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Abstract

Purpose – Extant literature resoundingly praises Crisis Intervention Team (CIT) programs for the multitude of benefits they provide for law enforcement agencies and individuals with mental illnesses. The majority of CIT research is based on perceived benefits of this approach. Most of the goals of CIT programs are readily amenable to empirical study, yet there are few outcome evaluations of the programs. The purpose of this paper is to examine why empirical studies examining the effectiveness of CIT programs are nominal.

Design/methodology/approach – Structural and practical impediments to the collection of empirical data for CIT programs were identified through including examinations of the types of data routinely collected, interviews with CIT participants, and the researchers' own observations of hindrances to the data collection processes. By triangulating these methods, the authors were able to observe a number of impediments to the collection of empirical data on this topic.

Findings – The multi-jurisdictional CIT program under review had several data problems. First, there was a lack of official data concerning CIT calls. Second, it was virtually impossible to follow a person with mental illness throughout the system from first contact to final disposition. Third, data sharing was hindered by a lack of memorandums of understanding. Fourth, important information was not being properly recorded.

Originality/value – This manuscript provides recommendations to address data concerns for CIT evaluations. Suggestions are intended to help facilitate more robust data for analysis and evaluation purposes, helping to grow the literature on the effectiveness and efficiency of CIT programs.

Keywords Innovation, Evaluations, Problem-oriented policing

Paper type Research paper

The criminalization of persons with mental illness (PMI) is a documented problem in the USA (Steadman *et al.*, 2001; Lamb *et al.*, 2002; Oliva and Compton, 2008; Ralph, 2010). For many PMI, contacts with law enforcement occur on a regular basis (Clark *et al.*, 1999; Hafani *et al.*, 2008; Skeem and Bibeau, 2008). Research indicates that seven to ten percent of law enforcement contacts involve someone who has been diagnosed with a mental illness (Borum *et al.*, 1997, 1998; Deane *et al.*, 1999; Steadman *et al.*, 2000; Franz and Borum, 2011) and that the overwhelming majority of police officers have had multiple contacts with PMI (Borum *et al.*, 1998). In fact, most PMI will be arrested at least once, and many will be arrested multiple times throughout their lives (Borum *et al.*, 1998; McFarland *et al.*, 1989).

Contacts with PMI can be challenging for law enforcement because PMI in crisis often have problems with impulsivity, disorganized thought processes, skewed perceptions of

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risk, and/or poor problem solving skills (Gur, 2010). Regular law enforcement tactics may intensify the individual's level of distress, and he or she may respond with violence that could result in injury to him or her and/or others at the scene (Strauss *et al.*, 2005; Gur, 2010).

The unique issues associated with law enforcement interactions with PMI have prompted some agencies to implement strategies to more effectively manage these types of situations. One such rapidly expanding effort is the establishment of Crisis Intervention Teams (CITs). CITs are programs designed specifically to improve officer interaction with PMI by increasing officers' knowledge and skills regarding mental illnesses and officers' response to individuals in crisis (Teller *et al.*, 2006). The CIT model was developed by officers within the Memphis Police Department in 1988, and there are currently more than 400 similar CIT programs in the USA (Strauss *et al.*, 2005; Teller *et al.*, 2006; Compton *et al.*, 2008).

Given that there are hundreds of existing CIT programs, it is surprising that there are relatively few outcome evaluations of CIT efforts. The lack of effectiveness studies may be the result of data impediments stemming from the multi-agency approach forming the basis for CIT. The purpose of this manuscript is to examine the issues and obstacles that might be encountered during CIT evaluations and to suggest improvements to the data collection process that would allow for the proper evaluation of these programs as well as provide agencies with valuable information for addressing these serious issues.

Background and purpose of CITs

As first responders, law enforcement personnel must serve as "street-corner psychologists" and "gatekeepers" who must decide how to best handle the situation based on both preserving public safety and meeting the needs of the individual (Bittner, 1967; Sheridan and Teplin, 1981; Teplin and Pruett, 1992; Borum *et al.*, 1998; Steadman *et al.*, 2000; Hails and Borum, 2003; Vermette *et al.*, 2005; Teller *et al.*, 2006; Hanafi *et al.*, 2008; Canada *et al.*, 2010). Traditionally, officers choose from two dispositions for PMI in crisis: arrest the person or attempt to connect the individual with mental health services. In many situations, arrests are made when mental health treatment would be best for the individual (Green, 1997; Dupont and Cochran, 2000; Teller *et al.*, 2006; Oliva and Compton, 2008).

