

# A Statewide Crisis Intervention Team (CIT) Initiative: Evolution of the Georgia CIT Program

Janet R. Oliva, PhD, and Michael T. Compton, MD, MPH

In late 2004, Georgia began implementation of a statewide Crisis Intervention Team (CIT) program to train a portion of its law enforcement officers to respond safely and effectively to individuals with mental illnesses who are in crisis. This overview provides a description of the evolution of the Georgia CIT, including discussions of the historical context in which the program developed; the program's vision, mission, and objectives; the importance of the multidisciplinary Georgia CIT Advisory Board; the training curriculum; the role played by state and local coordinators; the value of stakeholders' meetings; practical operations of the program; the importance of considering the adequacy of community-based and hospital-based psychiatric services; costs and funding; the program's expansion plan; and evaluation, research, and academic collaborations. These detailed descriptions of the Georgia CIT program may be useful for professionals involved in local, regional, or state CIT program planning and may provide a practical synopsis of one example of this collaborative model that is being rapidly disseminated across the U.S.

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Mental illnesses are prevalent conditions<sup>1,2</sup> that are associated with substantial disability<sup>3</sup> and are often undiagnosed, untreated, or undertreated.<sup>4–6</sup> Families and friends of people with mental illnesses also are affected by these disorders, especially when they are unable to facilitate treatment initiation due to individual-level factors (e.g., impaired insight), family- and community-associated obstacles (such as insufficient social supports), system barriers (e.g., inadequate community mental health services), or societal pressures, including stigma. Situations in which a loved one with a mental illness is in crisis but not engaged in treatment can contribute markedly to family frustration and strained relationships. Occasionally, families of individuals with mental illnesses may be confronted with no alternative but to involve law enforcement during a crisis. This path is one of several that lead to law enforcement/criminal justice involvement for such individuals. Criminalization of

people with mental illnesses is a widely recognized problem of personal, family/community, systems, and societal importance.

Law enforcement officers often are confronted with the dilemma of arresting an individual with a serious mental illness or leaving him or her at the scene of the crisis with only a short-term resolution.<sup>7</sup> To avoid the potential risk of an individual's harming himself or herself or another person, or because the law enforcement officer is unable to locate a treatment facility that can or will accept the person for evaluation and treatment, the officer often executes an arrest, generally for a nonviolent criminal offense. Thus, many individuals with mental disorders unnecessarily enter the criminal justice system, a system that is not prepared to give them proper treatment. Jails have become *de facto* treatment facilities for many people with mental illnesses. However, jails are often poorly equipped to provide mental health services, and many individuals in need of psychiatric services remain untreated and are released from jail without proper treatment planning and referral, only to re-enter the criminal justice system soon thereafter.

Because of the complex nature of the tasks performed by police officers and the challenges con-

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Dr. Oliva is an Inspector, Georgia Bureau of Investigation, Atlanta, GA. Dr. Compton is Assistant Professor, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, and Department of Behavioral Sciences and Health Education, Rollins School of Public Health of Emory University, Atlanta, GA. Address correspondence to: Michael T. Compton, MD, MPH, Emory University School of Medicine, 49 Jesse Hill Jr. Drive, SE, Room 333, Atlanta, GA 30303. E-mail: mcompto@emory.edu

fronting officers who respond to situations involving individuals or families in crisis, many law enforcement agencies, in collaboration with other community partners, have implemented crisis intervention programs. The most widely recognized crisis intervention model for police officers was established in 1988 in Memphis, Tennessee, after an incident in which a person with a history of a mental illness and substance abuse, who was armed with a knife, was shot and fatally wounded by local law enforcement. With the support of the Memphis Mayor's Office, the Memphis Police Department—in partnership with the Memphis Chapter of the Alliance for the Mentally Ill, mental health providers, and two local universities—developed a specialized unit, the Crisis Intervention Team (CIT), to establish an intelligent and safe approach to crises involving people with mental illnesses.<sup>8–10</sup>

