was able to change fundamentally, the way that law enforcement personnel responded to, and handled, calls involving people with behavioral health disorders (i.e., mental health and substance abuse problems) in crisis (Cochran, Deane, & Borum, 2001).

In the ensuing years, other jurisdictions experiencing similar tragedies turned to Memphis for advice and guidance. Hundreds of individuals from around the country have visited the CIT program and attended their training, attempting to bring the knowledge and technology home to their own communities. Many have succeeded. Some have not. Most of the lessons learned have not been shared, so very little is known about the principles and strategies needed to initiate, develop and sustain CIT in a new jurisdiction. In this article, we offer preliminary observations and suggestions for a successful cross-jurisdiction transfer of CIT-related knowledge and practice. We draw principally from our experiences in supporting numerous communities –including more than twenty in Florida – who have implement the CIT program model.

Historical Perspective

Most law enforcement administrators and managers know the challenges of responding to crisis situations involving people with behavioral health disorders (Borum, 2000). These encounters are very common, but most officers feel poorly equipped to

handle them. To resolve them successfully, law enforcement personnel often must navigate in the unfamiliar terrain of emergency rooms and mental health clinics where the officer's idle time is not considered a priority (Borum, 2000; Borum, Deane, Steadman, & Morrissey, 1998).

Nearly all law enforcement officers receive some training on behavioral health issues, but the nature and extent of it is quite limited (Hails & Borum, 2003). Standard training curricula most often focuses on protective custody laws, emphasizing policies and protocols. In recent years, the police recruit training has moved toward a problem solving approach. This new training emphasis is designed to assist officers in applying their knowledge in a variety of simulated real world scenarios.

These generalized training efforts alone, however, have failed to alleviate the operational challenge that behavioral health crises pose. Tragic – sometimes preventable shootings – continue to occur, and officers continue to experience frustration as they attempt to get appropriate help for individuals in a behavioral health crisis (Borum, 2000). The police officer must balance the goal of service while safely meeting the multi-demands of their peace keeping duties. Law enforcement administrators additionally must consider questions of departmental liability and damaged community relations when working with this vulnerable population. Police departments often struggle to fill gaps in community services for the large number of individuals who formerly may have been in state institutions (Borum, 2000). The CIT model is one model that has emerged from these struggles.

CIT operates on a generalist-specialist model. A select cadre of volunteer officers are chosen and trained to be first (and primary) responders to behavioral health crises.

The officer maintains the regular patrol responsibilities and geographic assignments, but they are given priority – and have citywide jurisdiction - to be dispatched to calls involving behavioral health crises. The operational objective is to have the most skilled officer for mental health problems positioned to respond to those calls first and be given authority as the "officer-in-charge" of that incident (Cochran, et al., 2000).

An early NIJ-funded study found that CIT was rated by police officers (including non-CIT officers) as being highly effective in meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing the amount of time officers spend on these types of calls, and maintaining community safety. The CIT program also had the lowest rates, among the models studied, of arrest and use of force for mental health disturbance calls (Borum, et al., 1998).

Since its inception, the Memphis modeled Crisis Intervention Team approach has been adopted by an estimated 100, or more jurisdictions throughout the United States (Spaite & Davis, 2005). In 2002, the Police Executive Research Forum surveyed and described 28 law enforcement agencies' police-based diversion programs for people with mental illness. Twenty-two of them (79%) were based on the Memphis Model CIT program (Reuland, 2004). In Florida, CIT programs cover county jurisdictions representing more than 73 % of the state's population.

Model Adoption Overview

It is unusual for a grass-roots initiative to have been so widely adopted by law enforcement. At the time of implementation almost none of these communities had statutory or policy initiates to spur its growth. No national or state funding backed its adoption. What then has contributed to the adoption of this best practice?

We suggest several reasons for its popularity. First, program costs are minimal. The Memphis Police Department has estimated that considering all program related costs, including special duty pay, the cost per response for mental health crisis calls from CIT was approximately two dollars. Secondly, the CIT is a police operation. Departments need not deploy any additional personnel, including civilians. Because law enforcement will almost always be the first line of response for mental health disturbance calls, there is an operational advantage to locating the specialized response with operational personnel. Even if mental health professionals also become involved, the on scene management and stabilization of the situation may improve by having specially trained officers serve as the primary response (Borum, et al., 1998; Cochran, et al., 2000). Spaite & Davis (2005) suggested that the specific management issues of importance provided by the CIT model to include:

1. CIT officers are a select group of volunteers
2. CIT officer recognition by their communities is a valuable incentive
3. CIT officers function in both their patrol duties and as responders for crisis incidents. This strategy allows officers to acquire field experience in crisis management

Finally, the model is rooted in a problem-solving approach, attempting to identify and ameliorate the underlying cause of the behavior that precipitated a call for police, rather than simply incapacitating the individual or removing him or her from the community.

