Crisis Intervention Teams: A Police Response to Mental Health Issues

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Abstract

In the 1960s, non-violent mentally ill patients in the United States were deinstitutionalized to allow them to receive the treatment they needed from community service agencies, as opposed to being institutionalized. With this change, police mental health contacts became part of the law enforcement profession. In 1987 Memphis, TN Police Department officers responded to a call in reference to a mother requesting assistance with her mentally ill son. That call culminated with the officers shooting the son several times. As a result of that incident, the "Memphis Model" of Crisis Intervention Teams (CIT) was created. Since then, over 2000 communities, in over 40 states, have implemented variations of the "Memphis Model" of CIT. Many more communities are currently in the process of implementing CIT's in their law enforcement agencies. In this paper, we will discuss several aspects of the CIT program. This comprehensive look at crisis intervention by law enforcement will look at the history of CIT programs and court cases related to the issue. We will examine the Louisiana mental health laws and how risk management relates to the CIT program. Lastly, we will discuss the current "defund the police" movement spreading across the United States and its potential effects on how law enforcement handles calls involving interactions with citizens who have mental illness.

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This paper is a collaboration of research from several leaders with diverse backgrounds in law enforcement. The purpose of the study is to discuss officers' responses to mental health crises. We will discuss the importance for agencies to have a Crisis Intervention Team (CIT). We will examine reasons why defunding the police will have an adverse effect on the communities they serve. The significance of this paper is to address how agencies use a CIT model to improve officers' ability to intervene safely, connect individuals to mental health services, and decriminalize them when appropriate.

Before an agency implements a Crisis Intervention Team, the agency must create a vision and action plan to align its values with the officers and citizens. There must be organizational communication so the officers can adapt, alter, and maintain the environment to achieve the agency's goals. Anderson, Gisborne, and Holliday (2017) state, "A leadership organization prepares leaders first. Eventually, everyone in the organization learns to work on the organization to improve it, as well as to work in it." (p. 43). Mental health-related calls are often unpredictable and risky. If an officer does not have adequate de-escalation training, it can cause the officer to respond in a way that can escalate the situation.

The first aspect this paper will emphasize is the deinstitutionalization of persons with a mental illness. Then, this paper will discuss the implementation of the Memphis Model and the current debate to defend or defund the police as it relates to the law enforcement response to mental illness crises. Next, this paper will discuss court cases that shaped law enforcement responsibilities when handling mental health calls for service. In this same area, this paper relates the Memphis Model to Louisiana mental health laws. Finally, this paper will demonstrate

how best practices regarding risk management will deliver tangible results from trained crisis intervention teams.

Review of De-institutionalization and Crisis Intervention

First, in relation to any discussion of law enforcement response to mental health crises, it must be accepted that officers and deputies respond to such calls daily. From this premise, the question is, "Why?" The traditional role of law enforcement has been established to enforce laws and to maintain peace and order. How did this expand to dealing with the mentally ill?

Next, over the course of time, the funding for in-patient mental health facilities has decreased. This is a direct result of the process known as de-institutionalization. In the past, mental health facilities had been seen as an embarrassment, having deplorable conditions, and being wrought with other problems, such as maltreatment of the infirmed. Due to these conditions, mental health professionals and civil libertarians championed the cause of de-institutionalization. With public support, this process was viewed as a way to return rights to the institutionalized, as many had been confined without due process. (Torrey, et al, 2005).

While the need for this was easily seen, it reduced resources available for the severely mentally ill that may have posed a threat to themselves or others. The reduction of resources was exacerbated by further cuts in government funding and court rulings aimed at protecting the rights of the mentally ill. Since 1955, over 500,000 inpatient psychiatric beds have been lost. (Torrey, et al, 2005). In 2014, approximately 170,000 individuals were confined to in-patient mental health facilities at any given time. (Lutterman, et al, 2017). It can be deduced that with the decline in available beds, the amount of services from mental health professionals have declined in terms of in-patient needs. It can also be deduced that with the transfer of services from in-patient to out-patient services and the generalized fear and stigma attached to the

mentally ill from lack of understanding that calls to emergency services have gone up drastically. As stated previously, law enforcement officers are often the first response to these situations.

As early as 1960, the National Institute for Mental Health produced a training film entitled, "Booked for Safekeeping," (Stoney, 1960). The film provided basic techniques for law enforcement to deal with mentally ill persons. This ranged from the older person dealing with some form of dementia to the paranoid barricaded subject. This film and some of the techniques may seem antiquated by today's standards, but some are still valid and useful.

