

Commentary: Is CIT Today's Lobotomy?

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Birthered in Memphis, Tennessee, in 1988, Crisis Intervention Teams (CITs) have had remarkable growth spurts with few, if any, developmental milestones to document their progress. Compton and colleagues investigated the evidence basis for CIT and found very little. They perhaps found even more than there actually is. There are contributions to CIT outcomes that are rooted in local variations in mental health services and regional culture. These are considered in this commentary, using Memphis as the example. None of us should be surprised that reform is evidence-absent. The mental illness delivery system and the criminal justice system have been instituting reform, and these reforms have had reverberating changes between the two systems, with little or no data to support the changes, for centuries. That there would be unexpected consequences should be obvious. But apparently not so evident that we don't continue to take one blind step after another. Is CIT on firm footing, or just another fool's journey?

J Am Acad Psychiatry Law 36:56–8, 2008

Being in favor of educating officers of police departments about mental illness and mental health services is like being in favor of motherhood and apple pie. Who could be against it? Refining this educative process to cadres of selected officers who become informed, benevolent intervenors on the streets of our cities (and maybe even our towns and villages), saving from jail those whose mental illness-driven behaviors bring them to police attention sounds even more right. It is this first-blush appeal that accounts for the proliferation of Crisis Intervention Teams (CIT) from their origin in Memphis, Tennessee, in 1988.

There is nothing new in this pattern of the development of services for persons with mental illness. We've witnessed the rise and fall of state hospitals, oophorectomies, total dental extractions, and lobotomies (to name just a few) for the care of the insane. We've seen the development and then the waning of mobile crisis intervention because at first "everyone *knew* mobile crisis intervention would decrease state hospital utilization" until there was evidence to the contrary.¹ We've participated in the revamping of the hospital-community balance of loci of service based on a U.S. Supreme Court decision that equates "being in the community" with "integration,"² with

one result being persons with mental illness becoming much better integrated into jails and prisons.^{3–5} Our follies are never-ending, because we are so quick to treat persons with mental illness with fashionable (for the era) social policy changes rather than evaluated treatment interventions. We pay lip service to evidence-based practice and practice the intervention *du jour*.

Compton and colleagues⁶ investigate these concerns as they relate to CIT. They seek the evidence basis for CIT and they find there isn't much. They do not conclude, nor should they, that CIT is not efficacious, and indicate that it might be. I agree that it might be, but find the evidence even weaker than they do.

The authors explore studies from several U.S. cities that seem to support the positive effects of policy training that is the foundation for CIT:

Memphis, Tennessee: CIT officers were more likely to indicate that they were well prepared in situations involving people with mental illnesses (100%) compared with their non-CIT counterparts (65.4%). CIT officers were more likely to rate the mental health system as being helpful (69.4%) than were non-CIT officers (40.3%).

Akron, Ohio: CIT-trained officers had significantly lower preferences for social distance from an individual with schizophrenia; CIT officers were more likely than were non-CIT officers to

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transport persons with mental disturbances to psychiatric emergency services.

Georgia: CIT-trained officers, compared with non-CIT officers, demonstrated an increased level of self-efficacy and reduced level of social distance in relation to interacting with individuals with schizophrenia, depression, cocaine dependence, and alcohol dependence.

Lafayette, Indiana: CIT training appeared to improve officer's comfort in interactions and communications with patients and their family members.

The assumption made is that the training accounts for these differences. But, as Compton and colleagues indicate, "the program provides self-selected officers (or, more commonly, volunteers selected after a review by a CIT coordinator or other senior officer) with 40 hours . . . of training" (Ref. 6, p 47). Persons on the police force who become CIT officers are not the same group as those who don't. The training no doubt provides information, but how does it actually affect attitudes and performance? These studies provide little information.

A second assumption is that the police force as an agent of social control is the major variable. Thus, studies the authors cite that compare outcomes in Memphis with outcomes in other cities tag the CIT training as the differentiating variable. It may well be that CIT has a minor effect while the nature, scope, and organization of community-based services are of significantly greater import.

Memphis has a very police-friendly system of acute dispositions for persons with mental illness. Centrally located is the MED, a large public hospital that receives persons with mental illness brought there by police. Within the emergency room, there is a separate section for persons with mental illness. Over the course of the existence of CIT, holding units that looked like jail cells and then had large, segregated spaces that held individuals behind Plexiglass (a situation that had patients looking much like they were in a zoo) provided emergency quarters for police drop-offs. There was easy access from the MED to the local state hospital. The distance used to be a couple of blocks and now is yards down hallways to a contiguous building (one doesn't even have to go outside or take the person off the stretcher). Tennessee statutes require the state hospital to receive all who are sent to its door. Admitting psychiatrists were

historically reluctant to evaluate and turn away patients rather than admit them, since the former was considerably more work and accrued considerably greater liability. The volume of admissions was so great that the psychiatrists did not have the time for as complete an evaluation as that required for a seen, but not admitted outcome. The Veteran's Administration Hospital, two blocks from the state hospital, does not take involuntary patients of any kind, and so that was not a consideration for the police. Booking the person at the jail, about five blocks from the state hospital and the MED, not only was less humane than treatment for persons with mental illness, but was a more time-consuming, form-burdened process than a drop-off at the ER.

So, how much of Memphis' CIT outcome is actually its police-friendly acute mental health system? Further, with TennCare decreasing outpatient options for persons with serious mental illness, the police-to-MED-to-state hospital route became the best track in town.

Thus, comparing CIT-trained officers with non-CIT-trained officers does not get one very far, because the two groups are not equivalent before the training. And comparing CIT in Memphis with CIT in other locations, or variants of police training in other cities, doesn't get one very far either, because the community-based service system, the insurance/entitlement system, the public hospital system, and emergency detention statutes can be so different as to wash out any police training variables.

Compton and colleagues indicate, "[R]esearch is crucial, especially considering that CIT is uncritically being touted as a model program and being adopted rapidly and broadly" (Ref. 6, p 53). Right they are. But despite their list of nine research interests, they fail to address how we can learn the actual effects of CIT. One could suggest—the authors do not—a randomized study of police officers (i.e., random assignment to CIT or non-CIT). But even this would fail. I've trained police officers, and those who are interested pay attention; those who are not, do not.

Finally, there's the cost of CIT. First, to train officers, police departments must carry part of their workforce on overtime since the officers in training are in addition to the normal workforce. This, in and of itself, hinders police departments from endorsing CIT. Second, there is a cost to the mental health system, since it is burdened repeatedly by receiving those who do not want services. Hospitals are called

on multiple times each year to provide care and treatment to the same cohort of unwilling consumers CIT delivers to it. This is, in part, because CIT is an unleveraged process. There is no contract, the prospective patient has no responsibility, and there are no consequences. For many folks who are the “beneficiaries” of frequent police pickups which lead to jail, emergency room, psychiatric hospital, or shelter, the immediate outcome is irrelevant. In a short time they’ll be back on the streets, and the play will repeat itself. For far too many, “CIT” might just as well stand for Consecutive Interventions without Treatment.

References

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