Police Response to Mental Health Emergencies—Barriers to Change

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The recent success of the Crisis Intervention Team (CIT) model of police-based intervention with behavioral crises has prompted a series of scholarly articles and presentations, widespread public recognition, and replication in municipalities nationwide. The CIT program grew out of a community response to a shooting event. It focused on the need for advanced training and specialization with patrol officers, immediacy of the crisis response, emphasis on officer and consumer safety, and proper referral for those in crisis. CIT has been shown to positively impact on officer perceptions, decrease the need for higher levels of police intervention, decrease officer injuries, and re-direct those in crisis from the criminal justice to the health care system. However, the active ingredients of the CIT model run contrary to tradition within the law enforcement and mental health systems. Law enforcement tends to view training as a panacea, to emphasize training by trauma, and to treat all patrol officers as equally competent generalists. Many mental health emergency systems provide excessive barriers to care, leave officers responsible for the custody of health care patients, and fail to organize the delivery of emergency care. Without a willingness to address these issues, it is unlikely that municipalities will be able to make the changes necessary to implement a CIT model of crisis care.

The role of law enforcement in mental illness crisis events has become recognized over the past 20 years. The initial focus on police officers as street-corner professionals gave way to an examination of the role of police discretion in mental illness emergencies.[1] More recently, attention has been focused on the increasing tendency toward inadvertent criminalization of mental illness through misdemeanor arrests.[2] This development has led to police-based intervention programs that emphasize jail diversion for individuals who are mentally ill.[3] Recent studies have found these models effective in reducing arrest rates among those with mental illness,[4] and further investigations have begun to establish the active ingredients in such programs.[5] Steadman and colleagues[4] have characterized the Memphis CIT model as the "most visible prebooking diversion program in the U.S.," and Torrey has said it should be "imitated in every city in America."[6]

This CIT program was featured at the 1999 White House Conference on Mental Health as a best practice and was recognized by Amnesty International USA in their paper on human rights and mental illness.[7] Although the CIT program has been replicated in seven cities nationwide (Portland, OR; Albuquerque, NM; Seattle, WA; San Jose, CA; Houston, TX; Logan, UT; and Waterloo, IA) and is in development in two more (Akron, OH; Lee's Summit, MO), this is a small fraction of the municipali-

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ties requesting technical assistance (150 in the past year). The comprehensive nature of the CIT program presents a challenge to both criminal justice and mental health emergency systems. It focuses on issues such as the use of force and police response protocols, while requiring the mental health emergency system to respond in an efficient, user-friendly manner. Although these issues would appear to be straightforward, they often provide significant challenges to both systems. In turn, this leads to a resistance to change. Hence, the CIT model is not just an intervention program with mental illness emergencies; it is a process of addressing system change for crisis care within a community as a whole.

Crisis Intervention Team Model

The CIT model originated in Memphis in 1988. It was developed in response to a crisis in which an individual with a history of mental illness and substance abuse was fatally shot while holding a knife. This incident was made more intense by ethnic and cultural considerations as the police officers involved were Caucasians and the individual shot was an African-American male.

The CIT model built upon work done by family advocates (National Alliance for the Mentally Ill (NAMI)) and drew together an additional community task force composed of law enforcement, mental health and addiction professionals, and consumer advocates. At the time, the Memphis Police Department had academy-based basic training of eight hours in crisis intervention with mentally ill individuals. This length of training surpassed the national average at the time (4.5 hours). As a consequence, it was clear that the issue was beyond the scope of initial training. The task force set out four basic goals in developing the CIT model. These were: (1) the need for advanced training, (2) immediacy of the crisis response, (3) emphasis on safety of the officer and consumer involved in the crisis, and (4) delivery of proper care for the individual in crisis. No model available at the time focused on these four elements (see Deane *et al.*[8] for a review of crisis models). Addressing these goals set into motion a dynamic relationship between community policing, mental health service delivery, and advocacy that focused on issues of police use of force and jail diversion.

