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System- and Policy-Level Challenges to Full Implementation of the Crisis Intervention Team (CIT) Model

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Abstract

The Crisis Intervention Team (CIT) model of collaboration between law enforcement and mental health is widely recognized as being “more than just training” for police officers; the core elements of CIT include a number of other components. However, several system- and policy-level obstacles can make successful implementation of CIT difficult in many communities. Three such challenges are addressed in this article: insufficient training and policies for dispatchers, poor availability of psychiatric emergency receiving facilities, and complexities related to implementation of CIT in rural settings. Collaboratively addressing these and other challenges will undoubtedly advance the goals of CIT.

Introduction

Police officers often serve as first-line responders to emergency crisis calls involving individuals with mental illnesses and therefore act as gatekeepers to both the criminal justice and mental health systems (Hails & Borum, 2003; Lamb, Weinberger, & Decuir, 2002; Shah, 1989; Teplin & Pruett, 1992; Watson, Corrigan, & Ottati, 2004). Yet, they usually receive very little training on mental illnesses, although they are interested in the topic and indicate that such training would be beneficial to their work (Vermette, Pinals, & Applebaum, 2005; Wells & Schafer, 2006). The schism between what officers are expected to do and what they are trained to do can be detrimental to officers themselves, people affected by mental illnesses and their families, and members of the community-at-large.

To improve officers’ responses to individuals with a mental illness, the Crisis Intervention Team (CIT) program was developed in 1988 in Memphis, Tennessee (Steadman, Deane, Borum, & Morrissey, 2000). This innovative program provides self-selected officers with 40 hours of specialized training presented by local mental health professionals, law enforcement officers, and family members of individuals with psychiatric illnesses who serve as advocates for mental health services (Cochran, Deane, & Borum, 2000; Dupont & Cochran, 2000; Oliva, Haynes, Covington, Lushbaugh, & Compton, 2007). The training consists of traditional classroom instruction, visits to local mental health services, and performance-based exercises that allow for the mastery of de-escalation techniques through

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role-play (Oliva & Compton, 2008). After training, officers serve as specialized first-line responders for calls involving individuals with a mental illness who are in crisis (Bower & Pettit, 2001; Hails & Borum, 2003). It is important to note that CIT officers do not intervene in situations with individuals with a mental illness simply because of the presence of a disorder, but because there is a crisis situation to which they are called for service.

Although the specialized training curriculum for police officers is a crucial aspect of the CIT model, it has been increasingly noted that CIT is "more than just training," as emphasized by the *core elements* recently promulgated by national leaders of the CIT movement (Dupont, Cochran, & Pillsbury, 2007). For example, the overall CIT model supports partnerships between psychiatric emergency services and police departments in order to facilitate referral to treatment in lieu of incarceration when appropriate (Cochran et al., 2000; Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Thus, in addition to its other goals (e.g., improved officer and consumer safety), the program is a form of pre-booking jail diversion. CIT is the most widely recognized crisis intervention model for police departments (Dupont & Cochran, 2000; Steadman et al., 2000). The Bureau of Justice Assistance (2007) has estimated that more than 400 CIT programs are now operating in the U.S.

The innovative CIT model consists of three sets of core elements—ongoing, operational, and sustaining—that are essential to the success of the program (Dupont et al., 2007). Ongoing elements include the necessary participation and leadership of the law enforcement, advocacy, and mental health communities. Collaboration and partnerships among individuals within these communities is critical in seeking solutions to crisis situations and issues that are unique to those with mental illnesses. For the CIT program to operate properly, adequate operational or personnel elements must be in effect as well. CIT officers, dispatchers, and CIT coordinators are required to effectively execute the program. These individuals receive comprehensive CIT training to learn how to proficiently respond to citizens experiencing a behavioral problem and recognize and receive calls involving individuals with a mental illness (Dupont et al., 2007). CIT-trained personnel depend on a designated psychiatric emergency receiving facility to which individuals with a mental illness can be transported. To further maintain the success of the CIT program, outreach efforts to surrounding communities are critical. Additionally, to sustain the program, research and evaluation must be conducted in order to ensure positive and effective outcomes and inform future program development (Dupont et al., 2007).

