MENTAL HEALTH FIRST AID OR CIT:

WHAT SHOULD LAW ENFORCEMENT DO?

A TALE OF TWO TRAININGS

The current focus on law enforcement's response to mental health and substance abuse-related issues and increasing demand for more training seem to lead to more questions than answers. Is more training the solution to bridging the gap? What is the "right" training? What does it require? Do all law enforcement officials need to receive training? If not, then who does?

The issue is further complicated because, historically, law enforcement and behavioral health have functioned independently, and too often, at odds with each other. Recent events make it clear that community behavioral health crisis services play a critical role in public safety.

While mental health professionals and law enforcement in some communities have already addressed the issue and worked together to create training programs, many are still searching for a solution. Two of the mostly widely discussed mental health/crisis training programs geared toward law enforcement are Mental Health First Aid for Public Safety and Crisis Intervention Team (CIT) programs.

Both programs have strengths and are frequently "pitched" to law-enforcement agencies as solutions. At the same time, both are often misunderstood.

To clarify the differences and similarities of these programs, brief summaries follow:

Mental Health First Aid for Public Safety is an eight-hour codified training curriculum, specifically modified to address the law enforcement population and provide a general awareness of mental health issues. It offers information and skills to support someone in a mental health crisis or who is developing a mental health problem.

This evidence-based best practice, run by the National Council for Behavioral Health in partnership with the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health, provides an overview of psychiatric disorders, suicide, and intervention strategies.

Some benefits are:

- The codified nature of the training
- The best-practice label
- Relatively short training commitment
- A system for ensuring/vetting adequately trained instructors

Crisis Intervention Team programs, based on the "Memphis Model," are widely viewed as the "gold standard" response. CIT includes a 40-hour Advanced Officer Training component, which delves deeply into topics and brings the face of consumers directly into the classroom. While frequently viewed as just a training module, CIT is actually a large-scale community collaborative program and law enforcement training is just one component. CIT's axiom is that it is "more than just training."

Partnership with the community's public health system is central to CIT. Fostering functional partnerships improves safety in the community and provides an opportunity for diversion into treatment for distressed individuals, leading to long-term solutions and recovery. Without these relationships, there are missed opportunities due to a lack of meaningful engagement between partners. Understanding that CIT programs are the foundation for developing meaningful collaborations with community behavioral health services, and not merely training for police is key to bridging this gap.

In this role, CIT can serve as a catalyst to create a spectrum of interconnected community health services with a "no-wrong door" philosophy. This paradigm shift leads to greater accessibility, improved public safety, and efficient utilization of limited resources.

WHICH TRAINING SHOULD A DEPARTMENT CHOOSE AND WHO SHOULD BE TRAINED IN WHAT?

The National Council has long believed that Mental Health First Aid is not a replacement for CIT. Mental Health First Aid for Public Safety is codified and easily used "off-the-shelf." When practiced with fidelity using a team teaching approach with two specially trained instructors—one from the law enforcement community and one from the behavioral health community—Mental Health First Aid for Public Safety ensures the quality of a "best-practice" designation.

With budget constraints, political pressure, and workforce shortages, it may be tempting for law enforcement agencies to require that all officers attend Mental Health First Aid for Public Safety sessions. However, viewing Mental Health First Aid for Public Safety as a cheap and easy substitute for CIT is a nearsighted approach. Mental Health First Aid for Public Safety should be incorporated into an existing CIT program as an enhancement and not a replacement. Investing in the difficult and important activity of redesigning and transforming a region's community crisis system is the best way to ensure tangible outcomes.

While Mental Health First Aid for Public Safety provides important learning opportunities, it is not designed to prepare and transform the outcomes of a community's day-to-day crisis response. When practiced with fidelity to the 10 Core Elements, CIT fosters collaboration and planning efforts with community health partners, which can result in tangible changes in how a community delivers behavioral health crisis services. This provides law enforcement 24/7 accessibility to care without "triage," a critical component that is missing in most communities. To change the way we deal with individuals experiencing a mental health-related crisis, officers must have seamless access to readily available crisis services. By ensuring that public health takes over the responsibility for care, officers can quickly return to their law enforcement role.