Several strategic decisions followed from these basic goals. The first was the use of experienced officers who volunteered for advanced training in crisis intervention techniques. The advanced training itself was intense (40 hours) and focused on scenarios developed from actual incidents. These scenarios allowed for the illustration of crisis de-escalation principles and included intensive feedback from fellow officers and mental health professionals. Other parts of the training included didactics in mental health and addiction issues, legal issues, cultural diversity, disposition options, and work with consumers and families. This last item allowed for interactions in real-life settings both during crisis events and outside of a crisis period.

To meet the goal of the immediacy of response, officers who volunteered had to be part of the uniformed patrol division, which would allow them to be first-line officers who respond to emergency calls such as those dispatched through the 911 system. To be cost-effective, these same officers would answer the entire gamut of emergency police calls as part of their workday. Yet, when a call involving a likely mental health disturbance was dispatched, these officers would be assigned the call as part of their workload. To allow enough of these officers to be spread throughout the city, covering every precinct and every shift, about 15 to 20 percent of the entire patrol division would eventually be trained. This would allow for the 911 operators to use a protocol to dispatch crisis calls to a network of CIT officers who are part of the patrol division. These officers provide the leadership and take responsibility for the outcome of a crisis event. However, they remain a part of the general patrol division without the risk of isolation from the community posed by more specialized police programs (i.e., Tactics Apprehension and Containment Team (TACT), organized crime units, narcotics, and anti-gang units).

The program emphasized officer and consumer safety through a number of mechanisms. Perhaps the most significant was the integration of officer safety training into the CIT training. Senior CIT patrol officers provided feedback, and CIT staff constantly worked both concepts into the scenario training. One of the strongest learning principles incorporated is that officers develop an understanding of their ability to impact on the behavior of the person in crisis, shaping it toward de-escalation and away from the need to use force. The second basic learning principle is that officers clearly realize that consumer safety and officer safety are intertwined.

Although referral of those in crisis to proper care

would appear to be the simplest part of the model, such a referral requires a change in attitude on the part of the officers and the mental health professionals. Officers are increasingly frustrated by what appears to be a collapsing mental health system that appears to put up barriers to care. The jail is appealing as an efficient, user-friendly system that provides for individual care and community safety. These factors lead officers to choose arrest as an alternative to a mental health referral. Hence, the process of criminalization of mental illness is reinforced, and the benefits of jail diversion are ignored.

Outcome and Evaluation Results

Outcome and evaluation data on the Memphis CIT program have provided support for the program's effectiveness. Officers have a positive perception of the program, and it appears to increase officers' confidence in their ability to handle crisis events. The response times have been excellent, generally within 5 to 10 minutes. The program has decreased the need for more intensive and costly police responses while at the same time also decreasing officer injury rates. Finally, the program has resulted in higher referral rates to emergency health care while maintaining an extremely low arrest rate.

Patrol officers appear to have positive perceptions of the CIT concept. Borum *et al.*[5] asked patrol officers if the CIT system: (1) met the needs of those in a mental health crisis, (2) kept those with mental illness out of jail, (3) minimized officer call time, and (4) maintained community safety. These ratings were compared with those of officers from two other major southern metropolitan areas with different models of crisis intervention (community service officers and mobile mental health crisis teams). CIT and non-CIT officers from Memphis rated their program significantly higher than the ratings given to the other two intervention programs by officers from the other cities. This same study also found evidence that CIT training appears to increase officer comfort and confidence in responding to mental health emergencies.

Deane *et al.*[9] examined response times from these same three crisis intervention systems. Here again, CIT response times clearly met the program objectives. Using 100 randomly drawn police mental health crisis events, they found that in 94 percent of the cases a CIT officer was on the scene in under 10 minutes, with the great majority of those calls responded to in under 5 minutes. This contrasts with the 10-minute response rate of 28 percent for the community service officer model and 8 percent for the mobile crisis team model. The long-term objective of the model for immediacy of response had clearly been met.

