The Crisis Intervention Team (CIT) Program

Because budget constraints, economic factors, and social problems have generated enormous numbers of homeless people, dumped-onto-the-streets mental patients who formerly would have been hospitalized as inpatients, many more mentally disturbed people now come into contact with the general public than ever before. Consequently, the Memphis city government, the mental health community, and the police department realized that incidents of police involvement with the mentally ill had resulted in the mentally ill themselves being vulnerable to serious harm and the increased possibility of police officers, untrained in dealing with the mentally ill, getting seriously injured or even killed. Why can't mental health workers take care of the enormous numbers of emotionally out-of-control people on the streets? Because it is a physical and fiscal impossibility to put enough mental health workers onto the streets to monitor and serve the needs of these out-of-control people and to do so in accordance with the "least restrictive environment" movement in a democratic society.

Spearheaded by the local affiliate of the Alliance for the Mentally Ill, the Memphis Police Department, the mental health community, the city government, and the counselor education and social work departments of two local universities formed a unique and creative alliance for the purpose of developing and implementing proactive and preventive methods of containing emotionally explosive situations in the streets that frequently lead to violence. Because the police were the first and often the only responsible officials on the scene of an out-of-control situation, calling in outside consultants proved unworkable. Therefore, the unique and cohesive alliance of several important community groups determined that highly

trained and motivated police officers were the logical personnel to form a frontline defense against the crisis of dangerously expressive, out-of-control persons in the streets. This massive alliance effort resulted in the CIT program's becoming an example of how a successful program can work to accomplish the objectives of public safety and welfare, economic feasibility, and police accountability (James & Crews, 2014).

The Concept. To comprehend what a difficult and delicate task it has been to bring to fruition a successful and workable CIT program, one must understand how the alliance network functions. If your community does not have such a program, and you think it would be a good idea to get one started, read the following very carefully. The problem of the mentally ill, particularly the homeless mentally ill, is endemic and pervades all jurisdictions that attempt to establish CIT programs. Major Sam Cochran, who was the longtime coordinator of the Memphis CIT program and has been instrumental in helping disseminate the Memphis Model all over the country, puts it very well when he says, "It is not just a program to train police officers to deal with the mentally ill. It is a concept that brings all kinds of interest groups together in a network, and if that concept is not nourished, the program will fail."

The network behind the Memphis CIT program consists of the Memphis city government and the Memphis Police Department (hereafter just referred to as the police); the Alliance for the Mentally Ill; five of the six local community mental health centers; the emergency room components of public hospitals; academic educators from the Department of Counseling, Educational Psychology and Research at the University of Memphis and the School of Social Work at the University of Tennessee; the YWCA Abused Women's Services; the Sexual Assault Resource Center; and several private practice psychologists (hereafter referred to as the mental health community). The power, force, and success of the alliance derive from the process and fundamental working relationship that the police and mental health community have used to both form and maintain the CIT program. The alliance was formed because both the police and the mental health community realized that the problem of crisis in the streets was too severe for either to handle alone and that working together would make life much easier and safer for both as well as provide improved and safer service for clients and the community (James & Crews, 2014).

The alliance conducted a great many collaborative, systematic, and democratic meetings over a period of several months to hammer out a workable CIT blueprint. As a result of these meetings, key individuals from all segments of both police and the mental health community developed effective working relationships with one another and learned a great deal about each other's problems, competencies, rules, and boundaries.

Police were brought into mental health facilities for orientation into the world of mental health. Mental health personnel were brought into the police academy and accompanied police on patrols to learn about the problems, procedures, competencies, roles, and boundaries that law enforcement officers face in their everyday work. Then formal training was developed to ensure that not only the CIT officer selectees but also all supervisory-level police personnel understood the problems, objectives, and operational procedures of the CIT program (James, 1994, p. 187; James & Crews, 2014). The development and training phases provided some essential attitudinal and professional understanding between the police and the mental health community. As a result, CIT officers and their superiors know precisely what training and consultation resources the mental health community can provide. And the mental health professionals know what competencies and resources the police in general and the CIT officers in particular have to offer.

This model is not just about training cops, but developing collaborative efforts among police, the mental health community, and consumer advocates to provide first response mental health help to acutely ill individuals (Kasick & Bowling, 2013). Concomitantly, all sides develop mutual respect, understanding, trust, and cooperation. A CIT officer intervening with a distraught mental patient will likely listen empathically to the patient's feelings and concerns, be familiar with the mental health services available (will possibly know the patient's caseworker personally), and will, within the boundaries of professional ethics, communicate to the patient an understanding of the short-term needs of that person as well as a desire to provide for the immediate safety and referral requirements to contain and stabilize the patient's current crisis. The mental health center caseworker will also understand and have confidence in the CIT officer's ability to be a stabilizing and safe influence on the patient and will, if needed, likely call on the CIT officer for emergency assistance with a particular client. The mental health caseworker may collaborate

with the CIT officer in obtaining anecdotal information needed to enhance the patient's treatment plan and prevent the recurrence of that particular patient's crisis in the streets (James, 1994, p. 191). All of the foregoing happens with consumer advocates such as the local Alliance for the Mentally Ill playing a critical advisory role in the process.