The original goal of CIT was to improve the quality of the police encounter to reduce the likelihood injury. As the program has evolved, however, many suggest that an equally important objective has been to divert people with mental illness from the criminal justice system whenever appropriate (Borum, 2000). The latter goal has

garnered additional CIT support from national organizations and advocacy groups, such as the National Alliance on Mental Illness (NAMI), which has substantially advanced CIT's recognition and acceptance.

Factors Influencing CIT Adoption

Whether, when and how a community adopts or sustains a CIT program will depend on a host of factors. Some are nearly universal, while others vary from community to community. Reuland (2004) proposed the following steps for "Planning a Police Based Specialized Response Program:"

1. Examining Available Models
2. Adapting the Model to the Locality
    a. Mental health services adaptations
    b. Training adaptations
    c. Response protocol adaptations
3. Educating the Community
4. Obtaining Necessary Reviews and Approvals
5. Setting Logistics and Administration

Adapting the Memphis model to distinct local characteristics seems to pose the greatest challenge for most jurisdictions. After 17 years of operation, CIT has become institutionalized in Memphis and visitors are often struck by how smoothly the program operates there. The struggles of startup, planning, implementing and sustaining the program are often less evident to outside observers. Here we attempt to outline some of the common issues encountered in transferring and adapting the Memphis model to other

localities, classifying these factors into three categories: Community Readiness, Implementation; and Sustaining Factors.

Community Readiness Factors

Different communities will come to consider, and ultimately adopt, CIT for different reasons. Typically, communities are brought to action by the cumulative effects of existing problems, and triggered by an incident that is "the straw that breaks the camel's back" (Reuland & Cheney, 2005). The precipitating event, such as the shooting that occurred in Memphis, creates a community crisis. In classic crisis intervention theory, individuals are propelled into crisis when their normal coping mechanisms are overwhelmed or ineffective. In this state of disruption, however, exists the adaptive opportunity to buttress existing resources, garner new ones, and emerge from crisis even stronger than before. This principle applies to communities as well as individuals. A community must be "ready" before it can successfully implement a CIT program.

A variety of readiness models have been proposed and used in the social sciences. Most originated from the study of health behavior, but the general principles may apply to community changes a well. One of the most commonly used is the Transtheoretical Model of Change (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997). The model is framed by a series of five progressive stages.

1. *Precontemplation*: Not planning to take any action in the near future (e.g., the next six months). May be uninformed about the nature or existence of the

problem or be frustrated and demoralized because past efforts to change have failed.

2. *Contemplation*: Thinking about and intending to change. May be strongly ambivalent because of the possible costs, challenges and difficulties. This ambivalence may cause some to "get stuck."
3. *Preparation*: Planning to take change action soon (e.g., with the next month). Probably has taken some small steps already, and has a plan of action for change.
4. *Action*: Has taken effective action and recently made some meaningful changes (e.g., the past six months). At this stage there is a real danger of "dropping the ball" and reverting to old ways.
5. *Maintenance*: Change has occurred and is being maintained. The risk of reverting to old ways is greatly reduced.

Readiness for CIT applies beyond the law enforcement agency itself. The CIT program is built on community partnerships, and different partners may be at different stages at different times. If this is the case, one of the initial challenges in to "get everyone on the same page," usually by helping or leveraging the slower partners to move more quickly to preparation and action. Education and enhancing motivation typically are key interventions. Each partner may, however, have different motivations or potential gains from adopting CIT. The range of benefits to different stakeholders must be identified and respectfully considered.

The charge to adopt CIT may be "championed" by a particular group or individual such as a sheriff, judge, county official, mental health professional or member of an advocacy group such as NAMI, but multiple agencies and stakeholders must

ultimately be represented and actively involved. In one community, for example, the absence of consumer advocates was evident and the initiative died after the first couple of meetings. Based on experiences in their state, NAMI Maine (2006), for example suggests that CIT's success requires the following elements of community support:

- leadership in the police department/jail fully supports the program,
- leadership in the local hospital supports the program, and
- families, consumers, and service providers volunteer to participate in the training and to stay involved in the program once implemented.