It appears that CIT de-escalation training may decrease the need for more intensive and costly police responses. Case study reports from the CIT officers have suggested they are able to resolve complex situations without the use of interventions based outside the patrol division, such as a tactical intervention unit. This ability appears to involve a range of situations, not just mental illness crises. Dupont and Cochran[10] have compared TACT unit callout rates from periods prior to the beginning of CIT program to callout rates after the program began. The TACT unit is similar to the Special Weapons and Tactics (SWAT) unit from other departments and responds for hostage negotiations and barricade situations, among others. TACT calls demonstrate a decreasing linear trend. The rate for the four-year period prior to the beginning of CIT was .042 per 1000 police events. The next three four-year periods show a continual decrease, with the last period having a rate of only .019 TACT calls per 1000 events. Although it is possible that other events occurring within the same time frame as the CIT program may have influenced this finding, similar results reported from other cities with the CIT model suggest that CIT has a significant role in explaining the lower TACT utilization. It appears likely that the CIT model decreases the use of high intensity police units through resolving conflicts earlier in the process.

The CIT program appears to be decreasing officer injury rates as well. Dupont *et al.*[11] examined officer injury rates during crisis calls that had involved mental illness prior to the CIT program. The rate for the three-year prior to the program was .035 mental illness-related injuries per 1000 events. The rate for the last three-year period was .007 officer injuries per 1000 events. A similar analysis for disturbance calls during this period (which include domestic violence calls) did not show a similar linear trend. This evidence suggests the CIT program is producing an effect unique to officer injuries on crisis calls involving mental illness. Because records on citizen injuries are not kept, quantitative data are not available. However, case reports from the emergency service indicate

that injuries to those with mental illnesses have likely decreased as well.

Finally, the consumers are receiving emergency health care outside of the criminal justice system. First, Dupont and Cochran[12] reported an increase in Memphis Police Department involvement with mental illness events after the CIT program began. The percentage of calls involving mental illness events doubled within four years of the program's start. This change followed a three-year period before the CIT program began, during which the rate of mental illness calls was decreasing. After the start of the program, the police department was more involved in calls involving mental illness crisis events. Additionally, although the rate of referrals from law enforcement to the regional psychiatric emergency service (MED) increased at a rate of 23 percent for the four-year period prior to the CIT program's start, the overall rate of increase in referrals rose to 42 percent within the first four years of the program's existence. Although a part of the increase in referral rates could be attributed to other factors, this change began immediately after the CIT program was initiated. It appears likely that CIT made a significant contribution to this increase. Thus, police officers were more involved in mental illness crisis events and referred a much larger number of these same individuals to the emergency health care system.

Further support for the effectiveness of CIT in reducing the criminalization of mental illness events was found by Steadman and colleagues.[4] They found the CIT arrest rate in 100 randomly drawn calls was two percent. This rate is lower than the estimated national average of 20 percent.[13, 14] It was also lower than the rates found in the two other crisis programs studied (13% and 5%). Taken together, these data provide support for the effectiveness of the CIT program in providing a systematic response to behavioral crisis events. The Memphis CIT officers have increased their department's involvement in mental illness events and referrals to the health care system. This increase has happened while they have maintained an extremely low rate of arrest for those with mental illness, while at the same time significantly reducing their own injury rate.

Challenges for Law Enforcement and Mental Health Systems

Although the CIT model appears to be an effective intervention strategy, communities can have a difficult time implementing the program.[15] The CIT model often presents a challenge for currently accepted practices in police training, police operations, and mental health delivery systems. For law enforcement, CIT focuses on training only as an adjunct to creating expertise within the patrol division. For mental health, it requires a willingness to take responsibility for the patients without preconditions. While these requirements might seem fairly basic in theory, they are often difficult to meet in practice. Law enforcement agencies tend to view training as an end in itself. In turn, the agency views the patrol officer as a generalist, able to handle all incidents equally well. The CIT model challenges these assumptions by focusing on developing expertise within the patrol division itself.

