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RESEARCH ARTICLE

Crisis Intervention Teams may prevent arrests of people with mental illnesses

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Historically, as many as 7–10% of US police contacts have involved persons with mental illnesses, with a disproportionate amount of these encounters resulting in arrest, usually for minor offenses. Crisis Intervention Teams (CIT) were created, and have proliferated, to ameliorate this problem by offering a specialized response and serving – at least informally – as a liaison between mental health services and police departments. Because preventing unnecessary arrests is one of CIT's principal objectives, this study examined the arrest rates of persons with mental illnesses and the number of arrests that might have been prevented after the implementation of a CIT program in a large county in Central Florida. The arrest rate after CIT implementation was found to be very low and even declined across time providing evidence that CIT programs may indeed be useful in reducing discretionary arrests among persons with mental illnesses.

Keywords: Crisis Intervention Teams (CIT); mental illness; arrest prevention; jail diversion

Introduction

People with mental health disorders frequently come into contact with the criminal justice system creating challenges for the police, for persons with mental illnesses, their family members, and for the community (Frankle et al., 2001). Prior estimates suggest as many as 7–10% of US police contacts involve persons with mental illnesses (PwMI) (Borum, Swanson, Swartz, & Hiday, 1997; Borum, Williams, & Deane, 1998; Ditton, 1999; Lamb & Weinberger, 1998; Steadman, Deane, & Borum, 2000), and these contacts disproportionately result in arrest, though typically for minor offenses such as trespassing, disorderly conduct, and other non-serious misdemeanors (Borum et al., 1997). Torrey, Stieber, and Ezekiel (1992) estimate that 685,000 people with severe mental illness are admitted to jail every year, resulting in what some have called the 'criminalization of mental illness' (Teplin, 1984). While comparable police contact estimates are not available for other countries, England, Wales, Canada, and Australia have all publicly struggled to find effective solutions for managing these calls, and European prison systems have also reported disproportionate prevalence of mental illness among their incarcerated populations (Blaauw, 2000).

Prior research has shown that police officers often feel inadequately trained to deal with mental health crises and are frequently frustrated by sluggish response times from mental health crisis teams. They resort to arrest because they lack available alternatives (Borum, 2000; Borum et al., 1998; Hails & Borum, 2003). Reducing unnecessary arrests would

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serve law enforcement interests by limiting the amount of time officers need to spend on these calls, and enhancing safety for the responding officer and for the community (Borum et al., 1998).

Arrest is also not an optimal disposition because in jail, people with mental health disorders often become disconnected from treatment and community supports, which may cause their condition to worsen and precipitate further instances of disruptive behavior (Lamb & Weinberger, 1998). Nevertheless, a substantial number of these discretionary arrests continue to occur creating a 'trickle-down' problem that ultimately burdens both people with mental health disorders and the criminal justice system. A number of factors probably contribute to this pattern of arrests. One major cause is the actual or perceived lack of dispositional options for responding officers. Police are often called out in situations where a person is experiencing acute symptoms and feeling out of control, frightened, agitated, or threatened (Borum et al., 1997; Lamb & Weinberger, 1998). Reversing the trend requires solutions that address the encounter itself (Borum, 2000; Borum et al., 1998) and the disposition (Bengelsdorf, Church, & Kaye, 1993; Steadman et al., 2000).

Initiatives designed to reduce arrest and incarceration among people with mental health disorders are referred to as 'jail diversion' programs. Their goal is to divert minor offenders with mental health disorders away from incarceration and into mental health treatment. Diversion can occur before or after a person is booked or arrested. Mental health courts are an increasingly common post-booking initiative, while pre-booking programs tend to focus on police response and decision-making (Steadman et al., 2000). Pre-booking initiatives have some distinct advantages because they may prevent deep criminal justice engagement – and its hazards – before it occurs and may result in better outcomes (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003).

Police-based diversion programs have become more popular over the past decade. A 1998 survey (Deane, Steadman, Borum, Vesey, & Morrissey, 1999) showed that while 88% of police departments provided some type of officer training on understanding mental illnesses, less than half had any kind of specialized mental health or law enforcement response available for PwMI in crisis. Training may be important, but it is generally insufficient to change the nature of police encounters and dispositions with PwMI in crisis (Borum, 2000; Hails & Borum, 2003; Thompson & Borum, 2006; Wells & Schafer, 2006).