The specifics may vary in other jurisdictions. Jails and law enforcement may or may not operate under the same administrative authority. Courts may or may not have a vital role in creating alternative dispositions for offenders with mental illness. Non-hospital-based mental health agencies, providers, clinics and facilities may or may not be critical in a given jurisdiction. The underlying principle remains, however, that CIT is a community effort, sustained by partnerships. The community – not just the law enforcement agency – must be ready for change before meaningful and lasting change can occur.

Implementation

A program to be adopted must meet felt needs of a community. In the case of CIT, several diverse goals are addressed. A survey of 80 law enforcement agencies by the Police Executive Research Forum (PERF) in 2003 summaries four key stated goals of the agencies to include: 1) safety of officers and civilians, 2) increased officer understanding of mental illness, 3) reduced numbers of people with mental illness going to jail, and 4) improved relationships with the community, particularly with mental health

professionals, people with mental illness, and family members. Of these stated goals the most frequent noted successes are improved relationships with the community and improved safety of officers and civilians (Reuland & Cheney, 2005). Although CIT may not equally achieve all, these goals resound as important to various stakeholders involved in the program adoption.

Once a community makes an informed decision to adopt CIT in its jurisdiction, the core components of the model must be examined, adapted (if necessary), and implemented. This also requires a community effort. The CIT model, by definition, is designed to have a local, direct impact and a problem-solving focus. This model is consistent, philosophically, with broader trend in US law enforcement toward community policing models.

Key community stakeholders must come together in the planning and preparation stages, so the forum for partnering on implementation should already be established. When communities have difficulty getting certain stakeholders to the table, CIT is much more difficult – if not impossible – to implement. Even if one element of the system has agreed to CIT in principle, they may fall short at implementation. Reuland & Cheney (2005) report that the key to success has been the strength of partnerships formed by the program.

Many of the CIT core components primarily require support and change by the law enforcement agency (or agencies). Law enforcement "buy-in" is obviously essential, though several communities have started with only lukewarm participation of the sheriff and/or chiefs. In these cases, the training component has proceeded but frequently full model implementation has stalled.

Memphis model CIT-developer Major Sam Cochran is quick to point out that "CIT is more than just training." Training is, however, the most visible component. For some jurisdictions the initial focus on advanced, specialized training is an important starting-point. Even, if law enforcement administrators are initially resistant to, or overwhelmed by changing their response system, training may be a "foot-in-the-door" that requires only the release of staff time to participate (Borum, 2000).

The CIT model for training provides an added advantage to building community partnership and full participation because *community partners provide the instruction.* The training itself is a vehicle for information-sharing and developing inter-system relationships. While training alone – no matter how competent – is insufficient to create a Memphis Model CIT program, the training courses have vital importance at many levels.

The low cost of the model both for the training and response system is an attractive factor. The most significant program costs are administrative and accrue from releasing officers from their regularly assigned duties to attend the training. Most communities receive donations to cover incidental cost of the training events.

Sustaining Factors

Perhaps the most elusive issue in CIT knowledge transfer is how best to sustain and nurture a successful program. Unlike models of individual behavioral change, community actions have a wider range of vulnerabilities that threaten them. Conflicts within or between any of the community partners can destabilize a successful effort. Routine personnel changes can fundamentally alter dynamics with the program or

relationships with partner agencies. Budget cuts in one part of the system can easily and profoundly affect the operation of the other components. The tendency to "drift" back to the old way of doing things can be an ongoing challenge. The lesson is that developing a successful CIT program is not a one-time activity. Like most worthwhile efforts, it must be actively monitored and maintained. How best to do that is a relatively open question, and one that likely varies across jurisdictions.

In our experience, actively sustaining a CIT program first requires a feedback loop. There must be a way for program partners to share information and concerns about what is working and what is not. Ideally, this includes some formal evaluation of whether and how the CIT program is meeting its intended objectives. One suggestion is for the community partners to "brainstorm" about possible problems with or threats to the program that may occur over time. The threats can be prioritized (in terms of likelihood and magnitude), and often preempted by creatively designing program operations to avoid them. Some problems, of course, are less foreseeable than others, which is why regular meetings among the partners – creating a feedback loop – is usually recommended.

Over the past decade or so, at least a few CIT programs have faced challenges that threatened their very existence. Rarely did these come from the "outside." No external agencies threatened to "do away with" the program. Rather, the programs suffered through neglect or insidious erosion. Four of the main offenders – based again only on our limited experience – are loss of command support, disrupted partner relationships, loss of program leadership, and inadequate recruitment and retention.

