

# RESPONDING TO INDIVIDUALS EXPERIENCING MENTAL HEALTH CRISES: POLICE-INVOLVED PROGRAMS



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*Abstract: As many as 10 percent of police contacts involve individuals with mental health conditions. A growing number of police and sheriff's departments have implemented specialized responses to mental health crisis incidents, including crisis intervention teams (CIT). Research indicates departments offering specialized responses show greater officer knowledge of mental health conditions and more positive police attitudes toward individuals with mental health conditions. However, limited empirical support exists for considering other outcomes evidence-based. This article examines specialized mental health responses with an emphasis on practices in Illinois and offers implications for future research and practice.*

## Introduction

It is estimated that between 7 and 10 percent of police-citizen encounters involve a citizen with a mental health condition.<sup>1</sup> Untreated mental health issues increase a person's probability of contact with police<sup>2</sup> and situations involving individuals in crisis can escalate quickly, heightening the risk of injury to both officers and individuals. Researchers estimate officers are 1.4 to 4.5 times more likely to use force during encounters with subjects who have a mental health condition than with those who do not.<sup>3</sup>

Police response can be a critical point of intervention and determine the outcome of a mental health crisis. This article provides an overview of three specialized response models used by police agencies to respond to persons experiencing mental health crises: the Crisis intervention Team (CIT) model, the co-responder model, and mental health-based responses.

### Crisis Intervention Team Model

The crisis intervention team model was created to help police departments more effectively and safely respond to calls for service involving individuals in mental health crisis. Created in Memphis, Tenn., in 1988 following the police shooting of a man experiencing a mental health crisis, the program was developed in a collaborative effort of police, mental health professionals, and advocacy groups. The primary goal was to advance a police response protocol that would improve outcomes and prioritize safety for all parties involved in mental health crisis incidents. CIT response programs have proliferated across the United States and abroad, with as many as 3,300 programs operating as of 2014.<sup>4</sup>

CIT model components include training for a subset of police officers who will assume responsibility for mental health crisis incidents and established partnerships between police agencies and mental health service providers in the community.

#### Benefits derived from the CIT model include:

- Reduced injuries of individuals in crisis.
- Better access to treatment for individuals in crisis.
- Reduced involvement with the justice system for low-level offenders.
- More efficient disposition of mental health calls for service.
- Fewer officer injuries.
- Fewer repeat calls for service.

#### Other groups, in addition to the individual and officer, that may benefit from CIT include:

- Families who are able to call police during a crisis with less fear of arrest or injury.
- Victims who are at a reduced likelihood of repeat victimization.
- Society, due to increased awareness can combat stigma surrounding mental health conditions.<sup>5</sup>

## **Component 1: Training**

Officers typically volunteer for CIT training, which generally consists of 40 hours of coursework on recognizing mental health conditions, de-escalation in crisis situations, and procedures for utilizing mental health treatment services in the local community. Knowledge and skills are gained through classroom lectures, role-playing, conversation with individuals with mental health conditions or their families, and experiential or field learning exercises (e.g. visiting a psychiatric triage center at a local hospital). Experts have estimated that 15 to 25 percent of patrol officers should be sufficient to ensure CIT availability at all times, though empirical research has not been conducted to consider population density, personnel counts, and community needs in determining the optimal saturation of CIT-trained patrol officers.<sup>6</sup> Training regarding mental health issues is also critical for call-takers and dispatchers to be able to properly identify crisis situations that require CIT officers.

## **Component 2: Community Mental Health Partnerships**

Program advocates emphasize CIT is “more than just training,” and strong partnerships with the mental health community are equally important for an effective CIT response.<sup>7</sup> The Memphis CIT model asserts the importance of a centralized, no-refusal drop-off point for individuals in need that is available to police at all times. Hospitals and mental health facilities without a no-refusal policy may decline to assess an individual or other policy may not allow admission of an individual that is considered a danger to themselves or others. This creates a lack of policing options other than arrest for individuals who are in crisis and perceived as dangerous.<sup>8</sup>

A streamlined intake process at the drop-off point taking no more time than a jail booking can eliminate a barrier to officers’ utilization of local hospitals or mental health facilities for individuals in crisis.<sup>9</sup> Mutually agreed upon policies and procedures that are practical and efficient create the most productive partnerships between police agencies and mental health service providers. Established partnerships may result in further collaborative efforts to develop additional mental health service components in the community, such as crisis triage centers and follow-up linkages to mental health treatment.