Crisis Intervention Teams (CIT)

The Crisis Intervention Team (CIT) program, pioneered in the Memphis Police Department by Major Sam Cochran and Dr Randy DuPont, has gained national recognition and interest as a 'best-practice' model for pre-booking diversion of persons with mental health disorders. CIT model-mobilizes sworn officers who have received intensive, special mental health training to provide on-scene crisis intervention services and disposition (Thompson & Borum, 2006). In jurisdictions where the program is implemented, CIT officers serve as the first-line police response to mental health crises and act as liaisons to the formal mental health system (Cochran, Deane, & Borum, 2000). CIT follows a generalist–specialist model; CIT officers maintain their regular patrol duties, but when a 'mental disturbance' call is received the CIT officer can be deployed anywhere in the jurisdiction to be the principal officer on the scene (Cochran et al., 2000). The 'Memphis Model' CIT program was the first major police-based response model and has served as an example for other cities developing their own CIT program.

CIT programs have proliferated widely throughout the USA and have emerged in Canada, Australia, and the UK as well. The National CIT Center at the University of

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Memphis estimates that 1079 CIT programs currently exist worldwide (Dr Wayne Pitts, CIT Center Director, personal communication, 29 April 2009). Research documenting CIT's effectiveness is still somewhat limited, but increasing (Compton, Bahora, Watson, & Oliva, 2008; Oliva & Compton, 2008; Thompson & Borum, 2006). As of 2008, Compton et al. were able to identify only 12 reports of empirical research on CIT, only two of which assessed police dispositions of CIT calls (Compton et al., 2008).

In an early study (Borum et al., 1998), CIT and non-CIT officers were asked to rate their own preparedness, the amount of difficulty that PwMI posed for them, the helpfulness of the mental health system, and the effectiveness of their program in achieving the following goals: meeting the needs of PwMI, keeping PwMI out of jail, lowering the time spent by officers on mental disturbance calls, and maintaining community safety. All CIT officers in the sample felt well prepared to deal with PwMI. CIT and non-CIT officers rated the CIT programs as being more effective than did officers from agencies with other specialized programs in: meeting the needs of PwMI, keeping PwMI out of jail, lowering the time spent by officers on mental disturbance calls, and maintaining community safety (Borum et al., 1998).

As a form of pre-booking jail diversion, CIT programs may also lead to a decrease in arrests and increase in treatment access for PwMI. Steadman et al. (2000) examined three pre-booking jail diversion models for PwMI to determine whether there was a difference in arrest rates between the programs. Dispatch calls and incidence reports from 100 'mental disturbance' calls were inspected to establish the rates of arrest. The proportion of calls receiving a specialized response was higher in the CIT program and, while each of the three programs had low arrest rates, the CIT program arrest rate (2%) was the lowest. The CIT program also had the most active procedures for linking PwMI to mental health treatment resources; more than one-half of the calls resulted in the PwMI being transported to a mental health facility and one-third of the calls were solved on the scene by the CIT officer (Steadman et al., 2000).

Teller, Munetz, Gil, and Ritter (2006) similarly studied the effects of implementing CIT in Akron, OH. They found that the proportion of identified 'mental disturbance' calls (suspected mental illness or suspected suicide) increased substantially after implementing CIT, which may mean that dispatchers became more aware of the signs of mental illnesses and could better identify the call as a 'mental disturbance' situation. The proportion of arrests for these calls was relatively unchanged after the program, but many more CIT than non-CIT officers transported people to treatment facilities, and many more of these referrals were voluntary, rather than involuntary (Teller et al., 2006).

In the present study, we estimate the number of unnecessary and discretionary arrests of PwMI possibly prevented by implementing a specialized CIT police-based response program.

Method

This study examines the dispositions of encounters between CIT officers and PwMI. Its purpose is to estimate the proportion of arrests occurring on CIT calls and the number of arrests 'prevented' by CIT. The sample included CIT calls (from nine different law enforcement agencies) in a large, mainly urban county in Central Florida from 2001 to 2005. The agencies varied widely in size and population; some were small and suburban with populations of less than 30,000, while others were large and urban with populations well over 100,000.

CIT programs began in the county in 1999. In addition to having officers who have successfully completed a 40-hour training program, which includes education about

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behavioral health disorders and treatment, experiential training in impacts on family and community support systems, and scenario-based crisis intervention practice with feedback, for a CIT program to be considered fully implemented, certain criteria must be met: (1) call centers must have a mechanism to identify CIT officers, (2) there must be a way to identify behavioral crisis calls, and (3) there must be at least one CIT-trained officer on duty and available to respond to mental disturbance calls on every shift. The Central Florida CIT program all met these criteria. The decision to deploy CIT response among the Central Florida CIT teams is typically made by the dispatchers (though other first responders or supervisors may also request CIT assistance). CIT officers are flagged and identifiable in the computer-assisted dispatch system. If the call for service suggests that the subject is exhibiting symptoms of mental or emotional disturbance (or the dispatch log indicates a history of such incidents at the call location), the dispatcher will send an available CIT officer to the scene. The CIT responder becomes the officer in charge of that call.

