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Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls

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Police encounters involving individuals with mental illnesses account for a significant portion of officers‘ time. Roughly 10% of calls in medium to large police departments involve a person with a mental illness; these calls often take more time to resolve than routine calls (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). When faced with such encounters, police officers make critical decisions related to the use of force and the appropriate disposition of the call. Due to limited training and the perception of inadequate service options, however, police officers find encounters related to mental illness both challenging and difficult to manage (Borum, Deane, Steadman, & Morrissey, 1998). As a result, police departments across the nation are collaborating with mental health professionals, substance abuse treatment providers, advocates, and other stakeholders to develop and implement specialized response programs.

One program in particular, Crisis Intervention Teams (CIT), seeks to promote safe and respectful interactions with police and individuals with a mental illness and to divert individuals to mental health services and away from the criminal justice system. Although the evidence base for CIT and other specialized response programs is growing, little is known about how receiving specialized training actually affects police responses to citizens with mental illness. The current paper addresses this gap by briefly reviewing the literature surrounding police officer response to persons with mental illness. We will then provide a brief overview of the CIT model and evidence to date, followed by findings from our qualitative study regarding CIT in Chicago. The relevance of the data is explored and implications for practice and policy are considered.

Police response to persons with mental illness

The frequency of police contact with individuals who have a mental illness has increased over the past 50 years (Cordner, 2006; Ruiz, 1993). Some scholars argue this is due to

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deinstitutionalization and the increase of individuals with mental illness in the community (Ruiz, 1993; Green, 1997). Regardless of the cause, police officers today are responding to a sizable number of calls involving individuals who have mental illnesses. When faced with these calls, police officers make critical decisions regarding the need for mental health treatment and, in turn, act as gatekeepers to the mental health and the criminal justice system. However, with limited training in mental health issues and scant service options police officers find calls related to mental illness challenging and often find the individuals and disposition options difficult to manage (Borum et al., 1998).

One challenge that police officers face when interacting with a subject with a mental illness is that people with mental illnesses may not respond well to traditional policing tactics (Engel, Sobol, & Worden, 2000). The use of traditional police tactics such as verbal commands, the use of verbal and/or physical force, and intimidation, especially when initially approaching a subject, may escalate a subject who is agitated or experiencing other acute symptoms resulting in subject and/or officer injury (Engel et al., 2000; Watson, Morabito, Draine, & Ottati, 2008). Research suggests that the manner in which the police approach and interact with individuals with a mental illness and the amount of time involved in responding to a call, impact the disposition, use of force, and safety of both the civilians and police (Ruiz, 1993, Watson, Angell, Morabito & Robinson, 2008). Further, police officer fear of injury and lack of understanding of mental illness are primary factors in aggression between police officers and individuals with mental illness (Peirson, 1976). This is especially important to address as a common misconception among police officers, as well as the general public, is that individuals with a mental illness are violent and cannot be reasoned with (Ruiz, 1993).

Although it may be useful for police to be able to identify an individual as having a mental illness, one study found that police response is more strongly influenced by characteristics of the situation and subjects‘ behavior than officers‘ knowledge of whether the subject has a mental illness (Watson, Corrigan, & Ottati, 2004). Ruiz (1993) argues that because subjects‘ behavior can be influenced by officers‘ posture, positioning, time involvement, language, and communication style, all of the foregoing factors should be altered when working with someone with a mental illness, ideally through specialized procedures and protocols within police departments. In many jurisdictions, however such specialized procedures are either absent or, when they do exist, are found by officers to be vaguely specified and difficult to implement in the field (Ruiz, 1993).

The Crisis Intervention Team model

In response to the challenges officers face with mental health-related calls and the growing need for specialized procedures for individuals with mental illnesses, police departments are implementing specialized response programs. One program, Crisis Intervention Teams (CIT), is gaining much support for its promise to promote safety, train officers to respectfully interact with people with mental illnesses, and divert people with mental illnesses away from the criminal justice system and into mental health treatment (Watson et al., 2008). Since the inception of CIT in 1988 in Memphis, Tennessee, there are now over 400 CIT programs operating across the nation (Watson et al., 2008).

CIT is often modified upon implementation to fit the unique needs of the police department (Watson et al., 2008). Despite modifications, CIT has three core components that stakeholders argue are essential components (Reuland, 2004). The first component is the training. Police personnel interested in CIT must complete an intensive training conducted by mental health professionals, families, and consumers (Reuland, 2004; Cochran, Deane, & Borum, 2000). Officers learn about mental illness, substance abuse, psychiatric medication,

and techniques for responding to a mental health crisis (Cochran et al., 2000). The training includes role-play, education, visits to mental health facilities, and open discussions between individuals who have a mental illness and the officers (Reuland, 2004).

