An In-Depth Analysis and Review of the Crisis Intervention Team Model's Effectiveness towards Law Enforcement and the Mentally Ill

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Abstract

An increased number of mentally ill individuals in the community has resulted in a greater need for mental health training for law enforcement. Since people with mental health issues do not think rationally and are in more danger to themselves and others, the Crisis Intervention Team model was developed to help. Studies have shown that the model is effective. However, there is a gap: the meaning of the word effective. What is considered effective and effective in what context are just some of the questions currently not answered clearly. This literature review intends to answer these questions and fill the gap of how effective the CIT model truly is by examining a vast majority of current CIT literature. Recommendations for future research are discussed.

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The deinstitutionalization of the mentally ill in the United States significantly decreased the number of long-term patients housed in psychiatric hospitals (Lamb & Bachrach, 2001). Community-based care was meant to replace such institutions, but the implementation of such measures varied widely across the county. With further reduction in social services in the 1980s, many patients did not receive the resources they needed to live successfully in the community (Mechanic & Rochefort, 1990). Most directly, this led to an increased homelessness for mentally ill individuals.

As the number of mentally ill individuals living in the community has increased, so too has the likelihood of contact with law enforcement (Akins, Burkhardt, & Lanfear, 2016; Bouffard et al., 2016; Kara, 2014). This chance of contact is also boosted by the fact that police officers are often the first responders to situations involving individuals threatening to hurt themselves or others (Courey & McDonald, 2009). When in contact with police, there is evidence that individuals experiencing a mental illness or episode tend to be more impulsive, irrational, delusional and do not possess the same problem-solving skills as the average person (Blevins et al., 2014).

The additional contact with the police has resulted in various individual and social problems. The primary challenge has been increased incarceration rates for mentally ill individuals (Raphael & Stoll, 2013). Unfortunately, prisons and jails tend to have an overall deleterious effect on mental health, often lacking the resources and expertise needed for

appropriate treatment and management of such individuals (Pustilnik, 2005; Sugie & Turney, 2017). Mental illness is also overrepresented in many use-of-force incidents involving law enforcement (Laniyony & Goff, 2021; Kesic, Thomas, & Ogloff, 2010). The nature of police contact with the mentally ill has also led to a proliferation of false perceptions and stigmatization among both law enforcement officers and the general public (Mulay, Vayshenker, West, & Kelly, 2016; Pescosolido, Manago, & Monahan, 2019)

Given the above, the legal system and law enforcement have faced several challenges in addressing individuals with mental illness. Specialty mental health and substance-use courts have been established in many jurisdictions to address such issues (Sugie & Turney, 2017; Desmond & Lenz, 2010). Law enforcement officers often face more difficult decisions about the appropriate use of force, arrest, and more. The Crisis Intervention Team (CIT) Model aims to answer these questions.

The CIT Model

The CIT model was first developed in Memphis, Tennessee, in 1987 after a fatal police shooting of someone experiencing a mental illness (Dupont & Cochran, 2002; Yinger, 2020). The mentally ill person involved was 27-year-old DeWayne Robinson with a history of mental illness. After hurting himself with a butcher knife and refusing to drop it, he was fatally shot. Following the incident, a task force, including members of the National Alliance on Mental Illness (NAMI), was formed to investigate mental health training and crisis intervention. They found several positive factors, including academy training above the national average at the time and involvement of mental health professionals as community service officers and in mobile crisis teams. However, the existing resources still could not respond adequately during the immediate crisis.

As such, the Memphis Police Department worked with community partners to develop the CIT model. The model combines interdisciplinary literature, including criminal justice, criminology, psychology, and sociology (Ellis, 2014). Its main goals are to improve the safety of the officer and mentally ill individuals and transition those mentally ill people into the healthcare system and not the justice system (Dupont et al., 2007). Three key components of the CIT model are put into practice to complete these goals: training, implementation, and facilitation (Rogers et al., 2019).

First, officers must undergo 40 hours of instructional training from community mental health workers, people experiencing mental illnesses and their families, and other officers well-versed with the CIT model. The training teaches the officers about the signs and symptoms of many mental illnesses and the facilities the communities have to help them. Next, the CIT model teaches officers how to implement their training in real-life situations. Special dispatch coding is put into place so that CIT trained officers are sent in and know beforehand that they are going into a situation where a mentally ill individual is involved. Finally, officers are taught to refer mentally ill individuals to mental health facilities first instead of holding them in criminal settings (Rogers et al., 2019).

Other Models Compared to CIT

Although the Crisis Intervention Team model is often the most used method of handling mentally ill individuals through law enforcement, other forms of intervention have arisen. Three different categories include police-based responses, police-based co-responses, and community-based responses. Each of these approaches has multiple models beneath them and has seen examples in Oregon, Washington, and Phoenix while studies have been conducted in Texas and California (Watson et al., 2019).