If the number of CIT-designated calls had begun to decrease after a year or two, the program may not have been stable and may not have been fully implemented. However, the number of calls remained consistent over the five-year period so it can be assumed that the CIT program was fully implemented at the time of the data collection.

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Data collection

Data on the number of arrests, total number of CIT calls, and estimated number of arrests prior to CIT were compiled from CIT Tracking Forms, collected from the Mental Health Association of Central Florida (MHACF). The responding officer fills out the CIT Tracking Forms on the scene of a CIT call. The forms are used to record information about the disposition of the case (i.e., arrest, no arrest, no action, transportation to treatment facility) on an ongoing basis. MHACF collects the written forms and enters the information into a database.

Two key variables were examined in the present study: arrest disposition and arrests prevented. Arrest disposition was defined as a call that resulted in the subject's arrest. The arrests prevented variable was found by subtracting the number of actual arrests from the number of forecasted arrests, based on the officers' judgment that a given person would have been arrested before CIT was implemented. This variable was recorded after the incident had occurred and was based on the officers' opinions. Before CIT, the officer on the scene often has much more discretion over whether the individual was arrested, so this variable can be representative of the number of arrests that have been prevented by implementing the CIT program. The number of mental disturbance calls and the number of arrests were recorded monthly for each of the nine agencies in the county from 2001 to 2005.

Data analysis

The data analysis for this study is fundamentally descriptive because none of the law enforcement agencies collected or recorded data on PwMI encounters before CIT. Therefore, we cannot construct a true 'pre–post' comparison. CIT cases across all agencies and all five years were aggregated for a total of 1539 calls. The number of arrests was divided by the total number of calls to calculate the percentage of arrests or 'arrest rate.' The number of prevented arrests was divided by the number of calls to calculate the percentage of prevented arrests. The arrest rate found in the current study was then compared with arrest rates of other CIT programs found in previous studies. An individual analysis by year was also done for each variable.

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Results

The number of CIT calls, number of arrests, and number of prevented arrests are shown in Table 1. A total of 52 arrests occurred out of 1539 total CIT calls yielding a 3% arrest rate. A total of 290 arrests were prevented among the 1539 total calls, yielding a 19% prevented arrest rate. This percentage is not a true 'pre-CIT' arrest rate; however, it does provide a judgment by the officer making the disposition decision.

Examining trends for each year we found that the number of CIT calls was fairly even across time, ranging from 293 to 325 per year across the nine agencies. The rate of arrest varied between 0 and 7% (generally declining over time), and arrest was prevented in between 10 and 23% of the calls in any given year.

In 2001, there were 296 CIT calls: 22 calls resulted in arrest and 53 calls would have resulted in arrest prior to CIT, yielding a 7% arrest rate and a 10% prevention rate. In 2002, there were 293 CIT calls: 14 calls resulted in arrest and 70 calls would have resulted in arrest prior to CIT, yielding a 5% arrest rate and a 19% prevention rate. In 2003, there were 325 CIT calls: 11 calls resulted in arrest and 74 calls would have previously resulted in arrest, yielding a 3% arrest rate and a 19% prevention rate. In 2004, there were 318 CIT calls: 5 calls resulted in arrest and 75 calls would have previously resulted in arrest, yielding a 2% arrest rate and a 22% prevention rate. In 2005, there were 307 CIT calls: none of the calls resulted in arrest, while 70 calls would have previously resulted in arrest. There was a 0% arrest rate and a 23% prevention rate. The trends for CIT arrests and prevented arrests are shown in Figure 1.

Discussion

The present results suggest that people with mental health disorders are rarely arrested when CIT officers respond to behavioral health crisis calls, and officers believe the programs actually prevent arrest in a substantial number of cases. The low arrest rate among CIT calls in Central Florida (3%) is consistent with prior estimates from CIT programs in other regions (Steadman et al., 2000). The current study also found that a sizable proportion of calls (19%) would probably have resulted in arrest before the CIT program, suggesting that many arrests in behavioral health crisis calls are discretionary and potentially preventable. This finding supports Lamb, Weinberger, and DeCuir (2002) and other researchers who regard police officers as system 'gatekeepers' because they have such a high degree of influence over whether a person enters the mental health or criminal justice system during a crisis event.