CIT is a police-based, specialized police response strategy, involving the delivery of crisis intervention services by sworn law enforcement officers who have received special training and are active liaisons to the formal mental health system.<sup>11</sup> CIT officers are trained by mental health professionals, family advocates, and mental health consumer groups, and therefore can provide, with confidence, a more humane and calm approach to these crisis events.<sup>8</sup> Several states, including Florida, Ohio, and Virginia, have developed CIT initiatives to respond to individuals with mental health needs who are in crisis. In addition, a multitude of cities and counties across the country have developed local CIT programs. In fact, the Bureau of Justice Assistance estimates that there are more than 400 CIT programs operating in the United States.<sup>12</sup> In Georgia, CIT is being implemented in numerous police departments, with administrative and technical support provided at the state level.

## Evolution of the Georgia CIT Program

### Historical Context

In early 2002, the Georgia chapter of the National Alliance on Mental Illness (NAMI) initiated a coordinated effort to facilitate a major jail diversion program in Georgia. This initiative, labeled "Partners in Crisis," included representatives from the Association of County Commissioners of Georgia, the Georgia Association of Chiefs of Police, the Georgia Department of Corrections, the Georgia Department

of Human Resources, the Georgia Sheriffs' Association, Inc., the National Mental Health Association, the State Board of Pardons and Paroles, and others, who met at The Carter Center in Atlanta to discuss issues related to jail diversion. This workgroup analyzed the problem of jail overcrowding in Georgia, especially in relation to detainees with severe mental illnesses. The workgroup determined that the proportion of inmates in metropolitan Atlanta detention facilities who reportedly had an identifiable severe mental illness significantly exceeded the proportion of inmates in the Memphis facilities.

Partners in Crisis also reviewed the success of mental health and/or drug courts in two urban counties: DeKalb located in north Georgia, and Chatham located in south Georgia.<sup>13</sup> Later in the year, the NAMI affiliate in Savannah (Chatham County) facilitated a partnership between Behavioral Health Link, an Atlanta-based health and crisis call center that provides a single-point-of-entry services in Georgia, and the Savannah Police Department to develop a pre-booking jail diversion program. The protocol allowed for law enforcement officers to transport persons with mental illnesses to a local designated facility where they would be evaluated by a mental health professional and linked directly with appropriate services.

Jail diversion was named NAMI Georgia's main priority in 2003, and state and local officials held a summit on the CIT model in October of that year. This event was supported by the Georgia Bureau of Investigation, the Georgia Association of Chiefs of Police, the Georgia Sheriffs' Association, Inc., and the Georgia Public Safety Training Center. The founders of the Memphis CIT program, Major Sam Cochran of the Memphis Police Department and Randolph Dupont, PhD, of the University of Memphis, gave presentations at the summit, and a vision for a statewide CIT program in Georgia soon materialized. The Memphis CIT model was selected because it is widely considered to be the gold standard for crisis intervention teams throughout the country. It has been embraced by local communities, cities, and states, and is recognized for its firm foundation in community partnerships. Preliminary evidence for the effectiveness of the Memphis CIT program has been reported in several research studies.<sup>14</sup>

A select group of Georgia law enforcement professionals, advocates, and community mental health professionals observed the original CIT model in

Memphis in January 2004. A class of 22 representatives from this original group later returned to Memphis in July of that year to attend a five-day, 40-hour CIT course. The initial professionals who attended the CIT training program were primarily selected by their department heads or were self-selected. Several professionals from this inaugural group were then instrumental in developing and delivering the initial CIT program conducted in Georgia. After realizing the need for a formal training program for potential CIT trainers/instructors, Georgia developed the Georgia CIT De-escalation Trainer Program (described later) to provide CIT officers with the skills necessary to train other CIT officers.