Although numerous cities and counties have implemented a CIT program, many find the training aspect of CIT to be easier to accomplish than some of the other, more complex and collaborative, core elements. Specifically, a number of system- and policy-level challenges —within both the law enforcement/criminal justice system and the mental health services system—can make the successful implementation of CIT difficult. Three such challenges are addressed in this article. First, inadequate training of and policies for dispatch personnel can seriously limit the effectiveness of the crisis intervention approach given that emergency communications personnel are an integral aspect of the inter-disciplinary team approach. Second, the limited availability of psychiatric emergency receiving facilities, which serve as a single point of entry into the mental health services system and that have no-refusal policies, will obviously undermine the effectiveness of the overall CIT program. Third, CIT implementation can be complicated when the model, which was designed in an urban setting and initially launched in a number of urban centers, is implemented in rural counties. In addressing these three commonly occurring challenges, law enforcement agencies seeking to implement a CIT program will have guidance to ensure that their program becomes "more than just training" and adequately meets the needs of their communities.

Challenges Related to Inadequate Dispatch Training and Policies

Because successful CIT implementation depends on the coordination of various units, each entity must be capable of effectively identifying situations involving a person with a mental illness who is in crisis. Emergency dispatchers, call-takers, and 911 operators are critical links in the CIT program (Dupont et al., 2007). These individuals are the first line of communication in emergency calls involving individuals with a mental illness and therefore potentially set the overall tone of the situation. Thus, they should be adequately trained to recognize such calls and route them appropriately. Training for dispatchers or "communications officers" varies and is based on local and state requirements and opportunities (Brown, A., personal communication, January 27, 2009). Dispatchers need to be trained to evaluate calls by asking key questions of callers and reporting the right information to the most appropriate emergency response personnel. Given the importance of dispatch personnel for the overall functioning of a CIT program, they should be included in the initial planning stages of CIT implementation.

Although it is obvious that the dispatch sector represents a crucial link in the success of a CIT program, a number of challenges can be present in addressing this component of CIT. How can dispatchers be included in CIT training classes when the priority is often the training of law enforcement officers? What should be done to the existing CIT curriculum, or in the development of a new curriculum, to ensure that it is relevant to dispatchers? What are the best ways to make dispatch personnel aware of such training and facilitate their attendance in light of staffing issues? Beyond training, what relatively simple policies can ensure that dispatchers are able to link callers with appropriate response personnel? In what ways should CIT evaluation and research address the dispatch sector? Each of these questions, representing a potential barrier to fulfillment of the core elements of CIT, is addressed below.

The CIT core elements (Dupont et al., 2007) include a component focusing specifically on dispatchers, which entails specialized coursework detailing the structure of CIT and how to properly receive and dispatch calls involving individuals with a mental illness. However, some CIT programs are being implemented without such specialized coursework (Strode, P., personal communication, December 28, 2009). Although a variety of professionals and volunteers from multiple disciplines work collaboratively to develop and sustain an effective CIT program, the training component is managed by law enforcement professionals (Oliva & Compton, 2008) and the demand for law enforcement officers to attend CIT training is generally considered a first priority; hence, the sending of dispatchers to training is usually contingent on the availability of space (Cochran, S., personal communication, January 28, 2009). In recent years, trainings are including more dispatchers, and the CIT curriculum should become more relevant to dispatchers and encompass more issues important to their work. Therefore, dispatchers should be involved in the development of CIT curricula. When dispatchers are present in the 40-hour training provided to police officers, simulated phone calls and more role-play scenarios have been included to make training more relevant and engaging (Strode, P., personal communication, December 28, 2009). Many law enforcement agencies are now making serious efforts to bring communications personnel into CIT training or similar educational sessions (Cochran, S., personal communication, January 28, 2009).