Table 1. Number of mental disturbance calls, arrests by CIT officers on those calls, and estimated number who would have been arrested before CIT was implemented.

Year	Number of arrests after CIT	Number of estimated arrests before CIT	Number of mental disturbance calls
2001	22	53	296
2002	14	70	293
2003	11	74	325
2004	5	75	318
2005	0	70	307
Total	52	342	1539

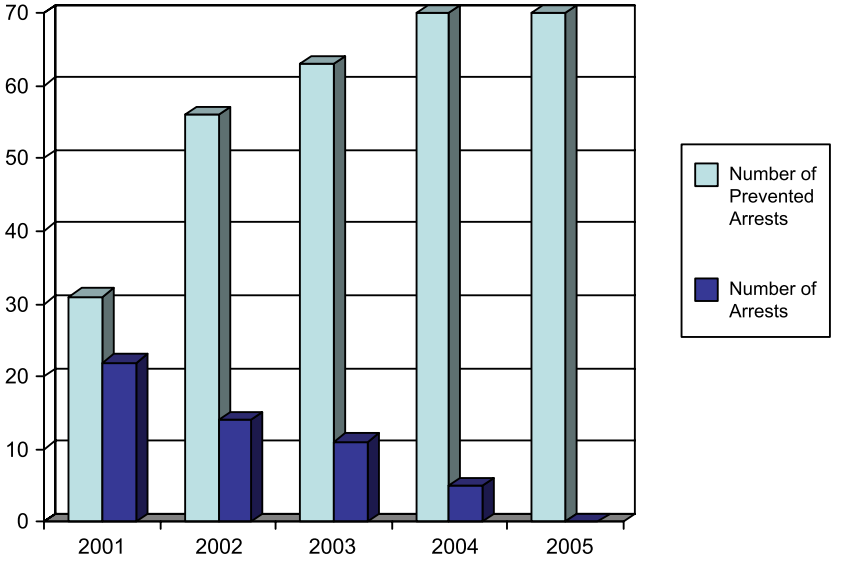

Figure 1. Number of arrests and prevented arrests by year.

Maintaining a low arrest rate in responding to people with mental illnesses in crisis is consistent with one of the primary aims of CIT programs – lowering discretionary arrests of PwMI. The current study is also consistent with Steadman et al.'s finding (2000) that fewer PwMI were arrested in police encounters with a CIT officer than in any of the other jail diversion models that were examined. The very low arrest rate and substantial number of prevented arrests found in this study also support officers' perceptions (Borum et al., 1998) that CIT programs are effective in keeping PwMI out of jail.

A major limitation in this study was the lack of 'pre-CIT' data. Before the CIT program was implemented, a special dispatch code for suspected mental illness did not exist and the calls involving PwMI were coded for the specific crime that had occurred. The absence of 'pre-CIT' data makes it difficult to draw causal inferences about the effectiveness of the program. Another limitation in this study was the lack of information regarding the total number of calls for service received by each police department, which would have provided more insight on the volume of mental disturbance calls that are now being answered by a CIT-trained officer that previously would not have been. Finally, having the CIT officer designate (on the tracking form) whether the person would have likely been arrested in this circumstance before CIT is certainly subject to some limitations and potential biases. On balance, however, it may be the most direct measure available using within-case rather than between-case comparisons because the responding officer would have been the one making a dispositional decision anyway.

An expansion on this study could include contacting police agencies to find the number of total calls for assistance in a given period, and the total number of calls involving a person with mental illness, to better discern the proportion of relevant calls being identified by the agencies and being covered by CIT. Future research might also examine police dispatch records to identify calls involving PwMI to find a 'pre-CIT' or 'non-CIT' arrest rate to provide more accurate time-point comparisons and better control for historical trends. We hope that future studies will more rigorously examine the effect of CIT programs in preventing arrests and facilitating treatment access for people with mental health disorders.

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Conclusion

Police calls involving persons with mental illnesses pose a significant challenge for law enforcement and criminal justice systems internationally. Addressing this challenge we must consider the needs and interests of the law enforcement agencies, those people with mental health disorders, and those of the community. More than a thousand police agencies worldwide have developed Crisis Intervention Teams to create a more effective systemic response. The study described here suggests that one possible benefit of CIT programs is to reduce the volume of unnecessary and discretionary arrests of persons with mental illness in crisis. By preventing those arrests, officers may spend less time on these calls, escalations that result in officer injury may be prevented, the challenge is not passed along to subsequent phases of the justice system, and the people with mental health disorders are more readily connected to treatment services, reducing the occurrence of repeat calls for the same problem.

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