Law enforcement had to create a specialized concept in dealing with the mentally ill. This concept would come to be known as the Crisis Intervention Team (CIT). According to the American Academy of Psychiatry and the Law (Rogers, McNeil, & Binder, 2019), in 2018, one thousand people were shot by law enforcement. It is also presented that 25% of that number, approximately 250, were mentally ill. This rate is believed to have gone down since the creation of the CIT concept.

The Implementation of the Memphis Model

The acknowledged incident that spurred the creation of CIT occurred in Memphis, Tennessee in September of 1987. (Rogers et al. 2019). In short, a mother called the police to request assistance in dealing with her mentally ill son. She reported that the son had mental health issues and was engaged in self-mutilation behavior while using narcotics and threatening people. Once law enforcement was on the scene, the son would not respond to verbal commands and lunged at the officers. The police shot the man multiple times. In a review of the incident, the Memphis Police Department, community leaders, and universities created the Memphis Model of CIT. At the time, the primary goals were to reduce the instances of lethal force by law enforcement when dealing with the mentally ill and to reduce officer injury.

The Memphis Model introduced three components. The first was to provide training to sworn law enforcement personnel. This training would consist of at least forty hours and cover techniques and strategies for dealing with the mentally ill, broad education on issues dealing with the mentally ill to provide understanding, access to facilities, and partnerships with mental health professionals. The training would be conducted by law enforcement personnel, mental health professionals, advocates, and many times family and/or persons dealing with mental illness.

The second component was to provide training to dispatchers and call takers. In addition to learning about mental illness, they would learn to code calls for help with a reasonable probability of involving mental health issues. They would then be able to pass that information along to the appropriate personnel.

The third component is accomplished through partnerships with mental health professionals, facilities, and advocates. This entails establishing a centralized drop off point for those mentally ill persons not entering into the criminal justice system. The idea of the centralized facility decreases the time that the individual is in police custody and decreases the time before mental health professionals see them.

The CIT model can be seen as an early diversion program for the mentally ill. Many individuals have been sent to psychiatric facilities where they can receive help and are not placed into the criminal justice system. This expedites their treatment and diminishes derogatory aspects of being placed into a correctional setting. Some studies have indicated that the number of mentally ill persons injured by law enforcement has decreased since the inception of CIT (Rogers et al., 2019).

Defend or Defund the Police

The movement to “Defund the Police” needs to be argued and debated with a proper platform. As covered in literature, “The call to defund the police seeks to use the power of money to produce systemic change that previous, incremental efforts at reform have not yielded, according to many activists, researchers, and some leaders.” (Dictionary.com, 2020). It should require input from the proper professionals qualified to give essential and legitimate input from the local, state, and federal levels. For example, to focus this further, the town of Eugene, Oregon, had responded to approximately 24,000 “crisis” calls last year. Less than one (1) percent of those required the presence of armed police officers. (Roth, 2020). The town has utilized “unarmed” police officers that respond to act more as a social worker, if you will, to avoid the “criminalization” of mental health emergencies. The ability to prevent “mental health” incidents ending in criminal arrests will be beneficial not only to society but also for the affected citizens. The needed “push” to force police reform is fragile, a sensitive topic at best. As summarized by mental health professionals, they felt “moved to advocate for improved law enforcement responses and the decriminalization of mental illness.” (Rice, 2020, para. 3). It is known that the news media and “social media phenomenon” have contributed to the “laser-focus” police incidents that are scrutinized for today, especially if force is used. However, as stated in the literature, “The media does not always clearly explain interactions where the police use deadly force, especially in situations involving people with developmental disabilities and mental illness.” (Rice, 2020, para. 2).

As professional law enforcement officers, we never thought the day would come when there would be such an outcry to "defund the police" or abolish police departments. Glennon (2020) states,

> Although some of our nation's largest cities do have problems when it comes to satisfying those they are sworn to protect relative to other parts of the country, they generally also enjoy quite high marks from their citizens. According to a 2018 Gallup national survey, the police were ranked third behind the military and small business when it came to confidence in U.S. institutions. 85% had at least some confidence in the police, 54% had a great deal of confidence (para. 5).