## **Additional Elements: Implementation and Sustainability Factors**

Implementation and sustainability must be considered when creating a successful CIT program. Stakeholders develop policies and protocols to standardize and coordinate the processes for all activities that are to be undertaken in relation to a crisis intervention team (e.g. transportation, rapid intake procedure, custodial transfer). A memorandum of understanding can serve to clearly articulate the information to be shared between collaborating organizations. Buy-in must exist throughout the organizational structures of stakeholders, including support from leadership and an individual willing to champion the successes of the program. Program monitoring and data collection are also important because they allow for continued evaluation of the program. Evaluation can provide evidence on key performance indicators and demonstrate the value added by implementing the CIT response model.<sup>10</sup>

## CIT and Policing Theory

The CIT model is consistent with theories of police practice. The theory of [procedural justice](#) posits that outcomes will improve when police demonstrate their legitimacy through interactions that are transparent, fair, impartial, and that give citizens a voice. CIT incorporates procedural justice theory by employing the principle that the public, including those in mental health crises, should feel they are treated with respect by authorities. CIT teaches officers skills to actively listen, display empathy, and develop a rapport with the individual experiencing a mental health crisis, all of which can help to facilitate a sense of procedural justice for the individual. CIT training often includes opportunities for officers to hear from and interact with individuals with mental health conditions and their families, which can encourage officers to utilize procedural justice skills in the field and reduce stigma surrounding mental health issues.

Problem-oriented policing (POP) is a practice used by police to proactively approach an issue in the community. The model is based on the components of: Scanning, Analysis, Response, and Assessment (SARA). Agencies considering CIT use SARA to examine current mental health crisis interactions and the underlying causes of those interactions to develop an effective alternative response that specifically targets the needs identified. Dr. Randolph Dupont, who participated in the group that developed the initial CIT model in Memphis, contends that CIT provides “a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.”<sup>11</sup>

## Research on CIT

Although a large number of police departments in the United States, including many in Illinois, have implemented CIT programs, a lack of empirical research exists on the effectiveness of the specific components of CIT in achieving its goals and objectives. In fact, efforts by researchers in 2008 to summarize existing CIT research found only 12 studies that fit the criteria of empirical research.<sup>12</sup> A similar effort in 2016 used more stringent inclusion criteria (i.e. requiring an experimental or quasi-experimental evaluation design, and inclusion of arrests, use of force, or officer injury as an outcome measure) which returned only eight applicable studies.<sup>13</sup> Due in part to the scarcity of rigorous evaluation research published on the topic, CIT is not presently considered an evidence-based program in its totality by entities that compile evidence-based practices and programs (e.g. [crimesolutions.gov](#), the National Registry of Evidenced-based Programs and Practices (NREPP)).<sup>14</sup> A review published in 2017 concludes that CIT training can be considered evidence-based *if* the scope is limited to the outcome of improving officer attitudes and knowledge regarding individuals with mental health conditions; whether it is significantly associated with positive outcomes in other areas, such as reduction in future justice system involvement, is unknown at this time.<sup>15</sup>

Much of CIT research to date has focused either on the outcomes of CIT training, such as officer attitudes and knowledge of mental health conditions, or the dispositions of calls for service for mental health crises. Most compare CIT officers to non-CIT officers or use pre/posttest designs whereby data measuring elements of CIT are compared before and after program implementation or training. Although evaluations comparing non-equivalent groups and or using pre/posttest designs are better than having no evaluations conducted, they are not considered by researchers to be rigorous enough to draw strong conclusions about programming effects. One exception is a quasi-experimental design using matched controls

employed by Watson and colleagues to examine the Chicago Police Department's use of CIT.<sup>16</sup>