The CIT program is most effective when experienced officers attend voluntarily. Training 20-25 percent of a department's uniformed patrol officers in CIT normally constitutes adequate coverage, but rural/frontier communities may need greater coverage. Embedding CIT-trained officers into patrol functions, rather than placing them in a "specialty squad" with limited coverage, can inexpensively leverage their special skills and motivation within the existing workforce and framework. This typically makes a "CIT response" possible 24/7 for little added cost and increases the likelihood of positive outcomes for police, recipients, and the community.

Ideally, in addition to specialized CIT response, all uniformed officers possess some basic level of mental health awareness training. It is not necessary to require that they attend the intensive, full weeklong training; Mental Health First Aid for Public Safety provides adequate exposure to mental health awareness.

CIT is community-based law enforcement at its best, bringing communities together to provide a macro-level response to a community problem that does not require law enforcement to bear sole responsibility. It can take two years or longer to fully develop the partnerships, community resources, and community buy-in required to establish an impactful CIT program. When built appropriately, a CIT program can provide the backbone of a systemic community response to the behavioral health needs of its residents.

Providing department-wide Mental Health First Aid for Public Safety training during in-service, academy, or other times, is an effective complement to a CIT program. In addition to demonstrating a commitment to ensuring that an entire department has a minimum standard of mental health understanding, Mental Health First Aid for Public Safety can serve as a catalyst for officers to attend CIT training in the future, while it improves the overall commitment to quality. This implementation plan also provides agencies with a response if faced with demands to abandon the Memphis Model and adopt the "train everyone" phenomena currently taking root in many communities.

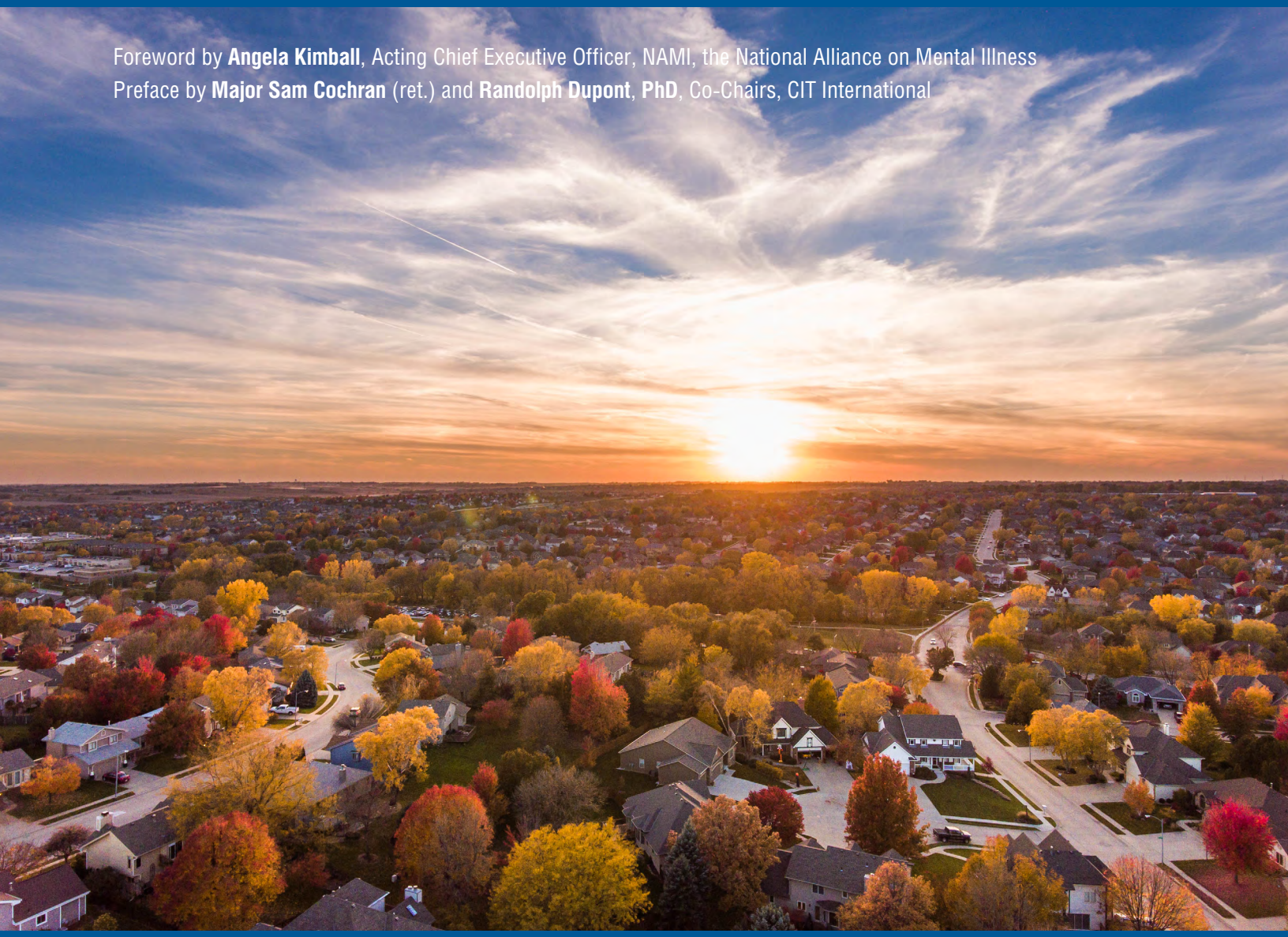
CIT International, Inc. and the National Council are excited to support this emerging best-practice plan. By using these complementary programs conjointly, we can eliminate gaps, leading to a large-scale, sustainable, macro-level response.