Based on the trust and confidence built through the powerful and cohesive alliance just described, the police department opted to select experienced police patrol officers to receive training and then serve in the dual role of police officers and Crisis Intervention Team specialists. Volunteers for the program had to have good records as officers, pass personality tests for maturity and mental stability, and be recommended, interviewed, screened, and selected to receive CIT training. The police department committed itself to putting trained CIT officers on duty in every precinct in the city, 24 hours every day. All upper-echelon supervisory officers received formal orientation about the role and function of CIT officers so that whenever any call involving a suspected mentally disturbed person anywhere in the city is received, the CIT officer is the designated responsible law enforcement official at the scene—regardless of rank—and all other officers at the scene serve as backups to the CIT officer who handles the case (James, 1994, p. 194; James & Crews, 2014).

CIT Training Using Mental Health Experts and Providers. An integral part of the CIT program is the special preservice training provided for the officers. The importance of effective training by competent, committed, motivated professionals cannot be overemphasized. We also insist that they ride with experienced CIT officers on a Friday or Saturday evening shift prior to the scheduled training of each new group of CIT officers. As Erstling (2006) states, spending 8 hours in a patrol car together goes a long way toward learning to trust and understand one another.

The following topics are covered in the 40 hours of CIT training:

1. Cultural awareness of the mentally ill
2. Substance abuse and co-occurring disorders
3. Developmental disabilities
4. Treatment strategies and mental health resources
5. Patient rights, civil commitment, and legal aspects of crisis intervention
6. Suicide intervention
7. Using the mobile crisis team and community resources
8. Psychotropic medications and their side effects
9. Verbal defusing and de-escalating techniques
10. Borderline and other personality disorders
11. Family and consumer perspectives
12. Fishbowl discussion on-site with mentally ill patients on patient perceptions of the police

While most of these training components are in a lecture-discussion format, two are not. These two components are considered absolutely critical in the training of police officers who do crisis intervention with the mentally ill. They are verbal de-escalation and defusing, and the client fishbowl.

De-escalation and Defusing Techniques. Verbal de-escalation and defusing techniques are taught throughout the weeklong training. These skills are considered so critical that four different trainers are used for 12 hours of training. Basic introductory techniques are taught first. How do you introduce yourself? What is the nonverbal message you convey by your body posture and language? What voice tone do you use? These skills are taught on the second day of training.

Next come basic exploratory skills and establishing a relationship. Skills taught include (1) how and when to use open-ended and closed-ended questions, (2) what owning statements are and why they are important, (3) how to keep clients secure without cornering them (see Chapter 14, Violent Behavior in Institutions), (4) officer and client safety, (5) crowd control, (6) when and when not to use reflection of feelings or thinking, and (7) a summary recapping techniques and restatement for client and officer understanding and communication. These skills are taught on the third day of training.

The training is also greatly enhanced if it can skillfully integrate the conceptual with the experiential. Realistic role play, video technology, playback, and discussion are essential. On the fourth day, 4 hours of training are devoted to role plays of actual police–client encounters. Veteran CIT officers role-play clients. These officers bring many valuable first-hand experiences into the learning environment that heighten interest, enhance motivation, and provide realism (James, 1994, p. 187). Trainees are divided into teams of four, and each member of the team is given 4 minutes onstage to attempt to defuse and de-escalate the client. The rest of the trainees (there

are usually about 24–30) watch all of the teams perform and hear their critiques. The idea is that by watching others perform, trainees learn from the others' successes and failures. Scenarios range from clients with senile dementia to schizophrenics to diabetic psychosis to enraged jilted lovers. The role players escalate or de-escalate their violent behavior depending on how and what trainees do. Each team segment is videotaped, and after all four trainees have performed the videotape is played back, during which veteran CIT officers comment honestly and objectively on both positive and negative aspects of trainees' performance.

On the fifth day of training, complex CIT scenarios are demonstrated. All of the verbal skills used in preceding sessions are integrated to deal with very difficult clients. Such difficult scenarios as suicidal and severely psychotic clients are demonstrated, and then intervention techniques are broken down and analyzed as to appropriate and inappropriate responses. At the end of the week, trainees are in possession of the basic skills necessary to intervene with the mentally ill. Like most beginners, the new CIT officers are a little unsure of themselves. However, one of our most rewarding experiences in this business has been seeing these officers come back to aid in training, having developed some of the most outstanding crisis intervention skills we have seen in the 40-plus years we have been doing this work.