Randomized control trials (RCT) are considered the “gold standard” in research design because they assist researchers in ruling out other potential causes of the outcomes observed. For instance, an experiment employing RCT might require researchers to randomly assign officers to receive CIT training or not receive CIT training.<sup>17</sup> Generally, however, departments have not been willing to use random assignment because the Memphis model emphasizes the importance of officers' voluntary participation.<sup>18</sup>

### *Officer Attitudes and Knowledge*

Notwithstanding the research limitations noted, researchers have found that CIT training is associated with more positive attitudes toward individuals with mental illness and increased knowledge attainment and confidence. Specifically, officers who have completed CIT training have been shown to:

- Score significantly higher on questionnaires designed to measure knowledge regarding mental health conditions, compared to their scores before CIT training.<sup>19</sup>
- Display significantly more positive attitudes toward individuals with mental health conditions than officers that have not been CIT trained.<sup>20</sup>
- Report higher levels of confidence in their own ability to effectively handle interactions with individuals with mental health conditions, compared to reported confidence before CIT training.<sup>21</sup>
- View the mental health system as more helpful than officers in departments that do not employ CIT.<sup>22</sup>

### *Case Disposition*

Researchers have also examined how CIT officers handle the disposition of crisis calls through arrest, referral to mental health services, and “contact-only” or informal resolution on-scene. The findings regarding the impact of CIT responses on arrest rate are mixed; multiple studies and a meta-analysis have found no significant differences in the likelihood of arrest between CIT officers and non-CIT officers.<sup>23</sup> In the year after the initial Memphis CIT response program was implemented, it was reported that the arrest rate of individuals with mental health conditions had decreased to less than 15 percent.<sup>24</sup> Similar findings of reductions in arrest rates that are not statistically significant have been reported by other jurisdictions that have implemented CIT programs.<sup>25</sup> In another study, researchers estimated that after CIT implementation arrests were prevented in 19 percent of mental health crisis situations.<sup>26</sup>

Decreasing arrests, however, is only one factor to consider; referrals to needed services also are important. Studies in Chicago found that, while there were no significant differences in arrest decisions between CIT-trained and untrained officers, trained officers were more likely to refer individuals to services than their non-CIT counterparts in police districts with more available mental health services.<sup>27</sup> This suggests “in Chicago, CIT is primarily influencing officers' decisions between directing persons with mental illnesses to services or resolving encounters without taking any action.”<sup>28</sup>

Definitions of what constitutes “utilization of mental health services” are inconsistent in the research literature making it difficult to draw strong conclusions. Across various studies, this measure may be defined as referrals to community mental health/social services, attending substance abuse or mental health counseling sessions, voluntary transport for psychiatric evaluation, involuntary transport for psychiatric evaluation, transport to a mental health facility other than a hospital, or arrest and transport for psychiatric evaluation. Further, many studies collapse a combination of the above outcomes into a single measure of “mental health treatment.”<sup>29</sup> These varying definitions limit the comparability of this outcome between studies.

Despite this limitation, some positive findings have emerged. One study found higher rates of transport to mental health services by Memphis CIT officers when compared to other cities without CIT response programs.<sup>30</sup> Consumers that received a CIT response, as compared to standard criminal justice processes, demonstrated better mental health outcomes in a follow-up exam; however, the study did not find significant impacts on reoffending.<sup>31</sup>

Another study involving Akron officers found that CIT-trained officers were more likely to transport individuals in mental health crises to a service provider than non-CIT officers.<sup>32</sup> Researchers found CIT-trained officers in Chicago referred significantly more individuals experiencing mental health crises to mental health or social services (without arrest) than non-CIT officers.<sup>33</sup> A study in Memphis found that individuals who were diverted from arrest during a CIT incident received significantly more counseling sessions during the 12 month follow-up period compared to those who were arrested and processed traditionally.<sup>34</sup>

