Police Responses to Persons With Mental Illness: Going Beyond CIT Training

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Since 1988, a major development to reduce lethal encounters between police and persons displaying signs of mental illness has been the adoption by many police departments of crisis intervention teams (CITs). Created in Memphis, Tennessee, CIT programs incorporate deescalation training, police-friendly drop-off centers, and linkage to community treatment programs. The authors summarize issues discussed at a recent Substance Abuse and Mental Health Services Administration workshop at which participants highlighted the importance of going beyond CIT training to most effectively include police in a crisis care continuum model. Such an approach focuses on how police can be engaged as partners with behavioral health providers who are designing and implementing services in the crisis care continuum. Reframing the approach to police responses to persons in mental health crises offers the prospect of improving both public health and public safety goals.

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Individuals in emotional crises accounted for approximately a quarter of all fatal police shootings nationwide during 2015 (1). At the same time, the number of communities with police officers who have had training in dealing with persons with mental illness, including various forms of crisis intervention team (CIT) training, is at an all-time high (2). The best estimate is that more than 1,000 U.S. communities have CITs. How is it that two such apparently conflicting trends coexist?

A March 2016 meeting, "Effectively Integrating Police in the Crisis Response Continuum," sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), offered some possible explanations to that question, along with a new paradigm for considering police involvement in a crisis response continuum. CIT was developed in 1988 in Memphis, Tennessee, as a response to a lethal police encounter with a person with mental illness. It was a joint community response by police, behavioral health professionals, family members, and consumers. It focused on deescalation training, a police-friendly center at which people with mental illness encountered by police could be dropped off, and linkage to community-based services (3,4). The SAMHSA meeting highlighted the fact that the full implementation of CIT can lead to effective integration of police and evolving services in the crisis care continuum, but full implementation is more than just CIT training.

Changing the Conversation

What more is needed for effective integration? The core concept of a novel approach reframes a basic CIT question. Rather than asking what police need to do when they encounter a person in distress in order to deescalate the situation and make appropriate referrals, the reframed question should focus on how police can be engaged as partners with behavioral health providers who are designing and implementing services in the crisis care continuum. In fact, the Web site of CIT International (http://citinternational.org/index.php), the organization formed to provide training to police departments, states that its mission is to "create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness." Partnerships among law enforcement, advocacy, and mental health providers form the first of its ten core elements. The following catch phrase has been used by the founder of CITs, Sam Cochran, since CIT's inception in Memphis in 1988: "CIT is more than just training, it is a community program."

This concept is often not recognized by communities searching for more appropriate police responses to persons in mental health crises. Communities become committed to the 40-hour CIT core curriculum, which generates important buy-in to the importance of better police training. However, communities may fail to recognize that training alone does not lead to an integrated approach that reduces trauma, unnecessary hospitalizations, and detentions. For a truly appropriate response, a number of other elements beyond police training are needed: avoiding police involvement when it really is not needed, offering police community-based alternatives to jail when some type of transportation

from the encounter is called for, and providing respite options for consumers and their families with differing lengths of time and varying intensities of services. These three needs are at the heart of the development of a community crisis care continuum, and police should be involved in the planning of this continuum.

A Crisis Care Continuum

Crisis response programs fall along a continuum of services designed to stabilize and improve psychological symptoms of distress and to engage individuals in appropriate treatment, including crisis stabilization beds, crisis residential services, mobile crisis teams, crisis phone lines, and psychiatric advance directives and peer support. A review of evidence for the clinical effectiveness and cost-effectiveness of different types of crisis services conducted for SAMHSA concluded that "There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes" (5).

Although most states have some of these components of crisis care, it is uncommon to find localities with the entire continuum of services. The exact practices to be implemented are best determined through dialogue among consumers, their families, administrators, and first responders, including police. Types of crisis response continuum services (with some typical examples) include prevention (high-quality behavioral health care, supported housing and education, peer and family supports, Wellness Recovery Action Plans [WRAPs] [6], psychiatric advance directives, and family psychoeducation), early intervention (warmlines, hotlines, mobile crisis outreach, and respite services), intervention and stabilization (recovery centers, 23-hour crisis stabilization, detox centers, short-term crisis residential settings, and inpatient settings), and "post-vention" (assessment and reassessment of services and supports, postcrisis WRAP planning, case management, family support, and "peer bridgers" to ease the transition back to the community).

A Complementary Role for Police

This framework recognizes the complementary roles of police to ensure safety and of providers to promote recovery and resilience. Not all crises need to, or even should, result in emergency room evaluations. Yet mental and substance use conditions account for one of every eight emergency room visits and are two-and-a-half times more likely to result in hospitalizations than visits that do not involve these conditions (7). Behavioral health providers working with police can link individuals to less intensive and costly alternatives to emergency rooms. For example, when the police call dispatch center in an Eastern Maryland community was recently being redesigned, the community mental health center partnered with police to integrate it with the mental health center's crisis hot line. This redesign resulted in triage of 30%–40% of 911 calls to the crisis center hot line, which avoided any police response at all (3). Collaboration between police and behavioral health providers also led to reduced arrest and incarceration in this Eastern Maryland community. It is important to recognize that most of the interactions between law enforcement and persons with mental and substance use disorders do not reach crisis levels. Many involve daily interactions over behavior in public spaces, quality-of-life issues, or homelessness. But when interactions escalate into crises, police should have alternatives to transporting individuals to the hospital emergency room or to jail.

The purpose of crisis response is not only to ensure safety but also to promote individual recovery and the behavioral health of the community. Crises are critical times for intervention and treatment, and providing the appropriate level of intervention, including peer support and crisis respite, can result in positive outcomes for the individual and family—and in safer communities. Better coordination, as CIT International describes in its policy and procedures core elements, means that police and mental health agencies share guidelines that direct the actions of both law enforcement and mental health personnel. In developing standards for states to use to establish Certified Community Behavioral Health Clinics (CCBHCs) in a major demonstration program, the U.S. Department of Health and Human Services codified the importance of this relationship and required the CCBHCs to establish protocols "that specify the role of law enforcement during the provision of crisis services" and have procedures in place "to reduce delays for initiating services during and following a psychiatric crisis" (8).

Situations Versus Crises

In fact, one language change suggested at the SAMHSA meeting was to stop talking about "crises" and talk instead about "situations." Such a shift would emphasize the occurrence of these events as a regular part of life to which the health care system usually should be equipped to respond, rather than high-profile events always requiring a law enforcement response.

A final point about more effective police involvement is to recognize that while CIT trains officers to deescalate situations involving individuals in crisis and work with behavioral health providers, there are few comparable programs that teach behavioral health providers how to deal with law enforcement. One such program is offered to behavioral health professionals and community members by the Linden, New Jersey, police department (9). The program is called "Why We Do What We Do," and it focuses on police protocols, procedures, and operations. Real cross-training is a two-way street.

Conclusions

It is time to go beyond CIT training as the sole law enforcement response. Behavioral health and law enforcement personnel need to be engaged jointly in designing, implementing, and operating all phases of our evolving crisis response and crisis care continuum. In fact, a careful review of the CIT core elements shows that this comprehensive involvement is already central to a full CIT program.

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