When it comes to the police-based models, the most common models are CIT and then case management teams, where police gather many different teams of people from different fields and gather data to identify people who frequent behavioral health services. These multidisciplinary teams then establish and provide individual responses for those people.

Police-based co-responses can be split into primary and secondary co-response teams. The primary co-response teams consist of behavioral health professionals who arrive with officers who respond to situations where there is a mental illness crisis. For example, the City of Boston developed a co-response model involving master's level clinicians who would ride with patrol officers and respond to mental-health related calls (Morabito, Savage, Sneider, & Wallace, 2018). The clinicians would help de-escalate situations and provide assessment and stabilization. Research on the program is limited, relying primarily on law enforcement impressions, which were generally positive towards the programs. Secondary co-response teams consist of the same police and behavioral health specialist who respond to a mental health crisis, but only after being requested by officers who arrive on the scene first. That often comes in the form of so-called "mobile crisis teams" who are called to the scene in situations that appear to involve mental health problems.

Community-based responses are the third and largest category of responses to mental health situations (Behavioral Health Crisis Alternatives, 2020). The first model is "crisis and warm lines." Crisis call lines are manned and answered by individuals trained in helping the mentally ill instead of calling the police. These lines are often staffed by people who are either paraprofessionals or have dealt with mental health problems before. They may also receive some form of specialty training.

The next model is the peer navigator program. In these programs, people who have experienced mental health or substance abuse problems are hired and trained to counsel others who are going through the same problems (Behavioral Health Crisis Alternatives, 2020). The programs often provide direct support to avoid police calls or visits to the hospital.

Third, there are mobile crisis teams (MCT). Mobile Crisis Teams are comprised of a mix of medical personnel, crisis workers, and individuals who have had mental health issues. The team's primary tasks are to respond to individuals in a mental health crisis and connect them with mental health services within the community. These teams often coordinate with police and could alternate who responds depending on the circumstances. Scott (2000) found that 45% of the calls handled by mobile crisis teams resulted in hospitalization compared to 72% with law enforcement-only intervention. Of course, the overall evidence is mixed with some studies by no effect (Fisher et al., 1990), while others have also found significant effects, either in hospitalization (Reding and Raphelson, 1995), cost-savings (Bengelsdorf et al., 1993), or social goods, such as avoiding the criminalization of the mentally ill (Lamb et al., 1995).

Fourth, there are EMS-based responses. Similar to MCTs, these responses contain counselors, social workers, doctors, and EMTs and respond to mental health crises instead of police in hopes of reducing arrests. The programs are diverse and not very well defined. Over reliance on EMS services for mental health crises can be concerning, especially given the limited training that many EMS staff receive when it comes to psychiatric disorders and the stress it places on already overburdened emergency departments (Ford-Jones & Chaufan, 2017; Trivedi, Glenn, Hern, et al., 2019). Some jurisdictions have attempted to address the shortcomings by expanding response options or including mental health professionals on EMS teams.

The final community-based response model are the 911 diversion programs. In this model, dispatchers divert calls intended for police, fire, or EMS from non-emergent mental-health related calls to non-government-related mental health professionals (Behavioral Health Crisis Alternatives, 2020). These professionals then handle the situation over the phone by talking them through their situation and then connecting the individuals with the appropriate local mental health facilities or services. Examples of the different types of approaches can be seen in Eugene, Oregon, Olympia, Washington, and Phoenix, Arizona.

In Eugene, specialists have started to respond to a mental health crisis instead of police in a community-based response (Cowell, Broner, & Dupont, 2004). Their program, called Crisis Assistance Helping Out on the Streets (CAHOOTS), is a mix of mental illness clinicians responding to mental health calls if the situation is safe. Although they often respond separately from the police, they sometimes work together.

Similar to the CAHOOTS program and modeled closely after, Olympia established a Crisis Response Unit (CRU), which provides outreach to people who have gone through mental health problems and connects them with individuals currently experiencing problems and repeatedly requiring police attention. Mental health specialists also continuously monitor police activity and identify and respond to situations where their skill proves to be useful. In Phoenix, a police-based co-response model is being used. Here, 911 dispatchers transfer mental health issue calls to specialists trained in mental health crisis response. These specialists then either manage the crisis over the phone or dispatch mobile crisis unit teams instead of the police.