For further information please contact Nick Margiotta, CIT International margiotta.nick@gmail.com or Bryan Gibb, National Council for Behavioral Health bryang@thenationalcouncil.org

CRISIS INTERVENTION TEAM (CIT) PROGRAMS:

A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES

Foreword by **Angela Kimball**, Acting Chief Executive Officer, NAMI, the National Alliance on Mental Illness
Preface by **Major Sam Cochran** (ret.) and **Randolph Dupont**, **PhD**, Co-Chairs, CIT International



A Publication of CIT International

August 2019

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August 2019

Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises

CIT International aspires to be a leader in promoting safe and humane responses to those experiencing a mental health crisis. Our mission is to promote community collaboration using the Crisis Intervention Team (CIT) program to assist people living with mental illness and/or addiction who are in crisis.

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Crisis Intervention Team (CIT) Programs:

A Best Practice Guide for Transforming Community Responses to Mental Health Crises

A Publication of CIT International

With special thanks to our partners who have offered their endorsement of this work:

NAMI
National Alliance on Mental Illness

MENTAL HEALTH FIRST AID
NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
Healthy Minds. Strong Communities.

PRA
POLICY RESEARCH ASSOCIATES

Support Advocacy Leaders

> *"For advocates, CIT is very time-consuming, and when your loved one is in crisis, you aren't available. You're always sitting on the edge."*
>
> — Donna Yancey, NAMI Greater Indianapolis, Indianapolis, Indiana

In some CIT programs, advocacy leaders do a significant amount of unrecognized work to keep the program running smoothly—particularly community outreach, advocacy for services, fundraising, logistics, and similar time-consuming tasks. Their commitment to the program is for good reason: people living with mental illness and their family members have the most to lose without a CIT program. However, this can occasionally lead advocacy leaders to becoming solo coordinators without a lot of backup among their partners, or without a lot of recognition for their work. As a steering committee, make sure that advocacy leaders are getting sufficient support.

Support Leadership by People Living with Mental Illness

While many advocacy leaders are involved in CIT, it's common for CIT programs to have a lack of leadership by people living with mental illness. Look for this gap in your steering committee. While people living with mental illness make invaluable contributions, they face significant barriers to taking leadership positions: others may not take their contributions seriously, they may have financial challenges that make it difficult to participate in volunteer work, or they may have occasional mental health setbacks.

Despite these challenges, ensure that you are including people with mental illness on your steering committee and in other leadership roles. You can nurture the leadership of people living with mental illness by supporting peer specialist programs and placing trained peers in positions throughout your program. You can also ensure that people are able to take breaks for the sake of their health, then rejoin the group.

