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Crisis Intervention Teams in Chicago: Successes on the Ground

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Abstract

Police officers encounter a sizable number of calls involving individuals who have mental illness. In response to the challenges that officers face with mental health calls, police departments nationally are implementing specialized response programs. In this paper, we present findings from qualitative interviews with police regarding the implementation of a well-known specialized response model, Crisis Intervention Teams. Researchers employed a grounded dimensional analysis to examine how CIT is utilized in four Chicago police districts. Results indicate that police, irrespective of whether they received CIT training, perceive an array of benefits of CIT implementation in their district. Implications for practice and policy are discussed.

Police officers encounter a sizable number of calls involving individuals who have a mental illness. In a national survey, Deane and colleagues (1999) estimated that roughly 7% of police calls and investigations involved individuals with a mental illness. Owing to limited training and the perception of inadequate community service options, police officers find calls related to mental illness both challenging and difficult to manage (Borum, Deane, Steadman, & Morrissey, 1998). Challenges arise because mental health calls can be time consuming for responding officers; deciding on the disposition of calls is also often complicated as officers are responsible for serving the needs of the individuals involved in the call and protecting the safety of the community (Hails & Borum, 2003). In response to the challenges officers face with mental health calls, police departments across the country are implementing specialized response programs. The current study presents findings from a project that investigates a specialized response program, Crisis Intervention Teams (CIT), in a large metropolitan police department (Chicago).

CIT is an organizational intervention “that represents a shift in operating practices in relation to persons with mental illness,” (p. 363, Watson et al., 2008). CIT involves three core components: intense training, partnership with community resources, and the adoption of the new role that CIT-trained officers must play within their department (Reuland, 2004). In addition to the three core components of CIT, support from command staff, trust and communication among partners, refined dispatch procedures, and on-scene response options, including the availability of resources and transportation, are also important in practice (Reuland, 2004). The history and evolution of CIT are discussed in more detail elsewhere (see other articles in this issue; Watson et al., 2009).

CIT is gaining much support for its promise to promote officer safety, safe and respectful interactions between police and individuals with a mental illness, and diversion to mental health services in lieu of criminal justice system processing (Watson et al., 2008). Police officers are often the first responders to individuals in crisis. They act as gatekeepers who ultimately make the critical decision of who gets mental health services, who gets arrested,

and who gets released with no follow-up (Lamb, Weinberger, DeCuir, 2002). CIT provides trained police personnel with skills and knowledge that can be applied to assist officers in making crucial decisions and maintaining safety during first-responder circumstances. There are now more than 400 CIT programs operating across the country (Watson et al., 2008).

Outcome research on CIT effectiveness is sparse but preliminary data support the utility of CIT for improving officer preparedness and the disposition of mental health calls (Compton, Bahora, Watson, & Oliva, 2008). In general, CIT officers report feeling better prepared to manage mental health-related calls compared to non-CIT officers (Borum et al., 1998). Research also shows improved officer attitudes towards calls involving individuals with mental illness, increased knowledge of mental illness and its effects on behavior, as well as an increase in overall officer patience when responding to mental health-related calls (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Hanafi, Bahora, Demir, & Compton, 2008). Preliminary findings further suggest CIT also has the potential to alter beliefs about mental illness and to reduce stigma toward individuals with mental illness (Compton et al., 2006).

Outcome research demonstrates positive outcomes for CIT such as an increase in identified mental health calls (Teller, Munetz, Gil, & Ritter, 2006), more transports to treatment by CIT officers (Hanafi et al., 2008; Teller et al., 2006), and fewer involuntary transports (Compton et al., 2008; Teller et al., 2006). In addition, preliminary evidence shows that CIT increases access to mental health services by linking individuals to community-based providers (Compton et al., 2008; Watson et al., 2009). Although no evidence suggests that CIT significantly reduces arrests, Steadman and colleagues (2000) found that police departments with specialty response programs, on average, had lower arrest rates for individuals with mental illnesses compared to departments with no special response.

To date, CIT studies are largely preliminary and have not investigated the implementation and effectiveness of CIT in large urban areas. The current study addresses this gap in CIT research by exploring the impact of CIT on first-responder police personnel as well as trained and untrained officers in four police districts in Chicago.