Arresting PMI is sometimes viewed as the most expedient, but not necessarily the most appropriate option for a variety of reasons. First, it can be difficult for an officer not trained about mental illnesses to surmise that a person's behavior is a symptom of a sickness (Gur, 2010). Second, some officers are not familiar with mental health resources available, so they may believe that more appropriate alternatives are limited or not available in the area (Teplin and Pruett, 1992; Borum *et al.*, 1998; Borum, 2000). Third, available treatment options might be limited because of a lack of space or regulations that prohibit certain mental health facilities from accepting some types of patients (e.g. those exhibiting violent behavior or intoxicated individuals) (Oliva and Compton, 2008; Gur, 2010). Last, in the short term, the arrest option may be more efficient for the officer and the department because the officer is able to resume patrol more quickly than if he or she was obligated to stay with a patient during evaluation and triage at a local emergency department or until a bed is secured at a treatment facility (Gur, 2010; Lurigio and Watson, 2010). Overall, a large proportion of PMI are arrested, usually for minor infractions such as disorderly conduct (Strauss *et al.*, 2005; Oliva and Compton, 2008; Lurigio and Watson, 2010).

Arrests of PMI serve as the beginning of a process with damaging consequences for not only PMI, but also the criminal justice system and the public at large (Fichtner and Cavanaugh, 2006). If cases are dismissed, PMI are generally released without treatment. If PMI are convicted, judges must decide on the best sentencing option for each defendant. While community supervision such as probation is the disposition for many PMI, community mental health services are often scarce (Lurigio and Watson, 2010). Jails and prisons also struggle to provide adequate mental health services to these inmates, who are more expensive to house than inmates without mental illnesses (Axelson and Wahl, 1992; Cowell *et al.*, 2004; Lamb and Weinberger, 2005). Many PMI are therefore released without having received proper mental health treatment and community referrals. Consequently, numerous PMI will become immersed in a cycle of rearrest and eventual release without ever obtaining proper treatment (Draine *et al.*, 2002; Petrila *et al.*, 2003; Oliva and Compton, 2008; Lurigio and Watson, 2010).

Many law enforcement agencies have implemented specialized strategies to more effectively respond to PMI. One such strategy is the CIT model, which is based on strong partnerships between law enforcement, the mental health community, and, when possible, those persons closely associated with PMI (Cochran *et al.*, 2000; Dupont and Cochran, 2000; Compton *et al.*, 2008). Various stakeholders involved in CIT programs might have slightly different missions (Teller *et al.*, 2006). For example, the mental health community might be most interested in decreasing the number of arrests of PMI, while law enforcement might focus on the safety of officers and the public. Still, all stakeholders work together toward the overall goal of improving the safety of all parties involved when PMI have crises while also providing the best dispositions for PMI (Compton *et al.*, 2008).

Partnerships between multiple services providers can be complicated (Munetz *et al.*, 2006), but the cooperation and teamwork of mental health providers and law enforcement is key to the CIT model (Steadman *et al.*, 2000; Compton *et al.*, 2009). CITs are comprised of police officers, typically volunteers, who undergo specialized training conducted by mental health professionals that improves the officers' ability to recognize and respond to PMI in crisis (Deane *et al.*, 1999; Dupont and Cochran, 2000; Strauss *et al.*, 2005; Compton *et al.*, 2008; Oliva and Compton, 2008). During training, officers are taught about various mental illnesses and the signs and symptoms associated with them, psychiatric medications, substance abuse, mental health commitments, patient rights, and proper intervention techniques to use in a crisis. They also learn about the particular mental health treatment options in the area, as well as the protocol involved with obtaining treatment for PMI (Cochran *et al.*, 2000). Ideally, part of the law enforcement and mental health partnership will include agreements with local treatment providers, drop-off facilities, and emergency departments that will allow smooth and quick transitions of PMI in crisis from CIT officers to a treatment facility (Cochran *et al.*, 2000; Steadman *et al.*, 2000; Hanafi *et al.*, 2008; Oliva *et al.*, 2006; Compton *et al.*, 2008).

When a CIT program is implemented, telecommunicators should be trained, at minimum, to recognize calls that potentially involve PMI and then send CIT officers. Based on CIT training, the officers will assess the scene and intervene as appropriate. Cases usually will be resolved by CIT officers through de-escalation or some other verbal technique on scene, referral to a current treatment provider, referral to a new treatment provider, transportation to an emergency treatment provider, or arrest (Cochran *et al.*, 2000; Strauss *et al.*, 2005).

Although the core elements of CIT programs are fundamental to their success, it should be noted that all CIT programs do not operate in exactly the same way. That is, there is some room for modification among local teams. For instance, as Oliva and Compton (2008) point out, mental health resources are scarcer in rural areas. Accordingly, CIT in these types of jurisdictions might have partnerships with drop-off treatment facilities in neighboring jurisdictions, and they may depend on the local sheriff's office or ambulance service for transport. Especially for jurisdictions that are a part of a larger (e.g. statewide) effort to implement CIT, it is important to recognize that slight differences in local program logistics are the only way to create the best model for each community (Borum *et al.*, 1998).