Training as a Panacea

One tenet of police tradition is that additional training solves all problems. Legislative systems tend to encourage this view, often mandating additional training hours at the academy or in-service level. As a result, when a community crisis occurs involving an individual with mental illness, police administrations tend to respond with additional didactic training hours. Academy-based training can then become isolated and not fully integrated into operational changes. Yet, without this daily reinforcement it is unlikely that additional training will have much of an impact on performance. This same tendency to treat training as a solution to all problems also has limitations on an individual basis. It ignores the fact that the ability to learn new skills relates to the individual's experience base and level of maturity. Generally, academy level classes consist of 21-year-old individuals who are limited in their life experiences and are barely in an adult phase of psychological development. To complicate matters further, stigma and misinformation about mental illness abound in the mass media, which tends to shape the perceptions of officers in their initial response to mental illness crisis events, often leading them to the same prejudices found in the rest of society. However, society expects these same officers to react with good planning and judgment when faced with the complexity of a person with poor reality testing and minimal impulse control. This expectation is unfair to the officers.

Training by Trauma

An additional aspect of police tradition that presents a series of complications in crisis intervention work involves the training around use of deadly force. Officers are exposed to graphic videotapes of the consequences of the failure to properly use force. The foremost of these consequences is the death of the officer or his or her partner if split-second decisions are not made accurately. This training is well intended and designed to heighten young officers' awareness of the risk of failing to properly attend to their own safety. However, the training materials have become increasingly graphic in nature and reality-based over the years. One of the most influential of these types of scenarios involves what has become known as the 21-foot rule.[16] Most officers in the country have seen videotapes depicting the consequences of not drawing their weapon when confronted with an individual with a knife. Basically, officers have learned to respond with possible deadly force before an individual armed with a knife enters within a 21-foot perimeter of the officer. In academy training, this tape is usually combined with actual video footage of police officers being killed by citizens. Although this approach is no doubt well intended, it risks raising officers' anxiety level to the point where other approaches to conflict resolution will be minimized, even if the 21-foot zone has not been approached.

This approach tends to emphasize only the outcome of one particular moment in an interaction between a citizen and an officer. It ignores the process that leads up to that moment and opportunities to impact on the nature of the event itself. This approach permeates the issue of training in the use of deadly force in general. Academy training emphasizes firearms skills at great length. When combined with officer survival training, the academy requirements for both areas at most metropolitan police academies can exceed 100 hours. Yet, the use of firearms is a low frequency event in an officer's career. It is unlikely that any police training program in the country spends an equal amount of time on de-escalation skills, an event that will occur daily for most patrol officers.

Patrol Officer as a Generalist

The next challenge the CIT model brings to police tradition is that of treating the patrol officer as a generalist. This approach assumes that all officers are equally skilled, have similar attitudes, and are equally willing to intervene in a mental illness crisis event; it ignores individual differences, including such overt items as citizens' complaint records and supervisor evaluations. It also ignores more subtle items, such as an officer's exposure to individuals with mental illness and his or her interaction skills.

This lack of specialized expertise within the patrol division has an unintended result. It leads to the lack of accountability during an event. Often, a command officer is not on the scene of a mental disturbance crisis call because call volume and supervisory responsibility limits their presence. Most crisis calls are responded to by uniform officers of the same rank. This means that decisions are often based on informal police traditions such as seniority, precinct assignment, or whoever suggests the initial intervention approach. Thus, the responsibility for the outcome of the event is determined by chance rather than by design. The CIT model has established policy that places the CIT officer in charge of that scene with accountability for its outcome.

The success of the CIT model challenges the tradition of the police officer as generalist and suggests the usefulness of developing further expertise within the patrol division. It would not be hard to conceptualize expertise aimed at specific problems such as homelessness, domestic violence, and drug addiction. Increasing specialization within the patrol division may work against police tradition, but it may provide a solution to the increasingly complex societal demands placed upon police officers.

The CIT program also presents a series of challenges to the mental health system. These issues can be summarized in three major concerns. The first is the barriers to care put up by emergency systems, the second is the reluctance to take responsibility for the individual in crisis, and the third is the general sense that the mental health system is disorganized and failing.