#### *Costs and Savings Related to CIT Implementation*

Researchers also have examined the impact of CIT on police departments’ resources and associated costs and benefits to CIT implementation. Studies have shown a decrease in utilization of SWAT teams after implementing CIT response programs, which reduces costs associated with activation of high-intensity police units.<sup>35</sup> Evaluation of the Memphis CIT program demonstrated less time spent on mental health calls on average after implementing CIT; additionally, Memphis CIT officers were able to maintain efficient response times, with CIT officers arriving on scene within 10 minutes in 94 percent of mental health crisis incidents.<sup>36</sup> CIT evaluations across various police departments found that CIT implementation is associated with a decrease in officer injuries, fewer use of force incidents, and fewer individuals with serious mental illness being killed by police.<sup>37</sup>

The Washington State Institute for Public Policy (WSIPP) examines programs to analyze the ratio of benefits to costs in monetary values. After examining pre-arrest diversion programs that follow the CIT model, WSIPP reported that the benefit-to-cost ratio was a loss of \$2.94 for every \$1 spent.<sup>38</sup> The group also noted that there was only a 1-percent chance that this type of program would produce benefits greater than the total cost.<sup>39</sup>

Based on four case studies that were part of a multi-site study of diversion funded by SAMHSA, diversion to mental health services through interaction with a CIT cost an average of \$8,000 (in 2013 adjusted dollars) more per individual over the 12-month period of study than standard

criminal justice processing. The higher price associated with utilization of CIT was due to increased costs for healthcare/treatment beyond what is typically provided in the criminal justice system.<sup>40</sup>

A study evaluating the costs and savings of CIT in Louisville, KY demonstrated net savings of more than \$1 million per year, after accounting for all associated program costs.<sup>41</sup> The largest proportion of savings resulted from deferred admissions to hospitals, jails, and psychiatric institutions; Medicare and Medicaid programs recouped the largest amount of savings from the program. The Louisville Police Department incurred nearly all of the officer training costs (\$146,079), while garnering some savings through reduced arrests (\$9,825), the cost of training still far exceeded the amount saved.

### **CIT Training and Response in Illinois**

The Illinois Law Enforcement Training and Standards Board (ILETSB) is the state agency charged with maintaining a high level of professional standards among police officers and correctional officers.<sup>42</sup> Illinois law requires the ILETSB to develop a standard curriculum for use by certified training programs with regard to crisis intervention and police response to individuals with mental health conditions [50 *ILCS* 705/10.17]. These programs are to offer training on “identify[ing] mental illness, de-escalation training, and refer[ring] consumers to treatment.”<sup>43</sup> The statute also requires officers who complete the training program to be issued a certificate.

The statute also indicates that ILETSB is to create an introductory mental health awareness course that incorporates “adult learning models” that impart participants with awareness of mental health conditions, including “a history of the mental health system, types of mental health illness including signs and symptoms of mental illness and common treatments and medications, and the potential interactions law enforcement officers may have on a regular basis with these individuals, their families, and service providers including de-escalating a potential crisis situation.”<sup>44</sup> Lastly, the statute dictates that this course should be made available in an electronic format.

ILETSB has been a state-certified provider of CIT training since 2003.<sup>45</sup> The 40 hours of instruction include experiential learning exercises designed to provide insight into mental health issues, discussion with individuals that have mental health conditions and/or their family members, and roleplaying crisis scenarios with actors.<sup>46</sup> These course components aim to prepare CIT officers to be “resource specialists” that are able to provide safe and appropriate responses to individuals in mental health crisis in their community. ILETSB’s CIT training is available at locations across the state through Mobile Team In-Service Training Units, which allow for accessible and cost-effective training in smaller and rural jurisdictions.<sup>47</sup>

As of 2016, the ILETSB program has certified more than 4,750 officers from more than 280 different Illinois police agencies.<sup>48</sup> Although the state tracks the number of officers trained, less information is available on implementation practices and challenges. This information gap will be addressed in a statewide survey to be conducted by ICJIA this year.