A second core component of CIT is developing partnerships between police departments and community service providers (Reuland, 2004). Once police departments train personnel, there needs to be a place for officers to take individuals in need of emergency services. It is also critical that officers have knowledge of other community resources for individuals that may not need emergency services, but are in need of a referral or to be linked with a service provider.

Finally, a third core component of CIT is that trained officers take on a new role in their departments (Reuland, 2004). CIT trained officers play a critical role in responding to mental health crises as they are often the first responders. In many police departments, CIT trained officers respond to all calls, not just mental health related calls; however, CIT officers have a specialized skill set that other non-CIT trained officers and dispatchers should be made aware of through administrative means.

Outcome research on CIT effectiveness is sparse but preliminary data supports the utility of CIT through improved officer preparedness and improved disposition of mental health calls (Compton, Bahora, Watson, & Oliva, 2008). CIT officers report feeling more prepared to effectively manage mental health related calls compared to non-CIT officers (Borum et al., 1998). Research also shows improved attitudes, increased knowledge and patience, and an increase in support of local treatment programs (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Hanafi, Bahora, Demir, & Compton, 2008). Preliminary findings further suggest CIT also has the potential to reduce stigma and alter beliefs about mental illness (Compton et al., 2006).

In addition to the modification of officer attitudes and perceptions, research also suggests positive outcomes of CIT, such as increases in the number of identified mental health calls (Teller, Munetz, Gil, & Ritter, 2006), transports to treatment by CIT officers (Hanafi et al., 2008; Teller et al., 2006), and voluntary transports (Compton et al., 2008; Teller et al., 2006). There is also preliminary evidence that CIT increases access to mental health services through linking individuals with community providers (Compton et al., 2008) as well as increasing access to mental health services through mental health transports and referrals (Watson et al., 2010). Although there is no empirical support that CIT reduces arrest rates, Steadman and colleagues (2000) found that police departments with specialty response programs, on average, had lower arrest rates for individuals with mental illnesses in comparison to departments without any special response.

Chicago implemented CIT in 2005 in two pilot districts (Watson, Draine, Morabito, & Fisher, 2009) with initial funding from the Substance Abuse and Mental Health Services Administration. The program was expanded citywide in 2006 with additional funding from the state of Illinois and the Illinois Law Enforcement Training and Standards Board. The Chicago Police Department has continued to provide resources to hold CIT trainings monthly (on average). The speed of program expansion has been limited to the number of officers that can be trained each month. By the close of 2010, over 1,200 (out of approximately 13,000) officers had been trained. Trainings continue and Advanced CIT training, related to responding to military veterans and responding to juveniles, has been developed and implemented as well.

Outcome research on CIT in larger cities like Chicago is limited. Watson and colleagues (2010) addressed this gap with research on CIT implementation and effectiveness in Chicago. Researchers sampled both CIT and non-CIT officers. Among sampled participants,

55% of their calls involving adults with a mental illness resulted in them directing the individual into mental health services; 31% of calls resulted in the officers having contact with the individual but not taking any action; 10% of calls resulted in arrest; and 4% of call dispositions did not fall into one of the previous three categories. In comparison to non-CIT trained officers, researchers found that CIT trained officers report more calls per month involving individuals with a mental illness. Although CIT and non-CIT trained officers did not significantly differ in terms of the number of calls resulting in arrest, CIT trained officers directed significantly more individuals into mental health services compared to non-CIT trained officers while non-CIT trained officers report significantly more calls resulting in having contact only but taking no action. These findings suggest that CIT in Chicago may be impacting an individual‘s access to services (see Watson et al., 2010 for more detail).

The current sub-study is part of this larger study (see Watson et al., 2010). The focus of the current research is to investigate the impact of CIT on Chicago police officers‘ response to calls involving individuals with mental illnesses. We specifically examine differences in how CIT and non-CIT officers describe their response to mental health related calls.

Methods

Sample

Because of its exploratory nature, this study uses a qualitative research design to elicit the perceptions of CIT and experiences of stakeholders within the Chicago Police Department. Watson and colleagues (2010) began data collection on the impact of CIT in police encounters with individuals with a mental illness in four Chicago police districts in February 2008. 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., 2010). The current study samples from the four of Chicago‘s police districts that participated in the larger study.