Command commitment is often (though not always) a sustaining condition for program leadership. CIT is not the only issue, however, with which they must contend. Law enforcement administrators and command staff must pilot moving vessels through changing terrain. At the time the decision is made to adopt CIT, that issue may be the Sheriff or Chief's highest priority. He or she may never lose that commitment in spirit, but over time, other matters will inevitably demand attention. Without the active, unequivocal and ongoing support of top-level agency leadership, adherence to CIT procedures are likely to drift, officers' interest will wane, and community partners will perceive that the law enforcement agency is no longer committed.

If community partners believe the law enforcement agency has "bailed" on the project, tensions can build and a number of dysfunctional systems responses can occur. The same is true is law enforcement perceives that one or more of its partners is "not pulling weight." Community partnerships in this arena – as with others in community policing – are based on ongoing relationships that must be actively managed. Communication is essential.

The CIT program leader (often called a coordinator) is an essential part of sustaining a successful program. The coordinator, regardless of rank, must be respected by sworn personnel at all levels. She or he must keep CIT on the command staff "radar screen," liaise effectively with community partners, sustain the morale of existing team members, maintain quality control, stimulate and preserve interest in the program and its reputation, identify and remediate any CIT-related problems, and seek lessons and information from programs in other jurisdictions. Without energetic, committed program leadership, CIT is at risk to "die on the vine."

One common result of inadequate program leadership is an inability to recruit and retain high-quality CIT officers. In some jurisdictions, the reputation of CIT programs has devolved from that of an elite, skilled group to that of marginalized "social workers" in uniform. The Team image affects whether the best officers will want to sign-up or continue to participate. Retention is also an ongoing struggle because of transfers and promotions that routinely occur in law enforcement agencies.

Program Barriers

While CIT has gained wide acceptance and acclaim, certain barriers can impede or reverse progress at most any stage of readiness, implementation or maintenance. For law enforcement agencies, the primary implementation challenges seem to be (1) administrative resistance to creating a specialized unit, and (2) inertia in changing the response system so that CIT officers are primary responders to behavioral health crisis calls.

The "over-specialization" concern is only one of perception. As we noted, the CIT program operates on a generalist-specialist model. CIT officers are not taken from their regular patrol duties, and the agency is not responding to a "new" set of calls. The perceived disadvantages of a creating a specialized unit simply do not apply to CIT. Regarding the change in response/dispatch protocols, the logistical adaptations are minimal. Call centers and dispatchers must also have a mechanism in their system to "flag" or otherwise identify CIT officers, and have procedures allowing them to send those officers first to behavioral health crisis calls.

Several of the more commonly encountered barriers or challenges are the following:

- *Difficulty adapting the Memphis Model of CIT for small and/or rural jurisdictions*

Discussion: The Memphis model functionally requires that at least 15-20% of an agency's patrol officers be trained and identified by dispatch as available CIT officers. The purpose of that requirement is to provide adequate 24/7 CIT coverage throughout the jurisdiction. In small jurisdictions, however, a community could not have full coverage without a majority of the patrol officers being trained. If that is done, many of the advantages of having an interested, volunteer team are lost. As of the year 2000, a majority (52%) of the 18,000 US state and local law enforcement agencies employed *fewer than 10 full-time sworn officers* (Reaves & Hickman, 2002), so the scope of this challenge is not insignificant. CIT will require some adaptations to the Memphis Model to function effectively in some smaller agencies.

- *Lack of modifications or cooperation by system segments*

Discussion: It is not uncommon for mental health advocates and behavioral health providers to put the onus of CIT almost exclusively on the law enforcement agency, emphasizing their need to better train officers and to their response methods. The behavioral healthcare systems sometimes do not desire or see the need to change. Accordingly, in some localities, the barriers to effective implementation have not come from law enforcement, but from behavioral healthcare system. This is only complicated by the dynamics and incentives of

privatization. For example, when protective custody admissions are debated by hospitals that want more referrals, or those that resist referrals, the efficiency of CIT can be adversely affected.

- *Question of official state or federal endorsement or regulation for CIT training and program standards*

Discussion: Florida jurisdictions and its statewide CIT coalition have debated whether to seek endorsement of the 40-hour training by the State's Department of Law Enforcement to facilitate state funding, or at least, garner authorizations for mandatory retraining credits. Many CIT training officers have expressed concerns that if the training is subsumed by State authority that CIT program necessary control over the curriculum content and teaching methods will be lost. This may dilute the programmatic aspects of CIT by promulgating it as a "stand alone" course. Community steering committees also have expressed major concern that state or federal standardization would eliminate the strength of involving key community stakeholders. Conversely, CIT officers spend 40 hours in this specialized training, which is the amount of mandatory retraining required for their recertification every four years. Agencies around the country have adopted training courses of varying types using the moniker of CIT, but without the core program elements that define CIT as a program.