### **Vision, Mission, and Objectives**

Following their visit to Memphis, a small group of professionals in Georgia established a steering committee that later grew into the Georgia CIT Advisory Board. This group became instrumental in identifying, formulating, and publicly communicating the vision and mission of the Georgia CIT program. Proponents of the Georgia CIT program envision a Georgia where nonviolent individuals with mental illnesses and other brain disorders receive medical treatment, not criminal incarceration. The mission of the program is to equip Georgia law enforcement officers with the appropriate skills necessary to effectively and humanely assist adults and children with mental illnesses in crisis, thereby advancing public safety and reducing the stigma commonly associated with mental illnesses. To achieve this mission, the following program objectives were identified:

To train law enforcement officers to respond safely to persons in mental health crises;

To protect the rights of persons with mental illnesses and other brain disorders;

To ensure that persons with mental illnesses and other brain disorders receive treatment in lieu of incarceration, when appropriate;

To improve the quality and quantity of mental health services; and

To promote adequate training for criminal justice personnel about mental illnesses, developmental disabilities, and addictive diseases.

The steering committee embraced a major goal, previously adopted by the Memphis Police Department, of providing CIT training to approximately 20

percent of Georgia's law enforcement officers. Because not every law enforcement officer possesses the personal traits necessary to become an effective CIT officer, most law enforcement agencies involved in CIT programs throughout the country will train only a certain percentage of their officers or may establish a specialized unit of CIT officers to respond to mental health crises. Training about 20 percent of officers allows departments to access CIT officers to respond to crises during all patrol shifts.

### **Advisory Board**

In the latter months of 2004, the Georgia CIT Advisory Board was created to provide oversight for the program, particularly with regard to the expansion of the program from the initial area of metropolitan Atlanta to the entire state. The Advisory Board evolved from the Georgia CIT steering committee, a small working group that initially consisted of five to seven members, to approximately 30 members currently serving on the board. Board members volunteer their time and expertise to ensure that the mission and objectives of the program are achieved. The Advisory Board is composed of representatives from state and local law enforcement agencies, the state mental health system and other mental health providers, hospitals and universities, and consumer and family-based alliances. Local judges, attorneys, county mental health directors, advocates, consumers, and other volunteers from both the public and private sectors also serve on the Advisory Board. The Board consults regularly with officials from the medical, government, and business communities and monitors the program's progress and achievement of its objectives.

A Georgia CIT Executive Committee, which includes a core group of Advisory Board members, also was established to facilitate the daily operations of the CIT program. The Committee convenes regularly to discuss improvements to the program. This forum utilizes subcommittees to identify and develop resources and to inform and involve the community. Like the Advisory Board, the CIT Executive Committee includes representatives from various state and local agencies and from the public and private sectors.

### **Training Curriculum**

In 2004, an Advisory Board workgroup established a strong partnership with the Georgia Pub-

lic Safety Training Center, the state's centralized training facility for public safety personnel that houses the Georgia Police Academy. Through this partnership, a Georgia Peace Officer Standards and Training (POST)-approved CIT curriculum was developed for use by local communities throughout the state. The 40-hour curriculum is a consecutive five-day training course, comprising both classroom and practical law enforcement training provided by mental health professionals, other content experts, and trained CIT law enforcement instructors. The curriculum includes classroom instruction regarding various mental illnesses, developmental disabilities, and addictive diseases; site visits to local emergency receiving facilities and inpatient psychiatric units; and performance-based training, which includes the mastery of de-escalation techniques and crisis intervention skills through role-play scenarios. The curriculum was designed to ensure quality and consistency in the training provided throughout the state. Standardization of the course curriculum through Georgia POST ensured that the basic tenets of the Memphis CIT model were preserved across localities and allowed for increased uniformity and improved quality of training.

Each CIT class accommodates 15 to 25 law enforcement officers. The curriculum includes 20 training modules, one of which involves 10 hours of both classroom and practical training on crisis intervention de-escalation techniques. Each student receives a training manual that includes lesson plans and other pertinent information. During a graduation ceremony at the conclusion of the course, officers are awarded course certificates from the state's public safety training center, and a state CIT pin and patch to signify that they are Georgia CIT officers. Certified officers are able to utilize their de-escalation skills to minimize the risk of injury to individuals with mental illnesses and to others. Officers also are able to maximize the probability of a voluntary response to receive treatment.