Fishbowls With Clients. Fishbowl discussions are unique and powerful sessions for CIT trainees. During this component of the training, trainees are brought into a mental health facility to meet in a discussion group circle with selected mental health patients. A mental health professional, who also serves as an instructor in the CIT training program, sits in the center of the circle with the patients surrounded by the CIT trainees. The professional engages in interviews and dialogues with the mental health patients, in the "fishbowl," so to speak. CIT trainees observe and hear what the mental patients have to say about their own personal needs and about their prior interactions, experiences, and perceptions of the police. After the fishbowl interview and dialogue, trainees who had been observing the professional–patient dialogue have an opportunity to ask questions and interact directly with the patients. The fishbowl discussion has been described by CIT trainees as profoundly motivational and an essential part of their learning, orientation, and training.

The Success of CIT. In more than two decades since its start in Memphis, CIT has grown exponentially, with training centers now located throughout the country and thousands of police officers trained in its protocols (Saunders, 2010). It is noteworthy that the CIT concept is now international, with its own newsletter and convention. *The Team News*, the newsletter of CIT International, is available at http://www.citinternational.org. CIT programs can now be found across the United States, Canada, Australia, and Sweden. But is there any evidence it really works?

In its first 16 months of operation in 1987–1988, Memphis CIT officers responded to 5,831 mental disturbance calls and transported 3,424 cases to mental health facilities without any patient fatalities. Both calls and transports have increased significantly over the 20-plus years the program has been in operation. This increase in "mental disturbance" service calls happens in other jurisdictions as well (Kisely et al., 2010; Teller et al., 2006) and is most likely attributable to increased awareness by the public of the CIT program. That increased awareness is particularly true of relatives and others responsible for the care and well-being of the mentally ill. Publication and support by the National Alliance on Mental Illness (2011) for CIT officers has led to the belief that caregivers' loved ones will be handled in a sensitive manner and not be killed or injured by the police.

Along with increased calls, there appears to be a reduction in the use of force, more diversion from jail to hospitals (Compton et al., 2014b; Lamb, Weinberger, & Gross, 2004; Ritter et al., 2011; Skeem & Bibeau, 2008), decreases in time spent on each call, and increased cooperation between mental health service providers and police (Kisely et al., 2010). In a comprehensive review of research outcomes, Compton and associates (2008) found that there was indeed a reduction in the use of force by CIT officers, more sensitivity toward the mentally ill with commensurate diversion instead of arrest, fewer officer injuries, and reduced hostage team callouts. In Memphis it is noteworthy that only two fatalities have occurred to a recipient of service by CIT officers during the more than 20 years the Memphis Police Department CIT has been in operation, and in both of those cases police officers were found to be justified in killing the person.

Suicide by Cop. Indeed, it is extremely significant that the death toll is so low when CIT officers make the scene. A fairly common phenomenon called "suicide by cop" has been well established. In essence,

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people who do not quite have the courage to kill themselves engage in some activity that gains the attention of the police. Once the police arrive, they engage the police in a threatening manner and succeed in getting themselves shot. In short, the cops complete the suicide (Lindsay & Lester, 2004). We will speak to this phenomena more in Chapter 8, Crisis of Lethality. Police are highly aware of this dangerous phenomenon and are also very interested in learning how to handle it (Lindsay & Lester, 2004; Vermette, Pinals, & Applebaum, 2005). Indeed, the research suggests that tighter bonds and coordination between police and mental health providers such as occurs in CIT programs can reduce this phenomenon (Dewey, Allwood, Fava, Arias, Pinizzotto, & Schlesinger, 2013). At least in Memphis we believe the ability of the police to avoid helping complete this suicidal act and to reduce other mortalities is directly attributable to CIT training. Although no figures exist to determine how many persons have been injured while being taken into protective custody during the 20-plus years CIT has been in operation, statistics indicate that injuries to officers have been reduced significantly. Furthermore, barricade situations have also been reduced significantly. The advent of the CIT program has almost put the Memphis Police Department hostage negotiation team out of business because CIT officers arriving on the scene are often able to defuse and control the situation before the hostage team arrives (James, 1994, pp. 189–190).

Why is this so? A number of studies (Bonfine, Ritter, & Munetz, 2014; Compton et.al., 2006, 2014a; Ellis, 2014) have examined a number of variables of CIT officers immediately before and after undergoing CIT training. After training, those officers demonstrated much-improved attitudes, more support for treatment, more knowledge, less social distancing, more confidence in dealing with the mentally ill, and less stigmatization of them. In summary, besides their increased skill at defusing and de-escalating the violent mentally ill and emotionally disturbed, CIT police officers have become some of the most caring and concerned crisis workers the mentally ill have.