Studies in Houston, Texas, and Los Angeles, California have looked into the effectiveness of models other than the CIT. In Houston, the city created a case management team to combat challenges arising from interactions with the mentally ill. Dubbed Houston's Chronic

Consumer Stabilization Initiative (CCSI), the city hired two behavioral health professionals to work with the mentally ill that had the most police interaction. From the 30 individuals they worked with, there was a 70% reduction in police encounters during the first six months (Houston Police Department, 2010).

In Los Angeles, the city established two sets of community-based co-responses. The first of those responses was the Los Angeles Case Assessment and Management Program which aimed to "identify, engage, monitor, and provide case management to people with complex mental health needs" (Los Angeles Police Department, 2018). In contrast to the CCSI, this program established teams that included a police officer paired with a psychologist, nurse or social worker to connect mentally ill individuals with appropriate healthcare services and return them to their homes. The Los Angeles Statewide Mental Health Assessment Response team was the second Los Angeles program. This co-response-based team was composed of a police officer paired with a healthcare professional from the Los Angeles County Department of Mental Health. The study found that police working with mental health emergency teams responded appropriately to individuals with acute symptoms, violent behavior, and a history of contact with the justice system (Lamb et al., 1995).

Effectiveness of CIT

Current literature has had mixed results on the effectiveness of the CIT model, though most of the studies speak to its positive effects. In small regions that mirror the CIT's Model closely, results are positive; in larger multi-site regions, the results are not as clear (Rogers et al., 2019). Most studies have expressed the effectiveness of the CIT model in three different ways: subjective data of personal perceptions, objective data on level of force used, and arrest alternative outcomes.

Ellis (2014) completed a pre-test/post-test survey of 26 officers from the Miami-Dade County municipalities. The test consisted of multiple questionnaires and Likert scale-type questions regarding the officer's knowledge, attitudes, and perceptions of people with serious mental illness and was administered before and after a five-day forty-hour CIT training session. Results of the study showed that positive effects included attitude improvements and stigma reduction in officers as well as higher officer satisfaction and self perception. Additionally they showed more positive outcomes with officers trained in the CIT compared to those not trained. They were better able to interact, as well as, distinguish people with depression, cocaine use, schizophrenia, and alcohol dependency. Of course, this was based on officers' self-rating of themselves.

Similarly, a study conducted by Broussard and colleagues (2011) found that all four measures of importance passed the tests of internal consistency reliability, test-retest reliability, construct validity, and to be valid and reliable, in a study of 109 non-trained and 68 trained CIT officers. In this study, officers self-reported self-efficacy, referral decisions and de-escalation skills, attitudes toward psychiatric treatment, and social distance. Then, the answers were compared between the two groups. In the measures of self-efficacy, referral decisions and de-escalation, and psychiatric opinions, the CIT-trained officers were found to have significantly increased scores compared to the non-CIT trained officers. These results were then strengthened by findings of a significant decrease in scores on the social distance scale.

Another way the effectiveness of the CIT model has been measured has been by examining levels of force used by CIT-trained officers. Kerr and colleagues (2010) analyzed 865 incidents with mentally ill individuals throughout four Chicago Police Departments in early 2008. The incidents were then compared between non-CIT and CIT-trained officers and data was

reviewed involving the police officer's use of force, ranging from "My mere presence was enough" to "The use of my firearm was necessary." The study found that use of any weapon by a CIT-trained officer was quite rare, and the average level of force needed by officers was "Verbal Warnings and Commands" and "Persuasion."

Another study conducted by Compton and colleagues (2014) also looked into CIT's effectiveness regarding the use of force data, yet found differing results compared to that of Kerr and colleagues. In this study, 91 CIT-trained officers were compared with 89 non-trained officers on 1,063 separate encounters throughout Georgia. The study results showed that CIT training was not an accurate predictor of the level of force and that physical presence was the average level of force the majority of the time for both sets of officers. Although the second most common level of force of CIT officers was verbal engagement at 20% of the time, for the non-trained officers it was calling for backup 15% of the time.

A final way that the CIT model is examined on its effectiveness is through the lens of alternative outcomes instead of arrest. Teller and colleagues completed a major study focusing on this between May 1998 and April 2004 in Akron, Ohio. In this study, the experimenters analyzed the dispatch logs of police for two years before and four years after the start of a CIT training program (Teller et al., 2006). The study found that compared to non-CIT trained officers, CIT-trained officers were significantly more likely to transport mentally ill persons to psychiatric emergency services and less likely to transport them to other facilities. They were also more involved in interactions that led to a mentally ill person being transported and not just left at the scene.