Methods

Setting

The Chicago Police Department is comprised of 25 police districts and serves approximately 2.9 million residents. All Chicago police officers receive nine hours of training on mental health issues during their pre-service academy training (Watson et al., 2009). CIT was adopted as a result of recommendations set forth by a Mental Health Task Force, initiated by then Chicago Police Department's Superintendent Cline (Chicago Police Department, 2008). The Mental Health Task Force consisted of mental health and criminal justice stakeholders. They were asked to assess current policy and programs regarding Chicago's law enforcement response to individuals with mental illness. The task force recommended CIT as an initiative to enhance knowledge regarding mental illness and skills when responding to calls involving individuals with mental illness (Chicago Police Department, 2008).

In 2005, the Chicago Police Department began piloting testing CIT in two demographically different districts with the launch of two 40-hour CIT trainings. Officers in these districts were encouraged to apply to the program. In each district 30–40 officers and supervisors were trained. By July 2006, the Chicago Police Department began program expansion, training approximately 30 officers from across the city each month (for a more detailed discussion see Watson et al., 2009).

Sample

Because of its exploratory nature, this study employed a qualitative research design in order to elicit the perceptions of CIT officers and study the experiences of CIT stakeholders in the Chicago Police Department. The current study is part of a larger investigation that explores the implementation and effectiveness of CIT in Chicago (see Watson et al., 2009). In February 2008, Watson and colleagues (2009) began a study of the impact of CIT on police encounters with individuals with mental illness in four Chicago police districts. At the onset of data collection, 532 officers had completed CIT training and all of Chicago's 25 police districts had CIT-trained officers (Watson et al., in press). The current study samples from four of Chicago's police districts. CIT was initially implemented in two pilot districts, which now have more CIT trained officers than any other district in the city. These districts were included in the current study and are referred to as the high CIT-saturated districts. Watson and colleagues (2009) studied these two high-saturated districts in addition to two comparison districts with low CIT-saturation. Comparison districts were selected based on residents' demographic characteristics, crime rates, and mental health resource availability obtained through the U.S. Census 2000, Chicago Department of Public Health (2006) listings of mental health providers and service capacity, the Chicago Police Department Annual Report for 2007 (Chicago Police Department 2008) and lists provided by the CIT training program and District commanders (Watson et al., 2009). A full description of demographic characteristics, crime statistics, and mental health resource availability of the four districts is beyond the scope of this paper but can be found in detail in Watson et al. (2009).

Sampling

The Chicago CIT evaluation involved sampling 216 officers across the four districts in an initial survey conducted in person and three follow-up phone interviews. Watson and colleagues (2009) provide a thorough discussion of the Chicago CIT evaluation sampling strategies. For the present study, a sub-sample of officers, sergeants, lieutenants, and captains (n=20) in the four aforementioned districts was invited to participate in a qualitative, semi-structured interview. In accordance with a qualitative evaluation approach, a purposive sampling strategy was employed. This strategy was used in order to select participants to maximize diversity on participants' opinions and experiences of CIT in accordance with research questions (Marshall, 1996). The participants in this study were sampled from the pool of participants who participated in the larger study. Because the intent of this study was to sample police personnel with positive and negative attitudes toward CIT, the research team worked with the coordinators of the larger evaluation to purposively select officers who represented varied opinions of CIT within each district. In addition, the sample included officers who worked different watches (shifts) and who differed with respect to, seniority, rank, and CIT training. Participants were recruited by first sending a letter of invitation, which was followed by a phone call to confirm their willingness to participate and to schedule a convenient time and place to conduct the interview. Only one of the twenty-one police officers contacted refused to participate in the study. However, researchers were unable to reach five officers originally selected for the sub-sample because they were away on furlough. The final sample included an equal distribution of participants with key sampling factors in each of the four districts. Characteristics of the final sample are given in Table 1.