THE PITFALLS OF A TRAINING-FOCUSED APPROACH

Mandatory CIT Training Can Damage Your Program

> *"…Not every officer is well suited to effectively deal with people with mental illness. For example, during our investigation a patrol officer*

> *stated that his job was 'to put people in jail, not to provide social services.' This officer would not be the appropriate officer to conduct a welfare check on person with mental illness[sic]... Crisis intervention training done with experienced patrol officers and the leadership of a dedicated police-based crisis intervention coordinator also creates a culture change among officers, which often then permeates an agency."*[27]
>
> — Letter to Portland, Oregon, Mayor Sam Adams from the U.S. Department of Justice Civil Rights Division

Sometimes the feedback about CIT training may be so positive that a chief or sheriff will decide to train all their officers. Law enforcement leaders may also feel under pressure to address liability concerns and want to use the best training available. Sometimes advocates or mental health agencies may push for this approach because they see the benefits of the CIT program and believe mandatory training will bring even greater benefits.

The train-all approach, while driven by an admiration for CIT, can be quite damaging to your CIT program. Here's why: research shows that officers who volunteer for the training learn and perform better.[28] Researchers looked at officers' knowledge, skills, attitudes, self-confidence in dealing with crisis situations, use of de-escalation, and use of force–and found that volunteers performed better across the board.

A mandatory training approach also puts all your program's focus on the role of law enforcement officers, when time and resources could be spent improving crisis services before officers get involved, or improving receiving centers to serve people after law enforcement leaves. Officer training is expensive and time-consuming when CIT partners could be dedicating their energy to improving other aspects of the crisis response system.

27 Perez, T.E. & Marshall, A. (2012, September 12). RE: Investigation of the Portland Police Bureau [Letter to Mayor Sam Adams]. U.S. Department of Justice Civil Rights Division, 20. Retrieved from *https://www.portlandoregon.gov/police/article/469399*

28 Compton, M. T., Bakeman, R., Broussard, B., Dorio, B., & Watson, A. C. (2017). Police officers volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect. *Behavioral Sciences & the Law*, 35(5-6), 470-479. doi:10.1002/bsl.2301

Some poorly-performing CIT officers might seem like a small price for a better-trained force overall, but a CIT-trained officer who does not believe in the mission of CIT is a liability. Forced to take on the role, reluctant officers might act with indifference or even cruelty towards a person with mental illness. A few officers who create hostility during the training week can sour the experience for other officers, as well as that of the mental health professionals, individuals with mental illness, and family members who help teach the course.

With mandatory training, any officer misconduct towards a person with mental illness undermines your entire CIT program, because community members see a CIT-trained officer who is behaving badly and may assume that the program is a failure.

Department of Justice investigations of law enforcement agencies in Portland, Oregon and Cleveland, Ohio[29] specifically cited the shift to a train-all approach as the beginning of the end of CIT programs—with a focus on training, the programs stopped focusing on the volunteer-specialist role of the CIT officer (see page 122), and stopped investing in their partnerships. These law enforcement agencies that moved to train-all didn't get the results they had hoped. Despite their efforts, Department of Justice investigations found that they violated the civil rights of people with mental illness through excessive use of force. Ultimately, we believe the volunteer-specialist model gives officers and agencies the best tools to address liability concerns and provide safe, compassionate, and effective response.

To learn more about the importance of avoiding mandatory training, read CIT International's *position statement*.

Avoid Moving CIT Training to the Pre-Service Academy

Similar to the desire to train all officers, sometimes CIT partners will propose moving CIT training to the pre-service academy. This has not been shown to be an effective approach, and it's not consistent with the CIT model. CIT requires officers that have patrol experience as a point of reference and the self-motivation to volunteer for CIT training. This is called the volunteer-specialist officer

29 Gupta, V. & Dettlebach, S.M. (2014, December 4). Investigation of the Cleveland Division of Police [Letter to Mayor Frank G. Jackson]. U.S. Department of Justice Civil Rights Division, 54. Retrieved from *https://www.justice.gov/sites/default/files/opa/press-releases/attachments/2014/12/04/cleveland_division_of_police_findings_letter.pdf*

(see page 122 for more information about the volunteer-specialist model). Training in the academy does not support the volunteer-specialist officer or the broader goals of CIT.