There is a small amount of the population today who wish to defund the police. Safety is still the number one concern among people in this country. According to Glennon (2020), "Prior to the atrocity that happened in Minneapolis in May 2020, the vast majority of the more than 12,000 local police agencies enjoyed a very good relationship with their communities." (para. 3). Glennon (2020) also states, "In a recent Calibre Press poll on the state and future of policing, more than 10,000 officers from around the country shared their thoughts on policing. Only 7.2 percent said they would recommend law enforcement as a career to their children." (para. 12).

Law enforcement agencies budgets all over the United States are being slashed. As discussed in Law Enforcement Today, beginning Oct.1, St. Petersburg Police will no longer respond to "non-violent" 911calls. Within the police department, there will be a new division known as CAL, the Community Assistance Liaison. They will respond to various "non-emergency" calls. (Law Enforcement Today, 2020).

Civil Commitment Jurisprudence

The first significant "landmark" mental health case was a SCOTUS decision/ruling in 1974/1975 under Lessard v Schmidt (414 U. S. 473 and 421 U.S. 957). If you are to review past literature, it reinforces that "Lessard made it more difficult for family and mental health professionals to place individuals into treatment and has left this responsibility — by and large — to the police." (Eldridge, 2012, para. 1). In its ruling, the following occurred,

> Lessard v. Schmidt transformed mental health law. A federal district court in Milwaukee struck down Wisconsin's commitment law as unconstitutional. Setting

> aside traditional *parens patriae* grounds for commitment, the three-judge court set a narrow dangerousness standard: involuntary commitment was only permissible when there is an extreme likelihood that if the person is not confined, he will do immediate harm to himself or others. Moreover, the court for the first time required that commitment proceedings provide the mentally ill with all the protections accorded the criminal suspect — among them a right to counsel, a right to remain silent, exclusion of hearsay evidence and a standard of proof beyond a reasonable doubt. (Mental Illness Policy.Org, 2020, para. 2).

This case was essential in "forcing" the responsibility of taking care of people who summon help during "mental health" crises primarily to law enforcement agencies. It has been discussed by police publications that, "Consequently, cops need to have at least a basic understanding of how to communicate with Emotionally Disturbed Persons (EDPs) in order to diffuse possible violent encounters." (Eldridge, 2012, para. 2).

Additional cases that have been relevant to shaping law enforcement response for mental health crises have been decided as well. The use of civil commitment to deal with "mental health "crises" was improperly used frequently in the past. Several courts have ruled that "civil commitments" must nearly rise to the same burden as "due cause" for criminal proceedings by a court of competent jurisdiction. For purposes of this discussion, similar cases are listed by the American Academy of Psychiatry and Law (AAPL, 2014);

- Lake v. Cameron, 364 F.2d 657 (1966)
- O'Connor v. Donaldson, 422 U.S. 563, 95 S.Ct. 2486 (1975)
- Fasulo v. Arafeh, 378 A.2d 553 (1977)
- Addington v. Texas, 441 U.S. 418, 99 S.Ct. 1804 (1979)
- Parham v. JR, 442 U.S. 584, 99 S.Ct. 2493 (1979)
- In re Richardson, 481 A.2d 473 (1984)
- Zinermon v. Burch, 494 U.S. 113, 110 S.Ct. 975 (1990)

As summarized, "Without proper mental health and substance abuse services, these people often become recurring problems for family and law enforcement until such time as their emotional or mental issues result in arrest and eventual detention." (Eldridge, 2012, para. 12). One step might be to create an alliance among police, community, disability, mental health and homelessness.

The Memphis Model Relative to Louisiana Law

With more and more cuts to the mental health system, such as Medicaid, our mental health community is suffering more now in today's modern society than during de-institutionalization. Many of those in crisis often encounter the public and commit a crime, whereas that criminal behavior is a direct result of a person's mental health problem. In today's society, people dial 911, and the police are alerted. Long before the Memphis Model was conceptualized in 1988 after a fatal shooting of a mentally ill man by the Memphis Police Department, law enforcement has had no formal training in this area after the de-institutionalization period in the 1960s.