### **Coordinators**

Before the delivery of a local CIT training course, state-level law enforcement and NAMI coordinators are responsible for assisting local law enforcement agencies in selecting at least one local CIT coordinator for their community or jurisdic-

tion. Officers enrolled in the CIT program are selected by their local CIT coordinators, who are veteran CIT officers familiar with the personal characteristics required of a CIT officer. Officers selected for entry into the program are screened to ensure they possess certain personal attributes (e.g., kindness, empathy, maturity, leadership, patience, flexibility, and creativity). They must be observant and able to exercise good judgment, but must also possess a strong desire to help others.<sup>7</sup> CIT officers are trained to utilize appropriate active listening techniques and identify behavior that should be avoided when attempting to de-escalate a crisis situation.

A state CIT coordinator from NAMI Georgia, along with other NAMI volunteers, assists in organizing the law enforcement training, which includes securing an appropriate training location and inviting local treatment professionals to teach the approximately 20 mental health modules (using the POST-certified state curriculum, lesson plans, and slideshows). State law enforcement CIT coordinators facilitate communications with local law enforcement agencies to ensure that all the appropriate agencies are notified and involved in the training. A team of CIT-certified law enforcement officers delivers the de-escalation techniques component of the course. Local CIT coordinators identify consumers of mental health services and their family members who are willing to talk with officers during the CIT training week about their personal experiences. CIT coordinators are also responsible for scheduling transportation and site visits to local emergency receiving facilities, inpatient psychiatric units, or similar treatment facilities.

The De-escalation Trainer Program provides CIT officers with specialized training that enables them to teach the de-escalation training module for local CIT courses. For each class, the coordinators must schedule approximately six CIT officers and at least one clinician who are specially equipped to deliver de-escalation training.

### **Stakeholders' Meetings**

To ensure the effectiveness of the CIT program and the availability of mental health services (particularly emergency receiving facilities) in each community, local stakeholders' meetings are conducted before the implementation of a local CIT program. The

law enforcement and NAMI coordinators generally facilitate one or more meetings in the specific community to initiate the planning of a CIT training course. During these stakeholders' meetings, local resources are identified, perceived challenges to achieving an effective program are discussed, and communication and collaboration among multidisciplinary partners commences.

Representatives from both the public and private sectors are invited to attend these meetings. In addition to local NAMI affiliate members, these representatives often include city mayors, city managers, and city council members; county commissioners, county sheriffs, and local police chiefs; hospital administrators, mental health providers, clinicians, and social workers; defense attorneys, district attorneys, and judges; school educators and counselors; and representatives from faith communities. Family members of consumers are a critical component to the effectiveness of the CIT program and are involved in all aspects of the implementation.

Without the investment of and partnership among each community's stakeholders, the objectives of the Georgia CIT program could not be achieved. Local law enforcement officers must be able to utilize local mental health resources when interfacing with an individual or family in crisis, and must be able to access treatment services when an individual with a mental illness is in need of treatment. Therefore, stakeholders' meetings are a critical component and a prerequisite to the delivery of the training course in each locality.

### **Practical Operations**

In most departments, officers who are interested in becoming a CIT officer contact their local or state CIT coordinators to request enrollment in the training program. A local CIT coordinator, who is assigned to the requesting officer's law enforcement agency or his or her county of jurisdiction, generally conducts an interview of the officer to determine whether he or she possesses the skills and traits appropriate for an effective CIT officer. Officers who are recommended by their local CIT coordinators to become CIT officers and have obtained approval from their respective supervisors to attend the CIT training are then enrolled. More extensive screening, such as psychological testing or interviewing, is not employed. While officers do not have to be formally

recommended by their department, they must have departmental approval to attend the training.