- *Inter-jurisdiction conflicts*

Discussion:

Several of our Florida counties have twenty or more law enforcement jurisdictions, each with its own agency. Behavioral health systems throughout the

state also have multiple agencies whose services overlap. Especially when the police force has very limited personnel, it is necessary to develop a cooperative response system. This had led to some jurisdiction creating inter-agency CIT teams, some with community partners that cross jurisdictions. The issue is navigable, but is best addressed proactively through Memoranda of Agreement and building boundary spanners and inter-agency partner relationships.

- *Financial or manpower crunches*

Discussion: Law enforcement trainers, community citizens and behavioral healthcare providers typically volunteer their time for CIT training. This has kept the cost of training from being a major barrier to program implementation. However, diverting 20% of an agency's patrol force (although not all at once) for forty hours of training may be burdensome for certain departments. It is not unusual for law enforcement agencies to be generally understaffed due to budget crunches, recruitment problems, and officer deployment to the Middle East.

Evaluating the Model

Documentation regarding CIT's effectiveness is continuing to build. Anecdotal reports are almost uniformly positive. Hundreds of websites, newspaper articles and statements from agencies and consumers offer praise and stellar reports of success. Although these reports do not provide definitive evidence of positive outcomes, they do support the model's adoption in varying degrees. These reports clearly indicate the programs are well regarded and meeting the needs of at least some stakeholders.

More agencies are gathering data pertaining to the number of calls and patrol time involved. Data on injuries and jail diversion are collected in a few of the existing CIT programs (Reuland & Cheney, 2005). Satisfaction studies of law enforcement, mental health professionals, consumers, and family members are the most commonly used outcome measures qualitative method utilized (Reuland & Cheney, 2005).

Experimental designs in naturalistic emergency settings are nearly impossible to implement, however, empirical investigations regarding CIT's effectiveness have been conducted with very positive results (Steadman, Deane, Borum, & Morrissey, 2000)
A CIT evaluation report from NAMI Ohio paper (Spaite & Davis, 2005) lists six program benefits identified in prior CIT studies:

- fewer injuries to police officers
- reduction in arrest rates and use of force incidents
- fewer repeat commitments to inpatient care
- reduction in patient violence
- less officer time involved per call
- reduction in jail days for offenders with mental illnesses

Teller and colleagues' (Teller, et.al., 2006) study of dispatch logs from the Akron Ohio CIT program reported that more voluntary police transports to emergency treatment facilities occurred after CIT training. They conclude that CIT can assist persons in crisis in gaining access to the treatment system. They did not, however, find a significant change in the rate of arrest. PERF's (2003) survey noted that the specialized response programs have "infected" other parts of the criminal justice system and often prompted nearby agencies to adopt similar programs (Reuland & Cheney, 2005).

Conclusions

The widespread adoption of the CIT model for responding to individuals in behavioral health crises has been remarkable. The use of new technology by a community is not always determined by the amount of money available or the mandates from federal or state authorities. The volume of CIT programs in the United States reminds us that other more compelling factors are involved in social change. This paper has attempted to provide anecdotal information as to what factors are important in efforts to adopt a "best practice" policing model that has been successful in other communities.

In the near future it will be important for researchers and law enforcement agencies to partner in carefully evaluating the process and outcomes of implementing a CIT program. Understanding how the model is implemented and adapted by localities and their adherence to the model's core tenets is crucial.

Potential barriers and possible solutions must be more systematically identified. Associations should be examined between the perceptions of non-CIT officers and, among other factors, the degree of departmental involvement in planning, program philosophy, and CIT officer retention. Comparisons concerning program effectiveness should also be made from differing vantage points including those of consumers, members of AMI, mental health providers, officers, and law enforcement administrators. Perceived and objective measures of effectiveness should also be linked to features of the community's human service and behavioral health infrastructure, such as the existence of a crisis "drop off" point and the degree of its cooperation with the police.

Communities are strongly encouraged to consider ways to collect data and evaluate the benefits and outcomes of their CIT programs. These methods should include collecting incident data through standard, brief CIT tracking forms; continuing to examine program perceptions by all relevant segments of the community; measuring – as objectively as possible - how well the goals and objectives of the program are met; and assessing the potentially broader impact on improved community understanding, communication, and system development for serving individuals with behavioral health conditions.

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