Process and outcome evaluations of CITs

It has been suggested that properly implemented CITs will provide opportunities for appropriate treatment for PMI, reduce unnecessary arrests of PMI, result in fewer injuries, involve less officer time on PMI calls, and reduce the occurrence of repeat calls (Borum *et al.*, 1998; Dupont and Cochran, 2000; Steadman *et al.*, 2000; Bower and Petit, 2001; Franz and Borum, 2011). Although CITs have existed for more than 20 years, empirical evidence to support (or refute) these claims is scant. Much of the research concerning CIT has been based on surveys, interviews, and focus groups consisting of CIT officers (Compton *et al.*, 2008). These studies overwhelmingly conclude that CIT training improves officers' knowledge and preparedness in dealing with PMI with the majority of officers reporting that they feel comfortable applying their skills to deescalate or otherwise control a situation involving PMI. Most officers also say they have lower arrests rates for responses involving PMI after CIT training as compared to similar calls before learning CIT techniques (Compton *et al.*, 2006; Hafani *et al.*, 2008; Wells and Schafer, 2006; Bahora *et al.*, 2008; Canada *et al.*, 2010; Watson *et al.*, 2010). Although the aforementioned studies are informative, they are based on perceptions of CIT personnel rather than data derived directly from CIT calls.

There are a limited number of CIT evaluations based on empirical information collected as part of the CIT process. Outcomes used in these studies include CIT-related issues such as response and disposition of CIT calls, profiles of CIT vs non-CIT patients in emergency psychiatric facilities, officer use of force, injury to officer or suspect, and the cost effectiveness of CIT and jail diversion (Borum *et al.*, 1998; Dupont and Cochran, 2000; Steadman *et al.*, 2000; Bower and Petit, 2001; Lattimore *et al.*, 2003; Naples and Steadman, 2003; Cowell *et al.*, 2004; Strauss *et al.*, 2005; Teller *et al.*, 2006; Skeem and Bibeau, 2008; Compton *et al.*, 2008; Lord *et al.*, 2011). In a study of CIT in Louisville, police officer injuries went down significantly after CIT was implemented, and the number of patients treated by emergency psychiatric services increased (El-Mallakh *et al.*, 2003; Strauss *et al.*, 2005). Similar results were found with Akron's CIT program, with CIT officers being significantly more likely to transport PMI to psychiatric treatment (Teller *et al.*, 2006). In terms of arrest, Skeem and Bibeau (2008) and Steadman *et al.* (2000) found that the CIT arrest rates for PMI calls were about three to four times lower than the arrest rates of non-CIT officers.

Overall, the modicum of evidence indicates that CIT programs are promising and are beneficial for all parties involved (Strauss *et al.*, 2005; Teller *et al.*, 2006; Compton *et al.*, 2008; Canada *et al.*, 2010). Nevertheless, there seems to be a sizeable gap in the number of outcome evaluations of CIT, considering that there are hundreds of CIT programs across the country. Further, existing studies tend to use only one or two outcome measures (e.g. number of PMI transported to treatment vs arrest, injuries to officers)

rather than multiple outcomes that could illustrate both the effective elements and the shortcomings of the particular CIT program (e.g. arrest vs treatment for PMI, injuries to officers and suspects, repeat calls, and cost-effectiveness in terms of resources, time, and diversion).

Perhaps evaluating these types of programs is complicated by problems with official data related to CIT incidents. For example, Strauss *et al.* (2005) report there were missing data for dispositions of 24.3 percent of cases in their study of CIT in Louisville. Missing data issues may be a product of the fact that data for PMI cases often falls under the jurisdiction of both law enforcement and mental health authorities. These types of data concerns are the focus of the present study.

The current study

While the extant literature resoundingly praises CIT programs for the multitude of benefits they provide, the vast majority of this literature is based on officers' and PMI's perceptions of the benefits of this approach. While these perceptions are an important aspect of the program, its implementation and growth would be further strengthened by the existence of multiple outcome evaluations examining program effectiveness in a variety of contexts. Most of the goals of CIT programs are readily amenable to empirical study: reducing the incarceration of and repeat calls of PMI, decreasing injuries of PMI and officers, improving community relations, and decreasing costs to the criminal justice system.

The current study attempts to examine the issue of why empirical studies examining the effectiveness of CIT programs are nominal. The problem is examined from a variety of perspectives including examinations of the types of data routinely collected, interviews with CIT participants, and the researchers' own observations of hindrances to the data collection processes. By triangulating these methods, we were able to observe a number of impediments to the collection of empirical data on this topic. This manuscript identifies the structural and practical obstacles to data collection and suggests methods of addressing these to facilitate more robust data for analysis and evaluation purposes thereby facilitating the growth of the literature on this important innovation in policing strategies.