In the 1980s, the Alliance for the Mentally Ill, now known today as the National Alliance for the Mentally Ill (NAMI), collaborated with the University of Memphis and the Memphis Police Department and created what is referred still today as the "Memphis Model" of policing the mentally ill. This was to respond effectively to the mental health community and increase training in this area. The police were not suited to respond to these calls for service early on; however, that was due solely in part to the fact that many people in law enforcement lacked the empathy to respond effectively. The police in many corners of this country were not used to dealing with anything other than criminal behavior. With those types of responses came the mentality that officers must show authority at all times, and for a good reason. In today's society,

absent those in crisis, society demands that their police show compassion and empathy. To respond effectively to calls for service for the mentally ill, officers must be able to suspend their frame of reference while demonstrating empathy and using officer safety tactics. If officers can do this, the result will be a compassionate response, and the person in crisis will be directed to resources that will benefit them versus being incarcerated.

To convince any police agency that they need training in this area is to answer the question "Why?" The answer to this question is that it is our responsibility to protect our community. Of course, training in this area is required, but officers must collectively "buy-in." In the state of Louisiana, the law is straightforward on how an officer should respond to mental health calls for service.

When officers come to understand the options they have aside from taking someone in crisis to jail, they should understand why it is important to show empathy. Louisiana's mental health law can be found under Title 28 of the Louisiana Revised Statutes (https://legis.la.gov/Legis/Laws). If someone in crisis commits a crime, this behavior can result from a mental health crisis.

Crisis Intervention in Law Enforcement

During the day of a law enforcement officer, they are routinely sent to calls for service in reference to citizens having a mental health crisis. This may include an attempted suicide, citizens experiencing active episodes, or citizens who make routine calls related to episodes of paranoia and/or delusional thinking. These calls are often routine and happen frequently. As Maciag (2016) stated,

> In the country as a whole, mental health situations are responsible for about 1 in 10 police calls. Many stem from undiagnosed conditions unknown to police and first responders. The consequences can be tragic. While 3 percent of U.S. adults suffer from severe mental illness, they make up a quarter to one-half of all fatal

> law enforcement encounters, according to the nonprofit Treatment Advocacy Center (para. 3).

There is a need for more Crisis intervention across the country. The training of crisis intervention for first-line patrol officers would include the officers initially volunteering for training. As supported by literature, Watson and Fulambarker (2013) wrote that, "The rationale is that not all officers are cut out to be CIT officers. Those that volunteer and are accepted into the program may have a particular disposition and interest in handling mental health calls." (para. 5). Officers completing the training would ultimately observe an enhancement in their emotional intelligence and moral compass. The officers' emotional intelligence and moral compass would aid them in the areas of patience, empathy, and caring for the citizens in crisis. This training would further aid the officer in understanding what the person in crisis is actually going through at the time of the episode.

The officer's knowledge of their moral compass comes in to play in knowing to do the right thing for people in crisis, instead of just arresting them if the scene turns physical. Persons suffering from a mental illness may have never been diagnosed with a disorder. After contact with the police they are transported to a medical facility where they are evaluated by a medical professional. The stress from apprehension, when taken into a correctional facility, can increase the stress for the person in crisis. The subject in crisis may receive further trauma while in the environment if placed in the general population from the inmates they are incarcerated with. As covered in literature, Cooper, McLearen, and Zapf (2004),

> Calls involving persons experiencing mental health crisis can be particularly problematic for police officers. Surveys of officers suggest they do not feel adequately trained effectively to respond to mental health crisis, that mental health calls are very time consuming and divert from other crime fighting activities, and that mental health providers are not very responsive. (para. 5).

Both Law Enforcement and mental health providers need better and more extensive training in crisis intervention. The ratio of untrained and CIT trained officer's including mental health providers across the country is vast. Yearly training, if not every two-years, would provide broader safety protocols between the patient in crisis, the responding officer, and the mental health provider. When law enforcement responds along with Emergency Medical Services (EMS) to calls for service for mental health crises, evaluations are performed by EMS. If the person responds appropriately and/or is alert and properly oriented, law enforcement must resolve the situation. Our last resort is to utilize LRS 28:53 to transport the person in crisis to the hospital ourselves.

Risk Management Related to Mental Health

For law enforcement agencies, risks are a fact of daily life. There is the risk of litigation due to misconduct or negligence by officers. Now, there are social media risks that police organizations face. With the proliferation of smartphones, the likelihood of video taken during violent police interactions with the public often go "viral" through the media. Usually, in any violent encounter between law enforcement and a citizen, the optics will not be pretty. Even if the officer followed his training and departmental policies, the video could cause some citizens to make unjust or uninformed judgments. This is based on the perception of what is being viewed or a video that does not capture the entire incident. Additionally, there are risks to officers' lives and safety and to the public with whom they come in contact. Many times, officers come into contact with citizens who are suffering from mental illness. Most of these encounters occur when the mentally ill person is in a psychogenic crisis.