Specifically, CIT training in the pre-service academy:

- Removes the important selection process that identifies motivated and independent officers.
- Trains officers before they have experience in the field, making it challenging for officers to integrate their skills. CIT training relies on officers to have their decision-making and tactical skills already developed, and then integrates mental health awareness and de-escalation, giving officers an array of skills to use during crisis situations.
- Overloads officers with information. The typical pre-service academy is several months long; a week-long CIT training will get lost in the shuffle and will not be integrated well with all of the other skills taught in the academy.
- Fails to rejuvenate officers and remind them that they can make a difference. For experienced officers, CIT training often lifts some of the weight of secondary trauma that accumulates over the years of police work and provides them with new purpose. This benefit is lost on new recruits.
- Removes CIT training from the community setting, making it more of a law enforcement training with less access to community trainers, community resources, and site visits.

To learn more about why CIT International opposes CIT training in the pre-service academy, read our *position statement* on the issue.

Alternatives to Mandatory CIT Training

If your law enforcement agency would like to have all officers receive some mental health training, CIT International recommends providing a shorter training focused on mental health awareness and response. At times, there may be officers who are not trained in CIT dispatched to mental health calls—though, through dispatcher training and policy changes, these should be less common.

Therefore, the goal of agency-wide mental health training should be to help officers recognize a mental health crisis, call for a CIT officer, and keep the scene safe in the meantime.

There are a few options for delivering this training:

- You can draw from your CIT course and offer briefer training focused on mental health topics. See page 127 to learn more about the mental health topics in CIT training.
- You can provide *Mental Health First Aid-Public Safety*, an 8-hour awareness training, as recommended in IACP's One Mind Campaign. See page 158 for more information about the One Mind Campaign.
- You can provide the Police Executive Research Forum's *Integrating Communications, Assessment, and Tactics (ICAT)*, a 2-3-day training designed to integrate crisis communication skills with officer safety tactics.

SUSTAIN THE CIT OFFICER PROGRAM

Being a CIT officer can be incredibly rewarding—helping a person get access to services, hearing the gratitude of family members, preventing injury or trauma. However, it can also be incredibly frustrating and exhausting, because officers are responding to difficult situations and using all of their emotional resources. In addition to practical support, officers need regular reminders that the community values them and the work that they do. CIT officers also need ongoing support from their agencies to be effective.

Recognize the Important Role of CIT Officers and Other Responders

Part of supporting the volunteer-specialist role of CIT officers is honoring them for their role in the community. Many CIT programs host an annual awards banquet, where mental health advocates celebrate all CIT officers and honor a CIT officer of the year. During the awards ceremony, community members and leaders may be invited to speak. Advocates or law enforcement leaders can share a brief account of successful CIT interventions.

It is also appropriate to celebrate others' actions during these awards: outstanding mental health professionals, peer specialists, advocates, and champions. These honors recognize

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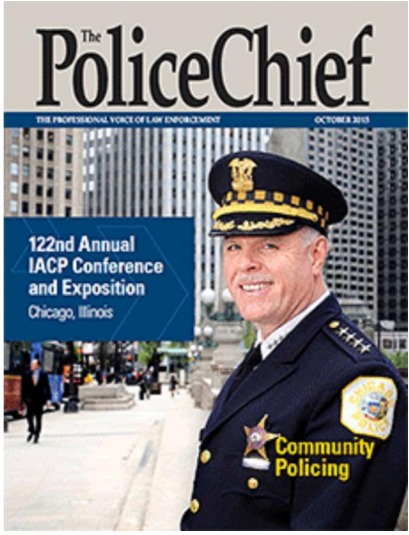

Feature Articles

The Five-Legged Stool: A Model for CIT Program Success

Nick Margiotta, MEd, CIT Coordinator, Phoenix, Arizona, Police Department

A Crisis Intervention Team (CIT) program, based on the "Memphis Model," is an innovative program designed to effectively assist individuals in their communities who are in crisis due to behavioral health or developmental disorders.[1] CIT is often mistakenly viewed as law enforcement training; in reality, it is considerably more. It is a program with a broad reach that relies on strong community partnerships and a vibrant crisis system that understands and responds to the role and needs of law enforcement.