Separate curricula could be developed for dispatch personnel rather than sending them through the officers' 40-hour training week. The Georgia affiliate of the National Alliance on Mental Illness (NAMI-Georgia) is in the initial stages of developing plans to increase dispatch training in Georgia's CIT programs, as well as training for other emergency medical service personnel (Strode, P., personal communication, December 28, 2009). A

model is being developed to deliver 20 hours of training for dispatchers, including 10 hours online and 10 hours in the traditional classroom setting. Another way to provide dispatch training is through in-service training, which is the current modality used in the Memphis CIT program (Cochran, S., personal communication, January 28, 2009). These shortened versions of CIT training appear to be more appropriate for dispatch personnel from a curriculum/content perspective and might also facilitate their ability to attend training in light of their time commitment and potential staffing shortages.

In addition to the absence of an appropriate curriculum, another barrier to training dispatch personnel is making them aware of such training and facilitating their attendance. In Georgia, state law enforcement CIT coordinators facilitate communications with local law enforcement agencies to ensure that all pertinent organizations are notified and involved in the training (Oliva & Compton, 2008). Nonetheless, in many municipalities, dispatchers are insufficiently involved in CIT training. The use of the Law Enforcement Technical (LET) and similar media has been suggested as a mechanism to make dispatchers more aware of CIT (Strode, P., personal communication, December 28, 2009). LET is a monthly magazine written for sworn members of law enforcement management that concentrates on emerging trends and technological advances in the field of law enforcement. It focuses on companies that provide products in categories such as computers and software, uniforms and body armor, communications aids, vehicles, weaponry, forensics tools, tactical equipment, and video imaging products (http://www.officer.com/magazines/let/, retrieved 2010).

Many municipalities simply do not have the staffing resources necessary to allow dispatch personnel to be absent for 40 hours of training. Sending dispatchers to the week-long training can be particularly difficult for small departments. The absence of communications personnel at such training places many, if not most, agencies in a position of hardship (Cochran, S., personal communication, January 28, 2009).

A few months after the initial implementation of their CIT program, the Akron, Ohio Police Department realized that training for their dispatchers had been overlooked (Woody, M., personal communication, January 11, 2010). To address the shortage of staffing, Lieutenant Michael Woody, then Director of Training for the Akron Police Department, developed an abbreviated, four-hour, introductory course specifically designed for dispatchers. The CIT program in Summit County, Ohio now includes the facilitation of dispatch training, which can accommodate six dispatchers per class. Teller and colleagues (2006) examined the average number of mental disturbance calls per month over a 6-year period and found that in the years following CIT implementation in Akron, Ohio, the number and proportion of calls involving persons with a suspected mental illness increased. The authors suggested that dispatcher training increased awareness and improved assessment of such calls (Teller, Munetz, Gil, & Ritter, 2006). Another remedy for the staffing concern—at least for municipalities with an established CIT program—is to include training about CIT in the initial training of new dispatchers *before* they actually begin working.

After dispatchers have received CIT training, a number of simple policies could be implemented to facilitate their involvement in the overall CIT program. A video recently produced by the Ohio Criminal Justice Coordinating Center of Excellence depicts a dispatcher receiving a call from an individual with a mental illness who is in crisis; the dispatcher scans a list of psychiatric medications to determine whether the individual may have a psychiatric disorder based on his reported medications (Northeastern Ohio Universities Colleges of Medicine & Pharmacy Department of Academic Technology Services, 2009). The list of medications shown in the training video and other simple tools could be used by dispatchers to elicit information from callers so that such calls can be directed appropriately.

Another possible measure to improve the role of dispatcher in a CIT program is to flag on dispatchers' daily rosters the names of officers who are CIT-trained (Strode, P., personal communication, December 28, 2009). Although rosters usually denote the various qualifications of on-duty officers, not all jurisdictions indicate whether an officer is CIT-trained. To add such an important qualification to the daily roster has the potential to make a difference in the outcome of calls involving people with mental illnesses.