Methodology

The authors were commissioned by a state agency in North Carolina to evaluate CIT programs in three areas of the state. North Carolina has 100 counties, 14 metropolitan areas, and approximately 9.5 million residents (US Census Bureau, 2012). Estimates indicate that nearly five percent (434,000) of North Carolina residents have a serious mental health condition, and, as with most jurisdictions nationwide, many PMI in the state have been or will be involved with the criminal justice system (NAMI, 2010).

During the time of the study, CIT programs had been completely implemented in several jurisdictions; officers were being trained in some jurisdictions; and the program had not yet been implemented in some jurisdictions. Though the CIT programs differed slightly based on available resources (e.g. drop-off and treatment facilities) in jurisdictions, each program was based on the same model and training methods. Each law enforcement agency had a partnership with mental health authorities in the area and had access to a regional CIT coordinator.

Types and sources of information/data collection process

Official data collection. The data necessary to evaluate many of the goals listed above can be garnered from official sources typically collected by law enforcement agencies.

In addition to the traditional call logs and databases designed to capture basic information about police-citizen encounters, each of the agencies in the state who have CIT trained officers were required to complete special CIT data forms detailing information such as the reasons for the call, basic demographic information on the PMI, the use of force, existence of injuries, the PMI's status, time of the call, and the disposition of the call. The current form consists of one page of basic information and another page where the officer can provide a narrative of the call describing the CIT intervention. The existence of these data allows for the evaluation of a variety of aspects of CIT programs including, but not limited to, an understanding of the prevalence and frequency of CIT-related calls for service, the disposition of these calls, important characteristics of these calls vs other types of calls (e.g. officer injuries), and associated costs of these interactions (e.g. mileage, time spent, etc.).

Statewide survey. A general self-administered survey was designed by the researchers to collect information concerning CIT data collection efforts in local CIT-related agencies across the state. Although no identifiers were collected, one survey item asked respondents to generally categorize the type of agency (e.g. police department, sheriff's office, treatment agency) and area (e.g. urban, rural) in which they worked. Other items on the survey covered a variety of topics including the types of calls that were considered to be mental health-related calls, when the data forms were supposed to be collected, the types of information collected, suggestions for additional information that would be helpful if collected on the CIT forms, and why officers might be reluctant to fill out the forms. Each item on the survey contained a list of potential responses, as well as an "other" option that allowed respondents to provide their own answer.

At the time of survey distribution, there was no centralized list of individuals involved in North Carolina's CIT efforts. Since there was no sampling frame containing representatives from all agencies involved in the state's CIT program, a purposive sample of potential respondents was selected to complete either an anonymous web-based survey or an anonymous paper survey. First, we contacted individuals participating in CIT via an e-mail invitation that contained a link to the anonymous web-based survey. Given that the researchers did not have contact information for CIT participants in the state, we attempted to reach them indirectly through e-mails sent by representatives from the state's Division of Health, Developmental Disabilities, and Substance Abuse, the state's Chiefs of Police Association, and the state's Sheriffs' Association. After confirming that officials from these three organizations were willing to forward the survey request to their agencies, investigators sent them the e-mail containing information about the project, instructions concerning who should receive the survey, and the survey invitation that contained a hotlink to access the instrument. Officials from the three organizations forwarded the e-mail to their primary contacts within their participating agencies. Per the information in the e-mail, the agency contacts were asked to forward the e-mail to individuals participating in the CIT program. Three weeks later, the same process was used to distribute a reminder e-mail to encourage individuals to participate in the survey if they had not already completed it. While we do not know the total number of individuals to whom the e-mail was sent because of the top-down process used to reach potential respondents, the web-based survey produced 38 responses.

The paper version of the same survey was later made available at a statewide CIT conference. Attendees who participated in CIT programs were told about the survey and invited to complete a paper version if they had not already completed the online

version. There were 108 responses from the conference. Comparative proportion analyses indicate that there were no significant differences in the types of responses given by those who completed the survey online and those who completed the paper version.

Table I contains a summary of types of survey respondents and their service areas. The majority of respondents (69.6 percent) were employed by police departments, followed by employees of local management entities (LMEs) or local mental health treatment facilities (16.8 percent), Sheriff's Offices (10.4 percent), "Other" respondents (2.4 percent, including county government and NAMI), and other mental health treatment provider agencies (0.8 percent). There were 21 respondents who did not provide information about their employing agencies or service areas, which may be a form of passive non-disclosure. Respondents were informed that the survey was anonymous, but they might have feared that such information could be used as identifiers for them personally or for their organization (Tomaskovic-Devey *et al.*, 1994; Joinson *et al.*, 2007).

Of the respondents that identified the type of agency for which they worked, 80 percent were employed by police departments and sheriff's offices. Although the researchers sought input from all types of CIT members, law enforcement personnel typically are the first responders and are responsible for completing CIT data forms. While the underrepresentation of mental health personnel in this sample limits our knowledge of their perspective, given the content of the survey items, it is not a problem since the law enforcement officers tend to be very knowledgeable about the CIT process and provide credible and informative responses.