Although a variety of professionals and volunteers from multiple disciplines work collaboratively to develop and ensure an effective CIT program, the training component of the CIT program is managed by law enforcement professionals. The training curriculum, developed in accordance with POST guidelines, is taught by both clinical and law enforcement professionals who possess content expertise. Each training course is managed by a local CIT coordinator who is an experienced local CIT officer. One or more local NAMI coordinators generally assist this CIT coordinator in planning the program (e.g., scheduling instructors). The CIT coordinator is responsible for ensuring that all training materials are available and disseminated to each officer attending the class, instructors arrive to provide the appropriate instruction, and officers receive appropriate training hour credits.

Many law enforcement agencies strive to ensure that at least one CIT officer is available to respond to mental health crises in a given patrol shift. A CIT officer may be dispatched to a call that involves a mental health crisis, or the officer may encounter this type of crisis while on routine patrol. On other occasions, CIT officers become aware of CIT-related calls while monitoring radio communications (traffic) and respond accordingly.

When responding to a mental health crisis involving an individual who is nonviolent, the CIT officer may be able to de-escalate the situation effectively by using his or her CIT training and crisis intervention skills. The CIT officer also may provide the individual in crisis and friends or family members with referral information so that the proper mental health resources can be sought. However, when an individual becomes violent and refuses to seek treatment, the CIT officer usually transports the individual involuntarily to a nearby emergency receiving facility for a psychiatric evaluation. CIT officers understand the importance of treatment in lieu of incarceration and may elect not to tender formal criminal charges in those situations in which the individual has committed a minor penal offense. Once patients are delivered to the local psychiatric emergency services, evaluations and disposition decisions are routinely made (e.g., hospitalization versus referral to outpatient services).

Because of the nature of the illnesses affecting people with whom officers often interact, CIT officers may encounter the same individuals on more than one occasion. However, because the CIT officer is often familiar with the individual's psychiatric history, the officer may interact with the individual more effectively. To disrupt the cycle of recidivism, properly identifying the signs and symptoms of mental illnesses and assisting individuals in acquiring adequate mental health services is imperative in any successful CIT program.

### **Adequacy of Community-Based and Inpatient Psychiatric Services**

The Memphis experience shows that the interplay of CIT training with adequate community- and hospital-based psychiatric services is critical. A crucial component of any effective CIT program is the strong relationship between law enforcement and the mental health community. This powerful dynamic is often observed when a CIT officer effectively deescalates a mental health crisis event and is able to refer those in need of mental health services to local providers. A successful CIT program is not limited to law enforcement training. CIT officers may be properly trained to respond to individuals with mental illnesses, but when providers refuse or are otherwise unable to provide treatment for individuals who have committed nonviolent offenses, officers are compelled to transport the individuals to local jails. In Georgia, the training aspect of CIT has progressed well. Individual localities, however, must continue working to ensure adequate services (e.g., emergency receiving facilities) and the partnerships (e.g., non-refusal policies) necessary for successful diversion from jail to mental health treatment.

### **Costs and Funding**

In 2003, NAMI Georgia received approximately \$10,000 in funding from Georgia-Pacific, an Atlanta-based company, to commence implementation of the CIT program in the metropolitan area and surrounding counties. AirTran Airways provided air travel for the inaugural group of representatives from Georgia to observe the Memphis CIT model. In addition to corporate funding, the Georgia Department of Human Resources, which houses the Division of Mental Health, Developmental Disabilities, and Addictive Diseases, was instrumental in providing initial funding for the program.

Operating expenses incurred as a result of statewide implementation of CIT include personnel costs for one or more full-time program administrators, who are responsible for the daily operations of the program. NAMI volunteers also assist in the coordination of local stakeholders' meetings and law enforcement trainings. The mental health and law enforcement professionals who provide classroom instruction are volunteers dedicated to the program and therefore are willing to donate their time. Training expenses include the printing of student CIT manuals and the production of CIT lapel pins and uniform patches, which are paid for by funds from the Georgia Department of Human Resources. Refreshments and, on occasion, lunches are provided for officers during training via donations from NAMI members.