As supported by literature, "It is well established and understood that law enforcement agencies – particularly those in urban environments – are tasked with responding to a variety of

non-routine and critical incidents including barricaded subject incidents, attempted suicides, confrontations with irate or violent individuals, confrontations with emotionally disturbed persons, and confrontations with persons suffering from mental illness." (Liebbe, 2012, para. 4). Finally, there is the risk of civil liability resulting from officers injuring citizens with mental illness due to a lack of training in crisis management.

One way to reduce these risks is to create and implement a crisis intervention team within law enforcement agencies. Crisis intervention trained officers are taught to recognize when a person is in crisis, are given rudimentary instructions on the different types of mental illnesses and are trained in the proper techniques to de-escalate an incident involving a person suffering from a specific mental illness. According to Skeen and Bibeau (2008),

> Although even fewer studies address the primary CIT goal of increasing safety, the results are promising. A comparison of the three years before and after CIT was adopted in Memphis indicated decreases in officer injuries for mental health related calls (from .04 to .01 per 1,000). Such findings are often interpreted as evidence that CIT-trained officers effectively defuse situations that might lead to the use of force on individuals with mental illness. After all, CIT emphasizes verbal de-escalation for handling potential violence. (para. 4).

Crisis intervention team programs can also reduce costs to the department. For example, there could be a cost reduction resulting from fewer injuries to officers and fewer work hours lost. There can also be a reduction in injuries to people with mental illness, which can reduce civil litigation and medical costs. Lastly, with the decriminalization of mental illness, CIT officers recognize that an individual may be better served to go to a hospital instead of jail. It reduces the cost associated with incarceration, such as medical care, food, lodging, and transportation. According to Klopovic, Javidi, Klopovic, and Franklin (2020), “When considering what to analyze, go back to your mission: Decriminalizing the mental health consumer via jail diversion to contribute to community well-being.” (p. 87).

It was found that officers often responded to calls that involved people with mental illness that posed a risk of violence to others or themselves. The amount of force used related strongly to the person's potential for violence. However, crisis intervention trained officers were conservative in the amount of force they used to detain subjects who posed a risk of violence. Lastly, fewer people were arrested due to most incidents being resolved through hospitalizations. (Skeem & Bibeau, 2008).

Proper leadership is important when it comes to risk management. According to Normore and Javidi (2020), "The progressive police leader can play a pivotal role in reducing inherent risks associated with law enforcement. Police agencies can achieve greater levels of intelligent decision-making concerning risk through the application of risk management to civil liability." (para. 11).

Tangible Results of Crisis Intervention Teams

Although there is a lack of evidence to confirm the effectiveness as it relates to the original goal of reducing lethal force during police encounters, crisis intervention training has been credited in positive outcomes with encounters with the mentally ill. There was a recent incident where St. Charles Parish Sheriff's Office deputies used their training to save a suicidal person from jumping into a river. The officers used their training to recognize that the individual was having a mental crisis and approaching excited delirium. Roth (2020) states,

> Our training allowed us to recognize that the subject we were dealing with was not in his proper mindset, which meant our tactics had to change in order to safely de-escalate the situation, Agnelly said. Once we had the subject safe in custody, we were able to use our de-escalation training to calm him down and ensure him that we were going to get him the help he needed (para. 15).

Conclusion

We live in a free country that is protected by law enforcement comprised of men and women of all races, religions, and ethnicities. Law enforcement has been and will always be the last line of defense in the communities in which we live, educate, and raise our families. The citizens in the community need to continue to witness the effectiveness of crisis intervention training; it will create community collaboration. When the public recognizes someone is in a mental health crisis, they will know what services are available. They will feel more comfortable helping by knowing that the person in crisis will not be arrested and brought to jail. Citizens will thank organizations for their interaction with officers in the field and see it as a personal connection (Ellis, 2017). When this happens, citizens will gain trust and respect for the officers and the organization. Officers must work towards decriminalizing citizens that have mental illness and provide them with the right resources. An effective CIT program will provide hope and recovery to those in crisis. When leaders and followers promote effective and transformational leadership within an agency, it will foster and encourage members to be "change agents" themselves.

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