More evaluation and research is needed to thoroughly address the aforementioned issues regarding dispatch training and increasing their involvement with CIT. Although studies have examined the officer-level effects of CIT training in terms of knowledge, attitudes, self-efficacy, and stigma (Bahora, Hanafi, Chien, & Compton, 2008; Compton, Bahora, Watson, & Oliva, 2008; Compton & Chien, 2008; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Demir, Broussard, Goulding, & Compton, 2009; Hanafi, Bahora, Demir, & Compton, 2008), no studies have explored the potential barriers to successful CIT implementation from the dispatch perspective. Such research should likely begin with qualitative designs that elicit reports of successes and challenges from dispatch personnel and their supervisors.

Future research should address a number of questions pertaining to dispatch involvement in CIT. Following implementation of dispatch training and formal dispatch protocols, does the number and nature of CIT calls dispatched change? Do law enforcement agencies that have incorporated these measures into their CIT programs report better program outcomes (i.e., fewer injuries, fewer use-of-force incidents, less recidivism) than agencies that have not incorporated these dispatch-related measures?

Challenges Related to Poor Availability of Psychiatric Emergency Receiving Facilities

The limited research on police officers' experiences in accessing mental health services for people with mental illnesses suggests that they find it time-consuming and frustrating when referred subjects are quickly released by psychiatric emergency receiving facilities (Gillig, Dumaine, Stammer, & Grubb, 1990; Green, 1997). Despite this common eventuality, officers typically view a mental health outcome as preferable to an arrest or informal response. However, they indicate that service acquisition should be much less time-consuming and complicated (Wells & Schafer, 2006).

The CIT model includes a designated psychiatric emergency receiving facility with a "no-refusal" policy and minimal turnaround time for police officers as a core element (Dupont et al., 2007; Steadman et al., 2001). In Memphis, a single point of entry, the Memphis Medical Center, has a separate section for people with mental illnesses, secure holding units for police drop-offs, and indoor access to the local state psychiatric hospital. Studies of the Memphis CIT program suggest that the central, no-refusal drop-off site has increased officers' satisfaction and their willingness to connect individuals with a psychiatric illness with mental health services in lieu of arrest (Borum, Deane, Steadman, & Morrissey, 1998; Steadman et al., 2000). Geller (2008) suggested that Memphis' CIT outcomes could have more to do with this "police friendly acute mental health system" than the CIT program itself, although some might argue that the police-friendly arrangement is an integral aspect of the CIT program.

Unfortunately, a single psychiatric emergency receiving facility with a no-refusal policy might be infeasible and is absent in many jurisdictions implementing CIT. In a recent survey of police agencies in English-speaking countries (Hartford, Carey, & Mendonca, 2006), only 18% of responding agencies indicated that they had CIT programs involving a facility with a

no-refusal policy for police referrals. Only 31% of the agencies with CIT indicated any type of formal agreement with receiving facilities. Apparent barriers to a single entry point with no-refusal arrangements can be related to local policies, incomplete cooperation on the part of the mental health system, or the size of the jurisdiction.

Many jurisdictions implementing CIT programs lack formal policies with emergency receiving facilities but have effective informal agreements. For example, for the Atlanta Police Department's CIT program, which has been in operation since 2004, the main emergency mental health drop-off facility is a county hospital. There is a single site but no formal agreement between the hospital and the Atlanta Police Department. Although there is no written policy or formal agreement, the psychiatric emergency receiving facility's routine practice of care for the receiving triage nurse is to give priority to the police and other first responders. No patients are ever turned away, so currently access is guaranteed (though informally). Therefore, first responders are prioritized during the triage process based on the triage nurse's assessment.

In some instances, legal barriers can present obstacles for officers wanting to transport for evaluation a person with a mental illness who is in crisis. For example, Georgia state law dictates that in the absence of a physician's certificate or court order, police officers can take a person into custody for transport to a psychiatric emergency evaluation only if there is evidence that the person has committed a crime (O.C.G.A. §37-3-42, 2009). In those situations, officers also have the option of charging the person and transporting to jail, which might be a more familiar and time-efficient process for some officers.