In Georgia, services relating to the direct management and supervision of the CIT program are provided by Georgia Bureau of Investigation personnel who are state employees or other staff whose positions are funded through federal and state grants. These staff members work directly with NAMI Georgia volunteers to coordinate all aspects of the CIT program statewide. CIT training is available to any law enforcement agency in the state at no cost to the agency.

The potential costs of overtime shifts for officers who must cover the shifts of those being trained must be considered. In some localities, police chiefs may resist even "free training" because it is not free for their department. However, this potential cost has not created a barrier in Georgia. Similar to other states, Georgia's POST requires that law enforcement officers receive a minimum number of training hours annually to maintain their peace officer certification. The CIT program affords an excellent opportunity for law enforcement agencies to comply with this requirement, because officers are provided with 40 hours of training, which exceeds the 20-hour minimum requirement, and CIT training is generally conducted locally, so that officers do not have to travel significant distances from their jurisdictions.

### **Expansion Plan**

The Advisory Board partners with its community stakeholders to address the continuing demand for CIT training throughout the state and to accomplish the program's goal of training 20 percent of the state's law enforcement officers, in all areas of the

state, within the forthcoming years. Because the state is divided into five regions according to the organization of public mental health services, five regional coordinators were identified who would be responsible for the continued coordination and further expansion of the CIT program. These coordinators facilitate the local collaboration that is necessary for a successful CIT implementation. State CIT program administrators or coordinators ensure that the necessary resources are provided to the regions at the state level. Regional coordinators' meetings are scheduled quarterly to facilitate communications between the regional coordinators and state CIT staff and to discuss and assess program expansion.

The successes of Georgia's program have been conveyed to the community through several newspaper and television reports and through the program's website.<sup>15</sup> In addition, the Georgia Bureau of Investigation produced a brief but informative video, *Introduction to Georgia's Crisis Intervention Team (CIT) Program*, which is also available on the website. An annual awards banquet honors supporters, teachers, and officers of the program. Georgia CIT has recently begun compiling a brief newsletter for all trained CIT officers and other interested people.

### **Evaluation, Research, and Academic Collaborations**

In conjunction with faculty from the Emory University School of Medicine and students from the Rollins School of Public Health of Emory University, several initial research projects have been conducted to begin exploring the effectiveness of the program. In a pretest/post-test survey involving 159 police officers, Compton and colleagues<sup>16</sup> found that after the week-long training, officers: (1) reported improved attitudes concerning aggressiveness among individuals with schizophrenia, (2) became more supportive of treatment programs for schizophrenia, (3) evidenced greater knowledge about schizophrenia, and (4) reported less social distance in matters involving people with schizophrenia.<sup>16</sup> A qualitative focus group project that included 25 CIT-certified officers provided feedback about the Georgia CIT program and its practical applications (Hanafi S, Bahora M, Demir B, *et al*: Incorporating Crisis Intervention Team (CIT) knowledge and skills into the daily work of police officers: a focus group study. *Community Ment Health J*, submitted). Officers reported marked enhancements in their interactions

with individuals with mental illnesses as a result of the training, and they attributed these improvements to the program's focus on practical instruction about mental disorders and de-escalation training. Officers also described increased empathy and patience when interacting with people with mental illnesses who are in crisis. Another pretest/post-test survey involved 58 CIT officers and 34 control non-CIT officers.<sup>17</sup> That study incorporated vignettes adapted from the MacArthur Mental Health Module of the 1996 General Social Survey<sup>18</sup> that depicted individuals with depression, schizophrenia, alcohol dependence, and cocaine dependence. The training curriculum was found to be effective in enhancing self-efficacy and reducing stigma/social distance among CIT-trained police officers. Upcoming research projects will examine retention of knowledge among CIT-certified officers in the weeks to years following training and will compare CIT-referred patients in a psychiatric emergency service with patients referred via other routes. Given the prominent dearth of research on CIT to date,<sup>14</sup> future research should examine officer-level outcomes with greater complexity rather than simply documenting attitudinal changes. More importantly, future research eventually must examine patient-level outcomes, as well as the ways in which the CIT program may stimulate system reform at the local level. An evidence base must be established to demonstrate clinical effectiveness (e.g., enhancements of patients' psychosocial outcomes) and cost-effectiveness from the societal perspective.