Officers who elected to participate completed an audio-recorded, in-person interview that lasted one to one- and- a- half hours. Although a list of questions and probes was used to guide the conversation, the format of the interviews was informal and unstructured. With the agreement of Chicago Police Department officials, officers were permitted to participate in the interview during a work shift, and private offices and conference rooms were made

available to ensure confidentiality of responses. The choice to participate was also confidential. Further, the research team coded the data with identification numbers in order to keep participants and their districts anonymous.

Analysis

A grounded dimensional approach to analysis (Schatzman, 1991; Angell, Mahoney, & Martinez, 2006), which is a variation of grounded theory (Strauss & Corbin, 1990), was used to explore and analyze the interview findings. A grounded dimensional approach uses an overarching symbolic interactionist framework, which focuses attention on how people's everyday actions are guided by individually and collectively held social meanings (Kools, McCarthy, Durham, & Robrecht, 1996). In this project, the dimensional analysis focused upon creating a synthesized account of how Chicago police officers perceive and participate in the application, implementation, and/or utilization of CIT across four police districts.

In this process, analysts scrutinize qualitative interview data carefully and break it down into small chunks or fragments, which are coded by labeling them as a dimension or property of the core phenomenon being studied (in this case, CIT implementation). As codes are created within and across participants, they are grouped according to similarity into a smaller number of higher-order codes and are compared and contrasted with disparate codes. By doing so, the analyst develops a parsimonious explanation of the phenomenon by comparing, contrasting, and integrating the codes into a single account of a phenomenon that varies according to different contextual factors. Once the overarching explanation begins to be replicated across different data observations, the analysis is considered to be "theoretically saturated", meaning that further analysis efforts fail to reveal new variations on the core theme. The product of this synthesis "...gives theoretical and explanatory form to a story that would otherwise be regarded, at best, as fine description" (Schatzman, 1991, p. 313). The researchers analyzed the emerging themes by comparing and contrasting references in three dimensions: (1) CIT trained officers vs. non-CIT trained officers; (2) District saturation level (i.e., high vs. low saturation); and (3) District resource availability (i.e., high vs. low availability of community mental health services). The process of developing the grounded theory was conducted collaboratively with authors.

Results

In total, 60% of the sample had completed the CIT training. Of the 20 study participants, 15 referred to CIT successes at least once during their interview; eleven of the 15 participants had received the CIT training. The grounded dimensional analysis uncovered five general themes identified by police personnel regarding the impact of CIT in daily police practices at the district level. Response themes varied in frequency by training status and district resource availability. Less variation appeared among districts with different saturation levels. Each theme is discussed individually with direct quotes to illustrate the findings.

Application of CIT Skills and Knowledge

Police personnel referred to successes related to the application of CIT knowledge and skills obtained during the training and practiced in the field more frequently than any other theme. Roughly 44% of all references related to the utilization of CIT skills and knowledge in the field. Not surprisingly, CIT-trained officers cited the majority of these references. The application of skills and knowledge broadly involved remarks about a particular aspect of the CIT training that were used in practice or about how knowledge gained from the CIT training informed understanding of mental illness and related behaviors. For example, one Sergeant reported:

The most bizarre was when they (CIT Trainers) gave us headphones to listen to what it sounds like to be listening to something else in your head, and then they give you crossword puzzles and you try to do 'em. I mean, after awhile, it really, really irritated me....I've encountered numerous people on the street, and I'm talking to them like I'm talking to you, and I'm not even there. And as police officers, we immediately think, "Oh, they're ignoring us," you know, now we gotta take some physical action. But, to actually be aware that something is going on, a conversation, a dialog, noises are going on in someone else's head, that was very helpful. –Sergeant from a high resource, high saturation district

Officers specifically discussed the usefulness of CIT skills and knowledge when initially responding to calls and interacting with individuals with a suspected mental illness. Several officers reported that CIT increased their overall awareness of mental illness and how symptoms of a mental illness can be distinguished from behaviors related to alcohol or drug use. Officers also reported success in utilizing the de-escalation skills that were highlighted in the CIT training. One officer recalled,

You know, first of all, we be thinking about our safety....they're going off....when I'm going into the situation now, I'm looking at it, you know, how can I calm this person down? How can I talk to them in a more calmer way....we need you to help us and we need you to calm down, so now I'm going in. I look at them—look a totally different way, just how can I calm this situation down and then we all get outta here safely and they go where they need to go. –Officer from a low resource, high saturation district

Participants recounted practical situations in which their CIT skill set was invaluable in protecting their own safety and the safety of others and in improving the overall wellbeing of the individuals involved in the call.