The CIT program encourages officers to access crisis facilities to redirect individuals in crisis away from the criminal justice system, when appropriate. This fosters engagement in the behavioral health system for connectivity to long-term treatment and services, which leads to sustainable change in the community.[2] The goals that are realized through implementation of CIT programs include increased officer and consumer safety and diversion of individuals in crises away from the criminal justice system and into the behavioral health system with the goal of long-term treatment and recovery.[3] The CIT model reduces both the stigma and the need for further involvement within the criminal justice system for those in crisis.[4]

CIT has existed for more than 25 years and is built on 10 core elements.[5] Despite the longevity of the program, there is still widespread confusion in many communities concerning what a healthy CIT program really encompasses.[6] This includes communities that have endorsed and implemented CIT training as well as communities that have yet to adopt a CIT program. To clarify, it may be useful to view CIT as a "Five-Legged Stool." This figurative stool cannot function at all with only one leg (i.e., one element of CIT), and really needs at least three legs to stand. Ideally, though, it needs all five legs to be strong, functional, and enduring.

1) Police Training

While the training of police officers is the most visible component of CIT programs, it is only one piece of a multi-level collaborative community effort. Nonetheless, the importance of the effective training of police officers cannot be underestimated. These are the individuals to whom everyone in the community turns in times of crisis. In most communities, the goal of law enforcement agencies should be to have 20–25 percent of their uniformed patrol officers trained in CIT. The 40-hour block of advanced officer training is most effective when the officers in attendance have volunteered to complete the training. Officers who volunteer to attend the program have shown initiative and interest and will generally be more amenable to applying the new tools they have learned upon returning to their units.[7]

An important concept to emphasize to officers at the very beginning of the CIT training is that it is not meant to replace anything they have learned as officers. Police officers are always officers first. CIT training is meant to give officers additional tools to use when they are in the field interacting with individuals who may be in crisis. This includes the ability, when appropriate, to utilize their discretion and divert the

individual away from the criminal justice system and into the behavioral health system, CIT training helps officers evaluate when they might use their discretionary powers and gives them the information regarding available resources to effectively and successfully accomplish this diversion.[8]

Much like a one-legged stool won't be able to stand, if a community only has this most common leg of a CIT program, it really does not function and accomplishes little, if any, tangible outcomes in a community.

2) Community Collaboration

It is vitally important that integral community partners are identified and utilized by the CIT development team. Community partners play an important role in the CIT process, and it is important to develop community ownership. This ownership can be accomplished by including individuals and organizations within the community in all phases of the CIT program's development and implementation—initial planning, training curriculum development, ongoing feedback, and problem solving. Local professionals and agencies who volunteer their time to assist in the training of patrol officers help increase the sense of community ownership and networking for CIT. It is this broad-based grassroots community collaboration that makes a CIT program achievable and sustainable. In times of fiscal challenges, budgetary cuts, and other financial constraints, the collaborative nature of a healthy CIT program helps it weather potential fiscal and political storms and permits the program to endure, providing better outcomes for officers and those in crisis.

3) Vibrant and Accessible Crisis System

Training and collaboration throughout the community are imperative for CIT. Perhaps the most meaningful leg, in order to accomplish real outcomes, is the need for a robust crisis system. Many communities have a system; however, CIT requires more than just "having" a system. It requires that the system be responsive to the needs of the police and the community as a whole. Having quality services and providers is the first step, but if they are not responsive and easily accessible, then they will not be utilized by police.[9] Thus, the CIT goal of reducing incarceration for those individuals who need behavioral health services cannot be achieved.

Accessibility is of paramount importance when it involves police "hand-offs" to behavioral health services. These interactions need to be quick, efficient, and guaranteed, regardless of capacity, funding sources, diagnoses, entitlement, and so forth. Triage must be kept to the minimum to ensure that officers are able to return to their police duties and behavioral health crises are handled by the behavioral health system.