In Chicago, significant efforts were undertaken to achieve a successful collaboration between the police and the mental health system; nevertheless, a single point of access was impractical given the size of the city. Thus, the Chicago Police Department developed memorandums of understanding (MOUs) with designated hospitals throughout the city. These MOUs established a no-refusal policy and gave police transports priority to reduce the time that officers spent waiting in emergency rooms. There is some variation across the city in how well the MOUs are being implemented, and occasionally police department and hospital administrators need to revisit or renegotiate the process. Most receiving facilities have no separate sections for psychiatric patients or secure holding facilities for people charged with serious crimes. Nonetheless, officers are generally satisfied with the drop-off process and its time efficiency, though but they are concerned that individuals transported to the hospital are quickly released without longer-term care (Canada, Angell, & Watson, 2010; Watson, Draine, Kriegl, & Bohrman, 2010).

Clearly, many jurisdictions have implemented CIT training without a designated, no-refusal drop-off site and even without collaboration or formal agreements with the local mental health system (Hartford et al., 2006). In the absence of such arrangements and collaboration, CIT training nonetheless equips officers to better negotiate the hospital admission process and surmount the barriers to obtaining emergency psychiatric treatment for individuals in crisis. However, the consensus in the field is that a designated emergency mental health drop-off site (or multiple sites) with a no-refusal policy is the key to improving officers' willingness and ability to access services for people with mental illnesses (Borum et al., 1998;Deane et al., 1999; Steadman et al., 2000). As noted above, MOUs between police departments and drop-off sites are a potentially useful tool for defining role expectations for a process that allows officers to access mental health services for people with mental illnesses who are experiencing a crisis, and to return to patrol duties in a timely manner (Finn & Sullivan, 1989).

Further research is needed to understand how different arrangements and agreements affect workflow for officers and receiving mental health personnel, and ultimately, the criminal justice and psychiatric outcomes for people with mental illness. What drop-off options work best in different contexts? Additionally, where collaboration is lacking, the field needs to understand what mechanisms can most effectively encourage and support collaborations between mental health and law enforcement professionals. Finally, a greater understanding is needed about which drop-off arrangements and policies lead to meaningful engagement in services and improved longer-term mental health and criminal justice outcomes for people with mental illnesses. This is critical, or as Geller cautioned, “For far too many, “CIT” might just as well stand for Consecutive Interventions without Treatment (p. 58).”

Challenges Related to Implementation of CIT in Rural Settings

Based on the 2000 U.S. Census estimates, about 25% of the nation’s population resides in a rural area (Bureau of Census, 2001). Rural America constitutes 90% of the nation’s landmass, resulting in low population density and greater distances between individuals and mental health services (New Freedom Commission on Mental Health, 2003). Factors such as mental health service disparities, greater social stigma related to seeking mental health treatment, and lack of early intervention services usually result in rural residents entering treatment with more serious, persistent, and disabling symptoms (New Freedom Commission on Mental Health, 2003). A major recommendation of the New Freedom Commission on Mental Health was to improve access to psychiatric emergency services in these areas. Rural law enforcement officers form an integral part of mental health emergency and crisis response systems. However, in addition to obstacles arising from rural culture, there are also specific system-, policy-, and environmental-level challenges to the successful implementation of CIT in rural areas.

The availability of a psychiatric emergency receiving facility, which is a key element in the successful implementation of CIT, is not guaranteed in rural areas (Kempf, 2008). Owing to a lack of local psychiatric treatment facilities, state mental health facilities are often the nearest available treatment option. The transportation of individuals with a mental illness to such distant facilities can result in law enforcement officers being out of service for up to eight hours (Kempf, 2008; Sullivan & Spritzer, 1997), potentially leaving rural jurisdictions with insufficient law enforcement protection during this time (Kempf, 2008). Long distances in rural areas are also a barrier to timely psychiatric mobile unit responses, which may contribute to longer waiting times for responding officers (Bonynge, Lee, & Thurber, 2005). The development of a regional mental health treatment transport component has been suggested as a means to address the issues related to the transportation of people with mental illnesses in rural areas (Kempf, 2008). The availability of an official system to transport people with mental illnesses to treatment facilities during crisis situations could help increase access to timely psychiatric care, as well as relieve law enforcement officials from the responsibility of transporting these individuals to distant treatment facilities.