Focus group. In addition to the data sources mentioned above, the researchers conducted a focus group made up of representatives from the professionals most involved with the CIT program in the jurisdictions covered by the study. The focus group consisted of a mix of CIT coordinators, trainers, and team members (both law enforcement and mental health providers) from two of the three sites studied. Representatives from the third site were unavailable to attend the focus group due to scheduling conflicts. Structured open questions and the survey results discussed above guided the focus group discussion. Shortly after the focus group, a similar discussion was held with representatives from the third site via telephone. Although the three sites differed slightly in terms of protocol, resources (e.g. number of officers and the availability of hospitals or other drop-off treatment facilities), representatives from each site offered very similar insights regarding problems with collecting and accessing information regarding CIT calls.

Table I.
Summary of respondents by agency and type of service area

	Urban, *n* (valid %)	Rural, *n* (valid %)	Combined urban and rural, *n* (valid %)	Total, *N* (valid %)
Police department	54 (43.2)	22 (17.6)	11 (8.8)	87 (69.6)
Sheriff's office	5 (4.0)	3 (2.4)	5 (4.0)	13 (10.4)
LME or local mental health treatment facility	6 (4.8)	3 (2.4)	12 (9.6)	21 (16.8)
Other mental health treatment provider agency	1 (0.8)	0 (0.0)	0 (0.0)	1 (0.8)
Other	2 (1.6)	0 (0.0)	1 (0.8)	3 (2.4)
Total	68 (54.4)	28 (22.4)	29 (23.2)	125 (100.0)

Note: A total of 21 respondents skipped this item

Findings

This section of the manuscript presents the issues uncovered during the data collection that we believe contribute to the inability to effectively conduct outcome evaluations as well as our suggestions for addressing these issues.

Issue no. 1: lack of official data

The majority of the data issues impeding effective outcome evaluation of the CIT program stem from issues surrounding the collection of official data. The most serious and widespread of the issues encountered was the lack of completed CIT data forms. The majority of the departments examined did not fill out the forms for CIT calls. Several departments stated that they completed the forms, but their CIT coordinators were unable to produce the forms and did not have any data related to the forms. Even in the department that was most diligent in completing the forms and utilizing the data obtained from the forms, we discovered mistakes in the data collection. For example, cases were listed in the telecommunications' files that were not listed in the CIT coordinator's file and vice versa. This is most likely a product of the fact that in most jurisdictions the CIT forms are paper-based forms that must be manually entered, increasing the probability of human error. In the studied county that had enough forms to analyze, these paper forms are collected by the CIT coordinator who then enters the data manually into an excel form without any crosschecking for error.

The statewide survey queried law enforcement officers and personnel from other agencies about the information that was supposed to be routinely collected for CIT calls (Table II). Interestingly, the data show that there was no single item for which all agencies collect information; however, most of the agencies state they collect data on several of the items listed. It is notable that nearly 30 percent of respondents said they did not collect information about the reason for the call or the PMI's demographic characteristics. Most of these respondents indicated that their agencies did not collect any information about CIT calls specifically, though a few of the law enforcement respondents did collect information regarding whether force was used during the contact and injuries to PMI or officers. Further, fewer than half collected information concerning the disposition of the CIT call, the use and compliance of psychiatric

Option total ($N = 146$)	n	%
Reason for call	101	69.2
PMI demographics (e.g. age, race, gender)	100	68.5
Officer observations concerning PMI (e.g. level of violence, suicide attempt, behavioral observations, physical observations)	90	61.6
Family/friend/guardian contact information	86	58.9
If force was used during the contact	83	56.8
PMI injury	77	52.7
Substance abuse suspected at time of call	77	52.7
Officer injury	74	50.7
Disposition of CIT call	72	49.3
Use and compliance of psychiatric medications	72	49.3
List of possible charges if PMI would have been taken to jail (if CIT had not been used)	64	43.8
If situation warranted a CIT dispatch (based on officer knowledge and training)	63	43.2
PMI status (new or current PMI, probation, etc.)	61	41.8
Previous history with PMI	60	41.1
Other	19	13.0

Table II. Types of information routinely collected for CIT calls

medications, list of possible charges, if the situation warranted a CIT dispatch, PMI status or any previous history with the PMI. Although not reported in Table II, it is also significant that only 43 of the respondents indicated that they have CIT data in an electronic format.

An additional concern is that officers often think that the forms are voluntary rather than required, and they have no incentive for completing these forms. Table III shows that only a slight majority (52.1 percent) of the respondents to our statewide survey indicated that the forms were required for mental health-related complaints that required CIT officer time. Fewer respondents (21.9 percent) reported that CIT data sheets should be completed when a PMI is arrested than when PMI are transported to a crisis facility or emergency room (32.9 percent) or when involuntary commitment papers are served (28.8 percent). Only 11.6 percent of respondents indicated that CIT forms should be completed for all mental health-related complaints.