I wanted different tools as far as how to talk to people, relax, and take your time like a calming effect. And after all, a lot of times, we're called on attempted suicides... What does it take if I have to stay there an extra 10 or 15 minutes to talk somebody down or hold their hand to save a life? And we've saved lives already, so the training works. –Officer from a high resource, low saturation district

Supervising personnel reported that when trained officers apply their CIT skills in the field, they often share their knowledge with untrained officers. One sergeant from a high-saturated district noted that CIT “rubs off” on the untrained officers. A lieutenant from another district agreed.

What makes it (CIT) work is the police officers that come through this door to be trained, that they leave as true believers. And when they do use those tools, they sell it to the rest of the department. –Lieutenant

The reported application of skills and knowledge is a crucial component in the assessment of the success of a program. Police officers receive a number of trainings, but the training itself is not enough unless the knowledge from the training is actually implemented. The data from this study indicates that trained officers are applying CIT skills and knowledge in the field, which also has an effect on untrained officers.

Diversion from Arrest to Mental Health Services

Police personnel stated that the CIT training and CIT trained officers in their district were a source of information that enhanced awareness of the alternatives to arrest for individuals in need of mental health treatment. Roughly 21% of references made regarding CIT successes involved diversion from arrest. Regardless of the different resource levels among the

districts, CIT trained officers reported that the training provided them with the ability to divert individuals with a mental illness from arrest and into mental health services.

Everybody wasn't aware of it, where you have to sign somebody in 'cause trying to—first somebody's on lock-up. I got a person that has mental illness issues. He goes and gets arrested. He's locked up for 12 hours overnight. He gets up. He hasn't been treated for mental illness. He's still got the problem. He's back on the street. He's back at home inflicting this problem on the family again. With the CIT program and involuntary admission, gets him the hospital. We can get him treated, maybe three days, seven days, depending on how bad they are. —Officer, low resource, low saturation district

Participants reported that information and resources regarding alternatives to arrest has not only helped with adult interactions but has also been useful in encounters with school-aged children. Police respondents reported that they were previously unaware that mental health services could benefit an individual with a mental illness and the community more than an arrest could, in certain circumstances. CIT provided that critical information and perspective to trained officers who, in turn, “spread the word,” as one officer reports, to other untrained officers. Although a reduction in arrest rates was not found in the quantitative study of the program, CIT trained officers did increase access to mental health services (see Watson et al., in press).

Officer Collaboration with Treatment Providers

Collaboration with treatment providers is a core component of the CIT program. According to study participants, it appears such collaboration is occurring. However, only police personnel from the high-resource, high-saturation district reported police and community provider collaboration. CIT trained officers reported that their district has a relationship with the local hospital. The hospital provides crisis workers and a separate section of the emergency waiting room for the police when they transport someone in need of services.

A lot of times we call ahead, so by the time we get there they already have the triage, but it's not the emergency room....and a lot of them (emergency rooms) are not equipped to handle the high risk. —Officer from high resource, high saturation district.

The district also has a sergeant who is CIT trained and instrumental in leading the collaborative effort between the police and mental health service providers. In reference to their sergeant, one officer stated,

...she has an excellent rapport and communication with many of the agencies... when there are discrepancies or stuff we don't like, which is not very often, she'll call them or she'll call somebody. —Officer from high resource, high saturation district

In the same district, study participants discussed the relationships that specific officers or teams of officers have with community agencies. Social workers call when police assistance is needed and ask for specific officers that have helped in the past. These officers build relationships with agency staff and individuals in need, which often helps in creating a safer, less volatile encounter and more effective outcomes for all involved.