A critical element to accessing crisis services is to ensure that community crisis services and receiving centers operate with a "no wrong door" philosophy for law enforcement. Regardless of an individual's diagnosis or presenting issue, the behavioral health crisis system needs to be prepared to respond to an individual referred by law enforcement. Police officers must have priority access to services for the people they refer, and the behavioral health providers must not turn an individual away because he or she does not meet specific and narrow criteria.

While this accessibility may create challenges for the behavioral health providers, it is imperative that behavioral health entities collaborate within their own system in order to ensure an individual gets to the right door. Behavioral health entities should not expect police officers to navigate their system—or, even worse, prevent law enforcement offices from handing off people to their facilities. The goal needs to be helping individuals in crisis. With that mind-set, behavioral health providers and police agencies can partner to build stronger and healthier communities.

While facility-based services operating with "no wrong door" policies are critical to a CIT program, an enhancement to consider in helping build healthy communities is the ability to also access mobile behavioral crisis responses out in the community. For communities with mobile behavioral crisis services or for those communities seeking to create this level of care, it is important to consider how these services can meet the

needs of law enforcement when they are dealing with a behavioral health crisis. To make sure that the service has relevance to CIT, the key is for mobile community crisis response teams to be readily available to respond to a police request in a prioritized manner and free law enforcement from the scene as quickly as possible. This level of responsiveness is needed to increase the likelihood that police will utilize mobile crisis services, thus increasing the opportunity to stabilize individuals safely at home, when appropriate.

The behavioral health crisis system's guiding philosophy should be accessibility, with the goal to build a culture in service providers that is focused on acceptance instead of placing clinical barriers to accepting "hand-offs." A consistent, prioritized, and seamless process needs to be in place in order to adequately meet the unique needs of the police and the individuals they refer. This consistency and commitment to meeting the needs of police helps build trust between law enforcement and behavioral health providers and increases the opportunity for therapeutic hand-offs.

4) Behavioral Health Staff Training

Training of behavioral health staff is critical in fostering positive working relationships between law enforcement and the mental health community. It is important that behavioral health staff have a clear understanding of the law enforcement officer's role in the behavioral health community. Sometimes, behavioral health staff tend to incorrectly develop an impression that because an officer is CIT trained, he or she has somehow become a combination of both a law enforcement officer and a social worker. A clear delineation of the two roles should remain intact. Emphasis should be made that the goal is collaboration, not integration. A social worker who gains an understanding of CIT does not become a law enforcement officer, and behavioral health staff need to recognize that a law enforcement officer who receives some specialized training in behavioral health remains, first and foremost, an officer.

Because the world of law enforcement is somewhat misunderstood by those outside the law enforcement community, it is key for behavioral staff to gain insight into what a law enforcement response to a mental health crisis looks like. To provide that insight, law enforcement agencies may want to identify some behavioral health staff members to participate in a ride-along with a CIT-trained officer. Nothing will provide more clarity to a behavioral health worker than witnessing an on officer perform all of the functions and constraints typical in patrol. Behavioral health staff can appreciate the differences between the two cultures. This appreciation promotes the beginning of an understanding that CIT-trained officers are, above all else, officers who, by choice, have received specialized training in behavioral health topics.

In addition to ride-alongs, it can be helpful for law enforcement to provide training to front-line behavioral health workers. Just as it is important for police to learn about behavioral health issues, it is also important for behavioral health staff to understand and respect the law enforcement officer's role and practices. If taught what law enforcement practices look like—and what they do not look like—behavioral health staff will become educated as how to best coordinate, collaborate, and cooperate with law enforcement officers. This has a two-fold benefit. It can lead to better interactions when law enforcement is handing off an individual, and it also can help guide behavioral health staff on appropriate times to request law enforcement involvement in a behavioral health incident.

Training for ground-level behavioral health staff can be one of the most productive undertakings to advance community understanding and appreciation of the value that CIT training brings to the community.