Also troubling is that almost half (48.6 percent) the respondents reported that officers were reluctant to fill out the CIT forms because much of the information being collected on the forms is duplicative of the information they are already completing on their traditional reports (Table IV). Similarly, 41.8 percent of respondents indicated that officers did not complete the data sheets because they are too time consuming, and almost a third (32.2 percent) blamed lack of repercussion for failure to complete the forms. More than 12 percent perceived that officers did not do the CIT paperwork because they were not sufficiently dedicated to or invested in the CIT program.

Table III.
Responses concerning instances when CIT forms or data sheets should be completed

Option total ($N = 146$)	n	%
For any mental health-related complaints that require CIT officer time	76	52.1
Only by CIT-trained officers for mental health-related calls	68	46.6
Whenever a PMI is transported to a crisis facility or emergency room	48	32.9
For any mental-health-related complaint that requires any type of transport of a PMI (including jail)	46	31.5
For any service of involuntary commitment papers	42	28.8
For any mental health-related complaint in which the officer or PMI is injured	39	26.7
For any mental health-related complaint in which the PMI is arrested	32	21.9
By any officer, whether or not CIT trained, who responds to a mental health-related call	22	15.1
For all mental health-related complaints	17	11.6
Other	27	18.5

Table IV.
Factors associated with reluctance of law enforcement officers to complete CIT forms

Option total ($N = 146$)	n	%
Redundancy of information that is already included in other forms that must be completed	71	48.6
Time consuming	61	41.8
They do not understand that completed forms may be beneficial to the system	50	34.2
No penalty for not completing the form	47	32.2
Because it is optional, not mandatory	43	29.5
No reward/incentive to complete form	41	28.1
Because the order to complete the form did not come from the Chief or Sheriff	25	17.1
Because the CIT officers are not sufficiently dedicated to or invested in the CIT program	18	12.3

There are several recommendations to help facilitate the completion of the CIT forms. The investigators recognize that the CIT forms may vary among jurisdictions and agencies because of differing resources and available treatment options. At the very least, all CIT forms should include essential information concerning the reason for the call, PMI characteristics, injuries, and outcome of the call. Once a form has been designed and implemented within the jurisdiction, it is imperative that forms are completed consistently for every CIT call.

Issue no. 2: format of the data collection sheet

First, the data need to be in electronic format, allowing for the easier analysis of the data, the sharing of data among agencies and CIT coordinators, and simplifying the process for officers. In addition, we believe that the required CIT information should be added to the preliminary field report officers currently complete on most calls. Forms are much more likely to be filled out if they are part of the computer-aided dispatch (CAD), clear and not redundant. This would help reduce the perception of wasted effort.

Responses from both open-ended questions on the surveys as well as in the focus group garnered suggestions for encouraging law enforcement officers to complete the CIT forms. Respondents overwhelmingly said that the upper administration of law enforcement agencies should be on board and invested in the CIT program, understanding the program's purpose and how it operates. Respondents also felt it was important for these administrators to create policies and procedures that would make the CIT data form mandatory for all CIT calls. It was also suggested that officers be educated about the importance of the forms, explaining how they will be utilized (e.g. to demonstrate effectiveness, to provide background for officers who may encounter the PMI in the future). Finally, the respondents felt that incentives should be offered to encourage completion of the forms. Suggestions for potential incentives ranged from positive reinforcements such as thank-you e-mails to giving officers updates on PMIs to demonstrate the positive impact the officers' interventions generated.

Issue no. 3: an inability to follow a PMI's case through the system

For a variety of reasons, agencies are unable to follow a PMI as they interact with different criminal justice and mental health agencies. One of the initial challenges is that the vast majority of law enforcement agencies have no initial way of coding CIT calls to trigger the process. In fact, many jurisdictions also lack specific labels for mental health-related calls. Although across the studied jurisdictions a large number of dispatchers are receiving CIT training, there is currently not a method of identifying the call as a CIT call from the beginning of the PMI-police interaction. Instead telecommunicators identify the call by the first responding officer, who is often not a CIT officer. Although agencies denote emergency commitment, suicide and overdose calls, these categories do not guarantee that these are CIT-involved calls. The lack of a designated dispositional code to identify a CIT call makes it is impossible to link the data that the telecommunicator collects with the data from the CIT forms.

Further, even when attempts were made to label calls for service as CIT calls, respondents indicated that one could only identify CIT calls by culling through either the report narratives or by the completion of the CIT forms. Neither of these is a reliable way of identifying calls. As mentioned above, the collection of CIT forms is extremely problematic, and due to the volume of calls received by most agencies, the former suggestion is unrealistic.