Other scholarly activities have emerged from the Georgia CIT program. Two Emory University community psychiatrists collaborated to produce a textbook for law enforcement officers and other public safety/criminal justice personnel that was inspired by the Georgia CIT program.<sup>19</sup> Although intended for a broader audience than just CIT trainings, *Responding to Individuals with Mental Illnesses* addresses the need for a standardized text to which officers can refer during and after training. Many of the leaders and teachers of the Georgia CIT program contributed chapters to the book.

Psychiatrists have been involved in the Georgia CIT program in several capacities. First, psychiatrists and other mental health professionals in the psychiatric emergency service setting were involved in the initial planning and visits to Memphis. Second, several psychiatrists developed syllabi, lesson plans, and slide presentations for many of the training modules. Third, many

local psychiatrists throughout the state volunteer as presenters for the standardized lecture topics. Fourth, psychiatrists and psychologists participate on the Advisory Board. Fifth, psychiatric researchers have taken the lead in conducting preliminary research on the Georgia CIT program and planning future research endeavors. While most of the psychiatrists and other mental health professionals involved in the Georgia CIT program are community mental health professionals with clinical, administrative, teaching, and research roles in public-sector settings, there is clearly a role for forensic psychiatrists and psychologists and their trainees.

## Discussion

The Georgia CIT program is a dynamic collaboration of professionals and volunteer advocates committed to reducing unnecessary incarceration and improving the lives of individuals with mental illnesses, addictive diseases, and developmental disabilities. The program is intended to increase knowledge of medical, mental health, and social work issues in the legal, judicial, and law enforcement communities, thereby resulting in increased multidisciplinary collaboration at both the state and local levels. The program trains law enforcement officers to respond safely, effectively, and compassionately to crises, and to seek appropriate psychiatric and social services that can address the mental health needs of individuals in crisis in lieu of incarceration whenever possible. The CIT program also assists communities in identifying local mental health resources and treatment services and is a useful tool through which knowledge is disseminated about mental illnesses. The program promotes local collaboration and cooperation to address mental health needs and provides education about mental illnesses to reduce the stigma that is so often associated with these disorders.

The Georgia CIT program provides an appropriate avenue for individuals who are in crisis to receive services both during and outside normal business hours. As additional law enforcement officers become certified in CIT, their respective agencies will have increased capacity to dispatch specially trained officers to mental health crises. Officers who have completed CIT training are familiar with the mental health services and resources available in their respective communities. Therefore, they are able to provide referral information to individuals with mental illnesses and their families or to secure treatment services.

Although the Georgia CIT program is well established in several urban counties, the state strives to expand the CIT program in the remaining areas of the state, particularly in rural counties where mental health facilities and resources are not as easily accessible. Since the inception of the program in 2004, responsibilities for daily operations have been assumed by state law enforcement and NAMI personnel, in collaboration with the CIT Advisory Board. The rate at which the Georgia CIT program is able to expand throughout the state is limited by the small number of staff members who are able to dedicate the time warranted for successful implementation of this vast project. In addition to limited personnel resources, the program is operated via grant funding, donations, and some limited state funding. Thus, Georgia strives to secure permanent funding sources that will allow for adequate staffing. To ensure the effectiveness of the Georgia CIT program and to improve the quality of CIT training, expanded evaluation and research will be necessary in the upcoming years.

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