A Conversation Regarding Crisis Intervention Teams As A Model for New Program Adoption

Dr. Larry Thompson
Psychologist
Department of Mental Health Law and Policy
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL, USA 33612
thompson@fmhi.usf.edu
phone 813-974-9003

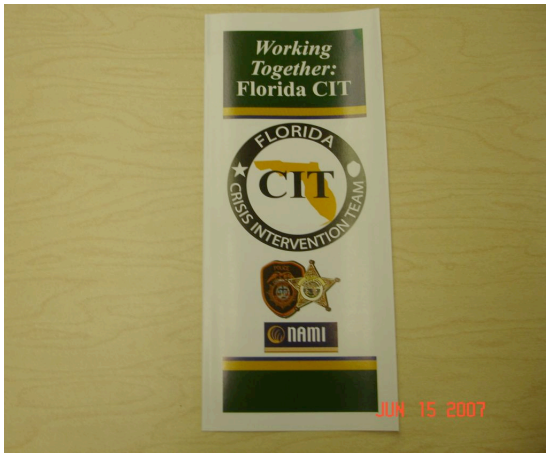
ABSTRACT

Law enforcement is charged with maintaining peace and public safety. The Police officer is often considered a necessary force in our society to deal with the "bad" guys. When an individual has symptoms of a serious mental illness or violates societal standards of behavior due do an emotional crisis, the law enforcement officer is generally the first responder. Without an understanding of mental illnesses or with the belief that the individual is resisting under his or her own freewill, the police officer may handle the individual with excessive use of force. Injury or death of either the officer or the citizen in crisis is common.

A grassroots initiated program called Crisis Intervention Teams (CIT) is widespread throughout Florida and the United States. The model itself is of interest to law enforcement not only for its success in directly addressing encounters with

individuals with mental illnesses but as a model of training and program adoption. Lessons can be gleaned from the rapid adoption of this model by communities considering it has neither government mandate nor funding.

This paper will explore conditions and factors that have supported or hindered the model adoption. The lessons may be useful for the law enforcement agency for development of S.O.P.s for police response to individuals with mental illnesses and to enhance the positive relationship between the agency and the community.



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Vignette # 1:

A police officer is referred to you for debriefing after he, in the line of duty, shot and killed a 16-year old boy. The officer reported that he was dispatched to a home after the mother called and reported some type of disturbance. When the officer arrived, he observed the boy waiving a case knife and yelling incomprehensible statements. When ordered to lay down the knife, the child did not respond. He then stepped toward the officer. The officer believing he was in danger, fired and killed him.

The internal investigation found the officer to have acted in fear of his own life complicated by the “resisting” of the boy to comply with the officer’s orders. The local newspaper later revealed the child to have a diagnosis of autism and was unset with his mother because she did not have any mayonnaise for the sandwich he was making.

During the debriefing, the officer was distraught that he had killed a mentally ill youth.

Vignette # 2:

An officer responding to a 911 call of a man threatening to jump from a bridge found a possible “suicide by cop” scenario. When the officer approached the

man who was standing on a side beam of the bridge, the man said, “You are going to have to shoot me to stop me from jumping”.

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

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

The lack of knowledge and skills of law enforcement to deal with individuals experiencing an emotional crisis is a universal problem. The police may see a psychotic individual whose behavior is determined by delusions as no different as the criminal who uses violence to achieve his own objectives.

Historical Perspective

Most law enforcement administrators and managers know the challenges of responding to crisis situations involving people with behavioral health disorders. These

encounters are very common, but most officers feel poorly equipped to handle them. To resolve them successfully, law enforcement personnel often must navigate in the unfamiliar terrain of emergency rooms and mental health clinics where the officer's idle time is not considered a priority.

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

These generalized training efforts alone however have failed to alleviate the operational challenge that behavioral health crises pose. Tragic – sometimes preventable shootings – continue to occur, and officers continue to experience frustration as they attempt to get appropriate help for individuals in a behavioral health crisis. Police departments often struggle to fill gaps in community services for the large number of individuals who formerly may have been in state institutions. The CIT model is one model that has emerged from these struggles.

CIT operates on a generalist-specialist model. A select cadre of volunteer officers are chosen and trained to be first (and primary) responders to behavioral health crises. The officer maintains the regular patrol responsibilities and geographic assignments, but they are given priority – and have citywide jurisdiction - to be dispatched to calls involving behavioral health crises. The operational objective is to have the most skilled officer for mental health problems positioned to respond to those calls first and be given authority as the "officer-in-charge" of that incident.