## **Alternative Response Models for Mental Health Crises**

CIT programs are the most widely available and well-known among models for police response to individuals experiencing a mental health crisis. In alternative response models, police agencies work alongside mental health professionals in the field or employ mental health professionals as non-sworn employees to consult with departments on a range of issues, including crisis response.

### *Co-responder Model*

One type of response model allows mental health professionals to handle the crisis incident on site and facilitate the individual's access to treatment in coordination with the police department. This response type is commonly seen in the form of "co-responder" programs.<sup>49</sup> Major cities in the United States, such as Knoxville, Tenn., and Los Angeles, Calif., and in DeKalb County, Ga., apply this model in mental health crisis situations.<sup>50</sup>

A systematic review of evaluations of co-responder models in the United States, Canada, and Australia concluded that the model demonstrates the potential to offer increased access to community-based mental health treatment and reduce the burden on police officers (e.g. decreasing officer time required on a mental health crisis call).<sup>51</sup> However, studies have found that officers do not perceive the co-responder model as more efficient than standard department response. Further, staffing for this model can be problematic because there are few mental health workers available outside of normal business hours, limiting the availability of the mobile crisis team.<sup>52</sup>

### *Mental Health-Based Responses*

Another alternative model involves police departments employing non-sworn mental health professionals to assist in responding to calls involving individuals experiencing mental health crises. The Community Service Officer (CSO) Unit within the Birmingham, Ala., Police Department exemplifies this category of response type as the CSOs are mental health professionals who are employed by the department.<sup>53</sup> CSOs are able to provide crisis intervention and wrap-around social services to consumers, while diverting them from further involvement in the criminal justice system.<sup>54</sup> This response type is the least common of the three models and few evaluations have been conducted.<sup>55</sup> Research examining the program in Birmingham described above found this model to have the largest proportion of incidents resolved on the scene, but also the largest proportion of mental health crisis calls resulting in arrest, relative to alternative crisis response models.<sup>56</sup>

## **Implications for Future Research and Conclusions**

Despite the rapid growth of CIT programs across the United States, there are still gaps in the available empirical evidence supporting their effectiveness.<sup>57</sup> Research has generally established that CIT training has a positive impact on officers' attitudes and knowledge, but more studies must be undertaken to determine if these changes lead to changes in officers' behavior.<sup>58</sup> Partnerships with mental health service providers are considered an integral component of CIT,

but this component also requires further study. Availability of mental health resources and the utilization of those resources are necessary for CIT-trained officers to effectively employ the CIT model.

Future research should rigorously evaluate the various ways consumers move from initial CIT interactions through the available mental health services to identify the most effective combination of treatment and services to achieve the goals of CIT. Finally, little research focuses on outcomes from the perspective of the individual in crisis. Follow-up periods beyond the call's initial disposition will be necessary to compare the effects of CIT responses to the effects of services provided through alternative models of crisis intervention.

Individuals with mental health conditions should not be arrested or incarcerated simply due to their diagnoses or their lack of access to needed treatment.<sup>59</sup> When responding to an individual in the midst of mental health crisis, police officers need an effective response protocol that provides a path for the individual in crisis to obtain treatment and avoid being processed further into the criminal justice system.

The models described here draw upon established partnerships with mental health service providers to increase access to treatment in the community for individuals experiencing mental health crises. Research evaluating the CIT and co-responder models has generally shown positive outcomes for individuals in crisis, as well as benefits for the departments utilizing the programs. However, further examination of variations in implementation is needed as specialized responses for addressing mental health crises have rapidly become ubiquitous in departments across the United States.<sup>60</sup>

Similarly, in Illinois, Chicago Police Department's CIT program has been rigorously evaluated, but the need remains for comprehensive research regarding the implementation and effectiveness of the specialized responses employed by many agencies across the state.<sup>61</sup>

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