Barriers to Care

Mental health crisis systems often establish criteria for admission that result in excessive barriers to care. In many systems, the patient cannot be intoxicated and cannot have significant impairments, other medical conditions, mental retardation, or dementia. Consequently, officers have to search for specialized treatment facilities before the patient's diagnosis is clearly established. As a result, the subjective nature

of diagnosis comes into play. The same patient might be viewed differently by different treatment facilities. The problems of an individual with a dual diagnosis might be seen as primarily involving substance abuse issues at the mental health entry point and then as primarily mental health-related at the substance abuse treatment facility. Especially in times of tight budgets and overworked staffs, the lack of a single entry point that accepts all referrals can lend itself to conflict over responsibility for the patient. This sort of situation leads to the use of the police as a taxi service from one type of crisis center to another. The whole scenario is more popularly referred to in terms of turf battles and patient dumping.

Responsibility for Care

The second major issue for crisis care involves the legal responsibility for the custody of the individual in question. Despite the fact that most diversion does not involve the formal arrest of a person in crisis, many crisis centers insist on law enforcement personnel maintaining custody of the patient. This is almost never the case for other medical conditions. Many state laws governing the transportation of individuals involved in the civil commitment process maintain the involvement of law enforcement in the health care process well beyond the point of entry. Most such laws require a local law enforcement agency (often the county sheriff) to meet transportation needs. This is perhaps the single most critical factor in maintaining the tendency to criminalize mental illness. In this situation, the crisis center leaves the law enforcement agency responsible for behavioral control of the patient, something that is virtually never done for other medical illnesses. Generally, if law enforcement officers are required to maintain this level of responsibility, they will choose a more expedient resolution to avoid waiting around for six hours or longer. Hence, they choose their local jail.

Organized Delivery of Care

Perhaps the problems faced by the mental health system that tend to be highlighted by the CIT model involve the basic failure to organize and structure most systems of crisis care. The Memphis CIT model was borne out of a significant crisis. Many cities that have expressed an interest in the CIT model also are responding to a crisis event. The municipalities that have successfully implemented CIT programs have mental health and substance abuse delivery systems that are well organized and reasonably well funded. Two of the best examples of such systems are those in the Portland, OR and Akron, OH areas. Both of these systems have a fairly decentralized system of service delivery at the state level but combine that with a fairly structured system at the county or regional level. They both have countywide authorities responsible for the care of those with mental health and addiction issues. This approach appears to lend itself to cooperative efforts with local law enforcement. In both cases, the mental health emergency system had to make adjustments to accommodate the implementation of a CIT model. It required a level of cooperation at the local level not generally seen in most mental health delivery systems. The ability of a countywide authority to plan for these changes appeared to be a critical ingredient.

Although these systems (in Oregon and Ohio) appear to have implemented the CIT model easily, the original site for the CIT program lacks such a countywide planning authority. Rather, the strength of the Memphis delivery system appears to be in its use of a hospital-based emergency service. This plan bypasses some of the barriers to care set up by the failure to integrate medical care with social service delivery models. Here, the ability to treat a wide variety of clinical conditions and a commitment to minimize officer time appears to moderate the lack of systematic organization within the mental health delivery system. Thus, some level of service integration would appear to be necessary for a municipality attempting to implement a CIT model. The best alternative would appear to be organized systems of service delivery with county-level authorities. However, it may be possible to accommodate the lack of service delivery planning capacity through the use of a "single source of entry" model, which would allow for the integration of care at the level of the crisis triage center. This approach may well overcome the disorganization of various mental health systems, allowing the staff of the triage facility to become the integrating force in the delivery of care. The Memphis success notwithstanding, cities that lack organized systems of mental health care appear to have a more difficult time implementing the CIT model of police-based crisis intervention.

The CIT model appears to have a series of requirements for municipalities to successfully implement a CIT program. These requirements start with a willingness to challenge traditional methods of police

training and police operations and also include the need to address barriers to care within the mental health delivery system. These barriers include the general lack of system organization and the lack of willingness to take responsibility for those in a mental illness crisis. Despite these formidable challenges, CIT appears to draw from the key strengths within both systems. It requires the efficiency and structure necessary for effective law enforcement. It also requires the ability to respond to complex behaviors on the individual level that is the best part of good mental health care. Overcoming these obstacles appears to result in a genuine community partnership between advocates, law enforcement, and mental health professionals. Recent tragic events involving persons with mental illness suggest that communities are demanding nothing less than a system that effectively resolves these crises.

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