Voluntary Officer Response to Calls Involving individuals with a Mental Illness

In the program model, CIT trained officers should be dispatched for all calls involving an individual with a suspected mental illness. According to study participants, this does not always happen because information breaks down in dispatch or too few trained officers are available to respond to all the calls. However, CIT officers reported that although they are

not dispatched when a call involving mental illness is heard over the radio, they nonetheless try to respond to the call. One CIT-trained sergeant indicated that he will assist by either reporting to the scene or calling the responding officers with all calls that he suspects involves a mental illness. Although occurring much less often, officers can ask for a CIT officer to respond or assist in the field when needed. Study participants reported that this happened on rare occasions.

Requests for CIT Officers and Families

Social service agencies call and request CIT officers in the high-resource districts. For example, officers in one high-resource, high-saturation district reported that they worked with the same agencies in their district whenever they are needed, which promotes familiarity with the community and agency workers as well as the individuals who need assistance. Families, agency staff, and non-CIT-trained police officers also reportedly request CIT trained supervisors. Study participants from high-saturation districts reported more requests for CIT-trained officers, but within those districts, both trained and untrained officers responded to these requests.

One officer from a low-resource, low-saturated district reported that CIT has helped him and his fellow officers connect with families in their communities. When family members are having a problems related to mental illness, CIT officers have resource cards from National Alliance on Mental Illness (NAMI) that they give families in need. Some officers reported that they help families make phone calls and have even provided the families with their cell phone number to address any follow-up needs.

I'll pass those (NAMI cards) out to people and a whole lotta times they'll call me and I'll talk to them and give them—a lotta times—I can't solve your problem but I can give you the resources through information to call them up and maybe they can help you. —Officer from a low resource, low saturation district

Perceived Impediments to Successful CIT Implementation

Although most participants perceived the benefits of CIT to their department, a minority of study participants discussed impediments to CIT success in their respective districts. Primary barriers included information breakdowns, inadequate community services, and insufficient police resources. Information breakdowns were problematic, especially in the low-saturation districts. Study participants felt that CIT-trained officers were not accessible to other officers because no system is in place to identify who is CIT trained on each watch. Further, participants reported that call takers are not always able to obtain sufficient details about calls for service. Calls are not always flagged as “mental disturbance” calls (a term used by police dispatch to indicate a call involving an individual with a reported mental illness) and therefore are not appropriately dispatched to CIT officers. Even if calls are flagged, one captain reported it would not matter because no system is in place to identify trained officers.

Study participants also identified inadequate community services as a major barrier to successful CIT implementation even in districts with higher resources. As one officer stated, “How can we do our job when there are no resources?” Several study participants found that their only option was to drop people off at the hospital. One captain indicated that when officers find that hospitalization is necessary for a person, the process is often time-consuming and frustrating because hospital personnel do not always find it necessary to hospitalize the person. A lieutenant from a low-resource community reported that the hospitals in his district are “revolving doors.” He reported that the quality of services provided to the community are inadequate. It is not uncommon, he stated, to have officers transport a person for emergency services and then see that individual on the streets 24 hours

later. “We’re doing our part, let somebody else do their part.” This same lieutenant stated further that services are so deficient in his community that officers routinely bring in coats, clothes, shoes, and food for their community members in need.

Finally, police personnel cited insufficient police resources as a barrier to CIT success. In the low-saturation districts, officers reported that in order for CIT to be successful, they need trained officers in each sector. One captain indicated that there are simply not enough trained officers to meet the needs of people with mental illness. There are too many calls involving individuals with mental illness to dispatch only trained officers to the scene. Having enough trained officers is difficult for some districts because there is not enough staff to send officers for a weeklong CIT training. Study participants attributed this barrier to a lack of support for CIT from department’s highest-ranking administrators. Many districts are in need of more wagons for transport. One officer suggested that department officials provide more resources or initiate proactive changes in policy rather than creating policy in response to tragedies. Finally, one CIT-trained captain reported that CIT would be successful if all new recruits received the training. He further suggested that all CIT trained officers should have access to a periodic refresher course to ensure CIT is being used effectively.