Since its inception, the Memphis modeled Crisis Intervention Team approach has been adopted by an estimated 400, or more, jurisdictions throughout the United States. In Florida, CIT programs cover county jurisdictions representing more than 73 % of the state's population. The extent of training vary from the training of a few patrol officers to counties such as Duval who are training all patrol and correctional officers.

Implementation of the CIT model also varies from those who have a few CIT identified officers to programs such as the Tallahassee Police Department who even provide follow-up visits to high risk individuals with a mental illness.

Model Adoption Overview

It is unusual for grass-roots initiative to have been so widely adopted by law enforcement. At the time of implementation almost none of these communities had statutory or policy initiates to spur its growth. No national or state funding backed its adoption. What then has contributed to the adoption of this best practice? We suggest several reasons for its popularity. First, program costs are minimal. Secondly, the CIT is a police operation. Departments need not deploy any additional personnel, including civilians. Because law enforcement will almost always be the first line of response for mental health disturbance calls, there is an operational advantage to locating the specialized response with operational personnel. Even if mental health professionals also become involved, the on scene management and stabilization of the situation may improve by having specially trained officers serve as the primary response

(Cochran, S., Deane, M. & Borum, R., 2000).

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

The original goal of CIT was to improve the quality of the police encounter to reduce the likelihood injury. As the program has evolved, however, many suggest that an equally important objective has been to divert people with mental illness from the criminal justice system whenever appropriate. The latter goal has garnered additional CIT support from national organizations and advocacy groups, such as the National Alliance on Mental Illness (NAMI), which has substantially advanced CIT's recognition and adoption.

Community Readiness Factors

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

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

The charge to adopt CIT may be "championed" by a particular group or individual such as a sheriff, judge, county official, mental health professional or member of an advocacy group such as NAMI, but multiple agencies and stakeholders must ultimately be represented and actively involved. The underlying principle remains, however, that CIT is a community effort, sustained by partnerships. The community – not just the law enforcement agency – must be ready for change before meaningful and lasting change can occur.

Implementation

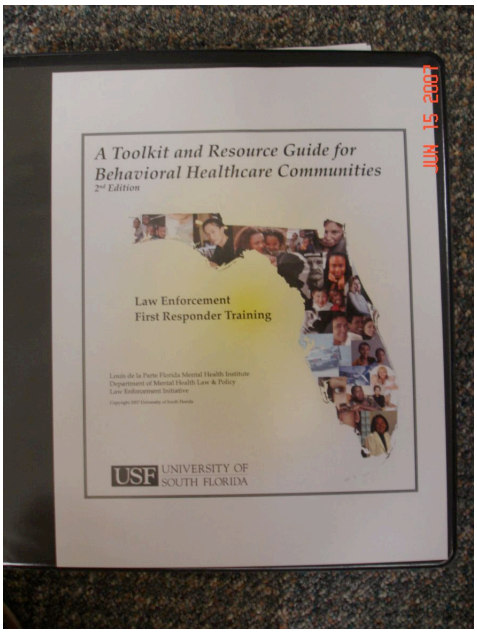
A program to be adopted must meet felt needs of a community. In the case of CIT, several diverse goals are addressed. A survey of 80 law enforcement agencies by the Police Executive Research Forum (PERF) in 2003 summarizes four key stated

goals of the agencies to include: 1) safety of officers and civilians, 2) increased officer understanding of mental illness, 3) reduced numbers of people with mental illness going to jail, and 4) improved relationships with the community, particularly with mental health professionals, people with mental illness, and family members. Of these stated goals the most frequent noted successes are improved relationships with the community and improved safety of officers and civilians (Reuland & Cheney, 2005). Although CIT may not equally achieve all, these goals resound as important to various stakeholders involved in the program adoption.

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

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

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



Conclusions

The adoption of the CIT model for response to individuals in behavioral health crises have been remarkable throughout the United States. The utilization of new

technology by a community is not always determined by the amount of money available or the mandates from federal or state authorities. The shear number of CIT programs in the United States reminds us that other more compelling factors are involved in social change. This paper has attempted to provide information as to what factors are important in efforts to adopt a model of service that has been successful in other communities.

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Photos:

Photographs were taken at a CIT Train-The-Trainer Retreat held at Chinsegut Hill, Hernando County on June 13 – 15, 2007.