Additionally, few non-law enforcement agencies attempt to differentiate CIT calls from other calls so their data cannot be associated with the data collected by law enforcement officials. For example, corollary agencies (e.g. Crisis Centers) that collect their own data do not distinguish which PMI are brought in by CIT officers and which are brought in by family or other agencies or are walk-ins. In addition to the fact that this inhibits matching the data with law enforcement data, this also means that one is unable to compare CIT calls with non-CIT calls, and therefore one loses the ability to make valuable comparisons showing benefits and risks of CIT intervention. This issue could be resolved by adding a CIT code to CAD systems that denote PMI calls as CIT calls from the beginning. If this is not possible (e.g. the initial report does not imply potential CIT involvement) then CIT-certified officers should have the ability to electronically add this code after the fact.

Moreover, respondents to both the survey and focus group indicated that statewide funding for the CIT program would help ensure that agencies would be able to properly collect and manage CIT data. Similar to the suggestions above, respondents felt that integrating CIT information into CAD reports or some type of web-based data collection system would help link together all involved agencies starting with the telecommunicator and ending with the law enforcement officer, detention or mental health professional.

Issue no. 4: lack of departmental CIT procedures and interagency departmental memorandum of understanding (MOUs) to facilitate data sharing

Unfortunately, written protocols and procedures involving CIT officers are lacking in many law enforcement agencies. This lack contributes to some of the misunderstandings found in the survey responses, as well as a lack of uniformity concerning the types of data that should be collected and the sharing of those data among agencies. We also discovered in asking participants if their CIT partnerships had formal MOU agreements that delineated the process, procedures, and responsibilities of each partner involved in CIT in regard to data collection, management, analysis, and reporting that over two-thirds of those queried responded that either MOUs were not in place, or they were unaware if they existed. Clearly both the existence of an MOU and the dissemination of this information to relevant stakeholders would help all involved to pursue clear, shared objectives in terms of data collection. This sharing would also help to standardize the data collection across jurisdictions so that meaningful comparisons could be made.

Issue no. 5: not all necessary and important information is included on the CIT forms

While the constructed data collection forms typically have fields to record important and vital information about the PMI and the service call, there is additional information that if added to the form would benefit both agencies and officers. One problem that stood out on the CIT forms was the lack of clearance time on the CIT forms (only arrival time was collected). This meant that the researchers were unable to calculate the total amount of time spent on the call; thereby, inhibiting cost-benefit calculations.

To facilitate an understanding of what types of information might be useful to collect, we queried individuals to determine their recommendations (Table V).

It should be noted that this question specifically asks about data aside from that which is already collected. Respondents were most interested in adding data concerning contact information for PMI families or friends, previous history with PMI, PMI status, and the reason for the call. In total, 40 respondents said information concerning PMI injury should be collected, while 33 thought a list of possible criminal charges if CIT had

Option total ($N = 146$)	n	%
Family/friend/guardian contact information	48	32.9
Previous history with PMI	46	31.5
PMI status (new or current PMI, probation, etc.)	44	30.1
Reason for call	43	29.5
If force was used during the contact	43	29.5
Disposition of CIT call	40	27.4
Officer observations concerning PMI (e.g. level of violence, suicide attempt, behavioral observations, physical observations)	40	27.4
PMI injury	40	27.4
Officer injury	39	26.7
PMI demographics (e.g. age, race, gender)	37	25.3
If situation warranted a CIT dispatch (based on officer knowledge and training)	36	24.7
Substance abuse suspected at time of call	35	24.0
Use and compliance of psychiatric medications	35	24.0
List of possible charges if PMI would have been taken to jail (if CIT had not been used)	33	22.6
Other	10	6.8

Table V.
Summary of responses for other types of data that would be useful to collect

not been used would be useful information (this information is collected on data forms used in some LMEs). Four respondents submitted responses indicating that it is important to collect as much CIT information as possible because it is all potentially useful. They go on to say the problem is that, because CIT is an unfunded mandate, agencies do not have the resources to properly review and utilize the data.

Discussion and recommendations

One reason for the limited number of empirical assessments of CITs is likely the difficulty in obtaining the necessary data to measure desired processes and outcomes and empirically examine the overall effectiveness of CIT. The lack of CIT data was certainly a problem in the jurisdictions examined in this study. As mentioned previously, CIT programs may differ slightly because of differences in mental health services and drop-off facilities between jurisdictions (Borum *et al.*, 1998; Oliva and Compton, 2008; Lord *et al.*, 2011). Nevertheless, model CIT programs will share the same core elements, including close collaborations between mental health professionals and law enforcement agencies and standardized CIT officer training (Teller *et al.*, 2006; Oliva and Compton, 2008; Lord *et al.*, 2011). Another important component, which apparently has been overlooked in some agencies, is a solid plan for collecting data related to CIT incidents. The results of our survey of individuals involved in CIT programs in North Carolina suggest that the key impediments to data collection derive from a few straightforward issues that are capable of being resolved.