Discussion

As first-responders, the police, especially in urban settings, encounter calls relating to mental illness on a regular basis. These calls can be time consuming and challenging to officers, in part, because of a lack of resources or information. CIT was designed to assist officers in safely and respectfully responding to calls in which people are in crisis. These findings suggest that CIT is having a favorable effect on police personnel. Overall, results indicate that police personnel, irrespective of whether they received the training, perceive the benefits of CIT implementation in their district. Aspects of successful implementation include the application of knowledge and skills gained through the CIT training to actual cases, police collaboration with community mental health service providers, diversion to mental health services, voluntary officer response to mental health calls, and community requests for CIT- trained officers.

In this study, researchers talked directly to officers and administrators who were able to provide their view of how CIT works in the field. Researchers sampled both CIT trained and untrained police personnel from districts with varying numbers of CIT- trained officers and mental health resources. These data, along with findings from the larger study conducted by Watson and colleagues (in press), begin to shed light on how CIT works in large, urban police districts. Specifically, this research suggests that all three of CIT’s core components are present in Chicago.

The first component, intensive training seems to be effective in providing officers with the knowledge, skills, and tools needed to apply the training to actual cases. Evidence also indicates that the Chicago Police Department is defining the new role CIT trained officers play, which is the second core component. Specifically, CIT trained officers are called on by other officers in their districts and by community-based social workers and family members to assist in cases that involve individuals with mental illness. These officers have cultivated the relationships and acquired the skills that others view as being especially helpful in addressing the needs of individuals in crisis. Finally, collaboration with providers, a third core component of CIT, seems to be in place in Chicago; however, most references regarding collaboration with agencies or hospitals were reported by study respondents from the high- resource, high-saturation district, which suggests that successful officer-provider collaboration requires adequate community mental health resources (Reuland, 2004).

Additional studies are needed to evaluate the community and district level factors that foster collaborative efforts.

Limitations

This study was a small scale, qualitative investigation designed to identify the basic ingredients of successful CIT implementation. The findings might not generalize to districts outside of Chicago. Although useful for contextualizing an intervention effort, such small investigations require replication and further testing using a range of research designs. In addition, it is possible that the four districts chosen for study, particularly the two districts chosen for early adoption of the model were unusually receptive to a training innovation. Thus, additional work is needed to determine how the CIT intervention would be received in districts with lower motivation to find strategies for working more effectively with people who have serious mental illness.

Conclusion

The findings from this study suggest that CIT in Chicago is being implemented and utilized in the field with success and adds to the growing body of knowledge regarding CIT in urban settings. Although the Chicago Police Department is larger in scale than the other departments studied in previous CIT research, it does appear that CIT's core components are being properly utilized. These findings have implications for practice and policy. With regard to practice, officers should continue to be encouraged to become CIT trained; supervisory personnel should also create an infrastructure to identify and connect CIT trained and untrained officers in order to promote knowledge sharing in the field. With regard to policy, the Chicago Police Department should continue supporting the CIT program as preliminary data suggests that this program is helping officers overcome the challenges of helping individuals with mental illness.

Collaboration with community providers is one important ingredient in the successful implementation of CIT, which was supported by this study's findings. Higher-resource districts appear to have built relationships with community providers but the evidence did not support collaboration in low- resource districts. Police efforts like CIT could be supported in low-resource districts with an increase in quality mental health services. In order for CIT to be as successful as possible, officers must have services available to divert individuals from the criminal justice system and into the mental health system. They must collaborate closely with service providers. Further research is needed to replicate this finding and to further examine how to promote community resource collaboration in low-resource districts.

The CIT model is being implemented in police districts all over the country. The present study and the larger study in which it is embedded (see Watson et al, in press) as well as a growing body of research suggests that CIT is helping police personnel better manage mental health calls. This study provides preliminary evidence that CIT effectiveness might be influenced by the availability of community resources, although further analysis is needed to answer questions regarding barriers to effective CIT implementation.

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Table 1

Sample Demographics (n=20)

Interviewees		
Sex	Male	60%
	Female	40%
CIT Trained	Yes	60%
	No	40%
Rank	Officer	50%
	Sergeant	15%
	Lieutenant	25%
	Captain	10%
Watch	1 st	15%
	2 nd	70%
	3 rd	15%
Tenure (in years)	Less than 5	10%
	5 to 10	5%
	11 to 20	35%
	More than 20	50%