In a second study done by Watson and colleagues, they again went back to the city of Chicago to analyze the effects of the CIT model on the mentally ill. This time the team analyzed

all 22 of Chicago's police districts, in which approximately 18% of those officers are CIT trained (Watson et al., 2021). Over five years, the team gathered data based on police encounters with the mentally ill and dispatch codes. Officers were also given surveys regarding the nature, location, and behavior of the call, etc. The data gathered from the surveys and police encounters were then analyzed between CIT and non-CIT trained officers. The study's results showed that a CIT response significantly affects the linkage of a mentally ill individual to a service; 1.7 times more likely for a call to result in a linkage than a non-CIT response. Additionally, if a call was a CIT response and pre-identified as a mental health call, it was 2.83 times more likely to result in a linkage to a service.

Shortfalls of CIT

Although current literature is in favor of the effectiveness of the CIT model, there remains a gap when carefully examined. This gap is focused on three aspects of the CIT model and the research surrounding it: the CIT model itself is not standardized, there is a lack of objective data regarding the CIT model's effectiveness, and there is no consensus on what constitutes effectiveness according to the model.

First, many of the police programs and agencies across the country say they used CIT or CIT-based programs within their departments, but what really is the CIT model? Is just training officers 40 hours with professionals and connecting them with local mental health facilities the standard for CIT or is it more? Is just connecting those officers with local health professionals considered to be a CIT based model? Even distinguishing CIT from other models can be difficult, as careful examination reveals that a diversity of interventions are often discussed under the umbrella of "CIT." The lack of clear definition makes the model significantly more difficult to research.

Next, there is a lack of objective data in the research on the CIT model (Blevins, Lord, & Bjerregaard, 2014). Most research cited comes from personal surveys and subjective opinions and not objective data. There are clear demand characteristics on police officers who have been trained in CIT, making it difficult to assess the accuracy of their self-assessment. Additional problems arise due to insufficient objective data in police reports themselves. In some studies it was found that officers do not fully complete CIT-related reports at all. The reasons given included, the forms not being mandatory, having to fill out the same information on a previous form, and difficulties with tracking individuals as they move through different parts of the criminal justice system (Blevins, Lord, & Bjerregaard, 2014). Relatedly, much of the research that has been done is not longitudinal and provides no comparisons on any objective data points across time or condition. Essentially, without clear comparisons or well-controlled variables, it is extremely difficult to draw any firm conclusions about the effectiveness of CIT.

The last major shortcoming of research into the CIT model is the lack of consensus on what is considered effective. The studies discussed above defined positive outcomes in a variety of ways. Effectiveness could be measured based on any number of potential variables related to officers, to the mentally ill individuals, or other factors. Referral to a mental health institution, level of physical altercation, and number of arrests are examples of different lenses through which the CIT model can be evaluated. Studies have determined the CIT model to be effective in different ways but have lacked agreement on what effectiveness means. Proponents of the CIT model are also not clear on exactly what might make CIT effective. That is, if CIT is made up of multiple components, which components constitute the "active ingredient." The type and length of training, adherence to a specific model, or any other ancillary characteristics need to be

analyzed. Such analysis could help to identify the most impactful aspects of the intervention and further clarify how CIT differs from other intervention models.

Solutions

Although there are many shortcomings of the CIT model, they are easily resolved through solutions as simple as standardizing the model, providing more objective data, and having a consensus on what makes the model effective.

Primarily, in order to analyze the CIT model more effectively, there must be a standard definition of what the program is and what is not. There has to be some level of agreement to establish what makes the CIT model unique and differentiate it from other types of police mental health training or interventions. It would be beneficial to have stakeholders come together to create a formal plan that explicitly spells out the CIT process, procedures, and responsibilities of each position involved in the CIT program. In this way not only can the CIT model be standardized, but adherence to the model can be assessed across diverse locations alternatively.

Next, in order to better analyze the effectiveness of the model, there needs to be more objective data. To do this have CIT forms be electronic and have them be part of initial paperwork of a mental health call for police officers. Either incentivize the forms or make them mandatory. Stricter data collection policies would allow officers who received standardized CIT training to be assessed on a longitudinal basis and compared to individuals who have not received the training. Centralizing data collection would also be important. The positive effects of CIT would theoretically be spread across a variety of systems, not just law enforcement. Data from police officers needs to be combined with data from community agencies, hospitals, corrections, and the judiciary.

Most importantly, proponents of CIT and researchers need to reach consensus on the meaning of effectiveness. To some extent, data collection and formalization of CIT require an agreement on the goals of CIT. Arguably, there appear to be some significant themes related to arrest rates, diversion to mental health services, and level of force. However, much of the research has over-focused on intermediary outcomes on relatively soft variables, primarily relying on self-report of police officers. There is a need for a major shift to the variables that most stakeholders and the public seem to care about. Once the effectiveness is measured more uniformly, the aspects of what makes the CIT model effective will become clear.

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