First, there should be a formal MOU that explicitly spells out the CIT process, procedures, and responsibilities of each stakeholder involved in the CIT program. All CIT participants, from administrators to line officers, should be made aware of the components of the MOU so that it is clear what is expected of each partner. That is, individuals working in CIT programs should know not only their roles, but also should learn the workings of the larger CIT program and the roles of each agency involved. The clear existence of such an MOU would also help to clarify command support for the program. The MOU should then be incorporated into policies and procedures

directing the deployment of CIT-certified law enforcement officers and then these officers' actions once they receive a CIT call.

Additionally, there should be consistency in what types of calls are potentially mental-health related, and thereby eligible for a CIT officer to be dispatched. To the degree possible, this list should be standardized for agencies with CIT programs and train telecommunicators to dispatch a CIT officer to those types of calls whenever possible. If a CIT officer is dispatched, the call should be logged specifically as a CIT incident. This label will make it possible to easily track calls for later evaluations that will compare CIT calls with non-CIT calls. Such comparisons will help agencies to identify both successful and problematic components of their CIT processes so that the program can be improved to be as efficient as possible.

Whether the information is collected via separate CIT reports or as part of a larger standard report, important data regarding the incident should be collected for every event that engages a CIT-certified officer. Involving representatives from all agencies in identifying what data are considered important will motivate data collection. To be clear, these data points should be recorded in specific fields, not just in a written narrative. Field supervisors can ensure that these reports are completed. CIT coordinators can also review the data and determine if follow-up is necessary especially in cases of reoccurring calls. If all agencies involved in CIT collect these standardized CIT data, comparisons and evaluations can easily be conducted to identify problems and best practices, and the agencies involved can improve their responses accordingly. Ancillary benefits would include such things as enhanced officer safety by providing important information such as history of violence and repeat PMI status available to responding officers.

Finally, CIT officers should also be trained in properly completing the CIT data fields and why the information is important. Periodic in-service examples of the impact of the data will help maintain motivation to complete all fields. All agencies' policies and procedures relating to interacting with PMI should detail the proper completion of the CIT data form and the circumstances under which it should be completed. There should be ramifications for not completing the required forms, and there should be positive reinforcement from administrators for those who properly complete the forms. When possible, the data collection sheets should be incorporated into other mandatory reports and forms that are completed for calls for service. For example, the CIT fields could be incorporated with police reports already in the CAD system. This type of process will reduce redundancy of information and the time required to submit CIT data.

While the sample for this study was not random and therefore, the results of this study are not necessarily generalizable, the findings nevertheless offer a number of important insights that likely provide an understanding for the limited number of empirical studies addressing the benefits/disadvantages of the CIT approach. Moreover, because all CIT programs share the same general objectives and elements regardless of jurisdiction, it is our hope that recommendations will be helpful to individuals involved in the start-up or remodeling phase of a CIT program.

CIT programs likely benefit PMI, law enforcement agencies and the criminal justice system as a whole, as well as the general public. Successful CIT models will help connect PMI with needed mental health treatment, reduce injuries to officers and PMI, and result in cost savings in terms of officer time and costs associated with incarcerating PMI. It is imperative that CIT calls are recorded as such, and that relevant data for each CIT incident are collected.

Ensuring the efficient and accurate collection of data regarding CIT calls would benefit departments in a variety of ways. It would assist departments in using an evidence-based policing approach currently growing in popularity. This approach emphasizes utilizing strategies supported by the empirical literature. Easy access to data would allow departments to quickly and efficiently analyze the effectiveness of their approaches to handling PMI. Evidence-based policing is also promoted as a method of assisting departments in times of fiscal challenges to more successfully utilize their resources (Bueermann, 2012).

Departments relying on CompState or its equivalent could utilize the information to help assess the CIT approach. It also allows for the use of timely data to identify problem areas and repeat patterns for these types of calls. In addition, managers would be able to trace decisions made within the department/agency and therefore, enhance public accountability and help evaluate the effectiveness of the approach (Borglund, 2005). Finally, such data would assist departments in effectively prioritizing calls, helping them to establish policies for diversion, track repeat calls for service, and ultimately reduce PMI-related calls for service (Matulavich, 2006). Further, evidence-based decision making can be a vital and necessary tool for promoting and gaining support for CIT policies and approaches. Relevant stakeholders will be much more likely to support programs where there is measurable evidence that the programs are beneficial in reducing crime, reducing calls for service, reducing citizen and officer injury, and/or saving departmental resources (including officer time and out-of-service). Both law enforcement and mental health authorities could then identify components that either strengthen or hinder the CIT process and, in turn, modify local CIT models to obtain the best outcomes possible using the results from empirical evaluations of CIT programs across jurisdictions.

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