5) Family, Consumers, and Advocates Collaborate and Educate

The final leg—family, consumers, and advocates—is often the "forgotten" leg. Involvement of these stakeholders is truly critical to help entrench a CIT program firmly in a community. In addition to having consumers participate in the actual training curriculum, the education and training of family and consumers help increase buy-in and ownership of the program. This buy-in helps to support critical elements in the program. There are two main benefits of this element: (1) improved understanding

of front-line interactions involving law-enforcement and (2) advocacy for the program needs. Supportive advocates of CIT processes and program needs are important to help foster positive relationships between the police and the community and to improve the efficacy of the program. Who better to spread that positive word than those family members and friends whose loved ones have been helped by a CIT-trained officer?

A CIT program that helps to educate consumers and advocates on the resources available in their community allows them to be more engaged in the program. The development of meaningful crisis plans; tips on how to improve face-to-face interactions when law enforcement is responding to a call regarding a loved one; and increased understanding of law enforcement's typical responses, limitations, and procedures can go a long way to increasing the likelihood for successful outcomes. When both parties in the interaction are more informed and willing to respect each other's perspective, the opportunity for mutually beneficial results increases exponentially. Families and advocates who are more informed, engage in pre-crisis planning, and have reasonable expectations for the outcomes of crisis situations greatly increase the likelihood of positive outcomes and, typically, are more supportive of the overall program.

At the macro-level, this constituency can also be strategically helpful in advocating for the protection, expansion, and accessibility of precious community behavioral health crisis services. As discussed, for CIT to be effective, accessible crisis services are paramount. A CIT program's ability to protect or acquire the needed behavioral health services to adequately support a true CIT program is greatly improved when community members actively advocate for this critical piece of a CIT program. Since quality and accessibility to these services are generally contingent on the funding provided by a region's behavioral health system or by the culture and vision of the agency providing these services, the consumers of the care can be amazing allies.

Conclusion

These five main "legs" are the foundation of creating a strong CIT program. Having three or four of the legs is certainly an improvement over having none or just training, but the presence of all five legs ensures that a community has a strong and stable foundation that is systemically responsive to those individuals who are experiencing a mental health crisis. This solid foundation promotes a CIT program that can be sustainable and weather the inevitable ups and downs that are certain to occur in a community over time.

Central to the success of CIT is not only the training of the law enforcement officer, but also the education of those agencies and individuals within the behavioral health community who will be involved in the process. Successful diversion requires accessible crisis services. True collaboration can occur only when law enforcement, behavioral health agencies, and families and advocates have a clear understanding of and respect for each other's roles in a CIT program. ♦

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Notes:

[1]Randy Borum et al., "Police Perspectives on Responding to Mentally Ill People in Crisis: Perception of Program Effectiveness," *Behavioral Sciences and the Law* 16 (1998): 393–405, http://scholarcommons.usf.edu/cgi/viewcontent.cgi?article=1567&context=mhlp_facpub (accessed February 2014).

[2] Henry J. Steadman et al., "Comparing Outcomes of Major Models of Police Response to Mental Health Emergencies," *Psychiatric Services Online* (2001); Edward P. Sheridan and Linda A. Teplin, "Police-Referred Psychiatric Emergencies: Advantages of Community Treatment," *Journal of Community Psychology* 9, no. 2

(April 1981): 140–147.

[3] TAPA Center for Jail Diversion, *What Can We Say About the Effectiveness of Jail Diversion Programs for Persons with Co-Occurring Disorders?* (Delmar, NY: The National GAINS Center, 2004); National Association of Mental Health Planning and Advisory Councils, *Jail Diversion Strategies for Persons with Serious Mental Illness* (Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005), http://www.namhpac.org/PDFs/01/jaildiversion.pdf (accessed September 2, 2015); Deborah L. Bower and W. Gene Petit, "The Albuquerque Police Department's Crisis Intervention Team: A Report Card," *FBI Law Enforcement Bulletin* (February 2001): 1–6, http://www.au.af.mil/au/awc/awcgate/fbi/crisis_interven.pdf (accessed February 2014).

[4] Michael T. Compton et al., "Crisis Intervention Team Training: Changes in Knowledge, Attitudes and Stigma Related to Schizophrenia," *Psychiatric Services* 57, no. 8 (August 2006): 1199–1202, http://www.state.nj.us/mhstigmacouncil/community/law/Crisis_interv_team_training.pdf (accessed March 2014).

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