Factors such as lack of transportation or unavailability of state hospital beds in rural areas can result in the detention of people with mental illnesses without any criminal charges or treatment while awaiting disposition. Sullivan & Spritzer (1997) surveyed a psychiatric population in rural Mississippi and found that 75% of the sample had been held in local jails without charges at least once in their lifetimes while awaiting state hospital admission. Psychiatric outcomes and experiences with the criminal justice system in rural areas vary greatly by individual states’ public mental health policies and services, as well as differences in socioeconomic and demographic factors in these areas (Sullivan & Spritzer, 1997).

For effective implementation of CIT in rural areas, it is imperative to develop policies that are tailored to local needs and are culturally competent, while fostering collaboration between local law enforcement and mental health officials (Chamberlain, 2006; New Freedom Commission on Mental Health, 2003). Projects conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in rural U.S. counties recommend that for successful implementation of CIT, rural officials must adapt urban models to their local community needs, while: developing an appropriate CIT curriculum and dispatch training, providing psychiatric helpline services, arranging for centralized psychiatric triage services, and developing effective jail diversion models (Chamberlain, 2006). In order to have an adequate number of CIT officers available to serve their community's needs, smaller, rural police departments might need to train a higher percentage of officers compared to larger, urban police departments (Dupont et al., 2007). Additionally, policies in rural areas must provide for contracts with service providers for evaluation, treatment, and crisis stabilization, as well as psychiatric consultation for jail inmates presenting with symptoms of a mental illness (Chamberlain, 2006). The field would benefit from descriptions and evaluations of CIT implementation in rural settings.

Conclusions

The Memphis CIT model is considered the "gold standard" for training police officers in crisis intervention (Addy & James, 2005) and implementing the diverse core elements of the program. Officers who complete the CIT training program are generally assigned to the uniform patrol division and therefore are first-line officers in responding to calls for assistance. These officers respond to an entire range of emergency calls but are specifically assigned to disturbance calls that involve people with mental illnesses, substance use disorders, or developmental disorders, who are in a crisis (Cochran et al., 2000). Although the Memphis CIT training model has been replicated in many localities and states throughout the country, the essential elements of CIT vary from one program to another. That is, while the police training component within these CIT programs is similar in terms of instructional content and curricular format, other aspects of the programs often differ.

A frequently occurring challenge in moving CIT to broader implementation so that it is truly "more than just training" entails the lack of dispatch involvement in the training itself, in addition to a lack of departmental policies governing procedures for dispatching CIT officers to crisis-related calls. Several law enforcement agencies have begun to develop and implement specific CIT-related training for their emergency communications personnel. The training affords these personnel with the opportunity to understand the objectives of the CIT program and the potential liability associated with incorrectly coding CIT calls. The training developed by a law enforcement agency or through a community-based collaboration could be based partially or entirely on the Memphis CIT training curriculum that was developed specifically for emergency communications personnel (911 operators/dispatchers), or it could be unique to an agency's policies and procedures governing the identification and dispatch of CIT calls.

Another prominent difference among municipalities that have implemented CIT, which presents an important challenge, is the availability of conveniently located, 24-hour, no-refusal psychiatric emergency receiving facilities. Additional research is needed on this key ingredient and other core elements of diverse CIT programs and how they influence officer-, subject-, and community-level outcomes of the CIT program. Research should also begin assessing issues related to CIT implementation in rural settings, which often brings unique challenges related to the availability of emergency receiving facilities and transportation across great distances.

As the CIT model is further disseminated in diverse settings, these and other challenges will inevitably arise. Such challenges, however, represent opportunities for improvements within both the law enforcement/criminal justice sector and mental health services. By addressing the challenges in a collaborative manner, professionals in both fields are more likely to feel satisfied in the services that they are providing to the public. More importantly, families and communities can rely on more responsive and well-planned services. And perhaps most importantly, individuals affected by serious mental illnesses who are in crisis, will have better outcomes by virtue of their interactions with both the law enforcement/criminal justice and mental health services communities.

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