The Chicago CIT study involved sampling 216 officers across the four districts and conducting an initial survey conducted in person and three follow-up phone interviews. Watson and colleagues (2010) provide a thorough discussion of the study sampling strategies elsewhere. For the present study, a sub-sample of officers, sergeants, lieutenants, and captains (n=20) across the four districts was selected, most of whom were from the larger study sample, and invited to participate in a qualitative, semi-structured interview. 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 study to purposively select officers who were either known to be champions of CIT within each district or who had either positive or negative perceptions of the program. In addition, the sample also varied across different watches, tenure, rank, and the receipt of CIT training. Participants were recruited by first sending a letter of invitation which was followed by a phone call to confirm a willingness to participate and to schedule a convenient time and place to conduct the interview. Only one officer out of twenty-one police personnel contacted refused to participate in the study. However, researchers were unable to reach five individuals originally selected for the sub-sample due to furlough. 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; however, three study participants refused to be audio-recorded, thus researchers took detailed notes throughout the interview. Although a list of questions and probes was used to guide the conversation, the format of the interviews was informal and somewhat unstructured. Per agreement with the Chicago Police Department, participants were permitted to take part 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 or not was kept confidential; the data collected was coded with identification numbers created by the research team to keep participants and their districts anonymous. This study was approved by The University of Illinois at Chicago Institutional Review Board and the University of Chicago School of Social Service Administration / Chapin Hall Institutional Review Board.

Analysis

A grounded dimensional approach to analysis (Schatzman, 1991; Caron & Bowers, 2000), which is a variation of grounded theory (Strauss, 1987), was used to explore and analyze the interviews. Like all grounded theory approaches grounded dimensional analysis use an overarching symbolic interactionist framework to guide the inquiry and aims to uncover the meaning of actions and interactions in the social world (Kools, McCarthy, Durham, & Robrecht, 1996). Dimensional analysis deconstructs components of a complex social process by beginning with dimensionalizing, or breaking down the component parts of all that is involved in a situation or phenomenon, including its attributes, context, and implications (Schatzman, 1991). In the current analysis, the dimensional analysis focuses upon how CIT trained and non-CIT officers construct and respond to encounters with individuals with a mental illness.

In this process, small chunks of narrative data are coded with categorical descriptors As data coding continues, these codes are grouped according to similarity and raised to a higher level of abstraction. The various codes are then compared, contrasted, and integrated to create an explanation. Once explanations become increasingly redundant throughout the data (i.e., theoretical saturation is achieved), multiple dimensions and their components are synthesized into an explanatory framework. 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 made by CIT trained and non-CIT officers regarding response to calls involving a subject with a mental illness. The process of developing the grounded theory was conducted in collaboration with a team of researchers.

Results

In total, 60% of the sample had completed CIT training. Respondents discussed calls to which they had responded or, in the case of Captains, Lieutenants, and Sergeants, to which their officers had responded. Police personnel, irrespective of whether they themselves had completed CIT training, perceived an array of benefits of CIT implementation in their district (Canada, Angell, & Watson, 2010). However, CIT trained police personnel described their response to calls involving persons with mental illnesses in different ways than non-CIT trained officers. Specifically, three categories emerged in which CIT trained and non-CIT trained police personnel showed differences. The three categories include assessment, response tactics, and disposition. Assessment refers to the officers' evaluation of both need and risk of harm in calls involving individuals with mental illnesses. Response tactics refers to officers' description of techniques, skills, and use of force utilized in calls involving individuals with mental illnesses. Finally, disposition refers to the actual disposition or outcome of calls (i.e., hospitalization, arrest) involving individuals with a mental illnesses. Each category along with examples is outlined individually below.

Assessment

Both CIT trained and non-CIT trained officers discussed the ways in which they assessed people for risk of violence to themselves and others in the community in order to develop appropriate plans of action (i.e., arrest, hospital transport, etc.). CIT trained officers reported

a more comprehensive assessment of potential danger in mental health calls and reported a varied understanding of why individuals may exhibit certain behaviors. One CIT trained sergeant credits a specific part of the CIT training to her understanding of behaviors related to symptoms of mental illness.

> …they 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 found it incredibly distracting…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.

CIT officers discussed techniques often used to determine if hospitalization is appropriate. One CIT officer reported, "I…assess the situation and see if that person needs to go to the hospital… [I] try to talk to them, calm them down…'Do you need to go to the hospital? How can I help you?" In many situations, CIT trained officers found themselves using CIT skills to assess if a person with mental illness presented a risk of harm to self or others and was in need of hospitalization, while non-CIT trained officers reported bringing all symptomatic individuals to the hospital and having hospital staff conduct assessments. CIT trained officers provided examples by which family members wanted individuals to be taken to the hospital, but upon assessment, officers did not find the individual appropriate for hospitalization. The following example illustrates an officer's interaction with a family member of an individual with a history of mental illness:

> …. so the uncle is an older guy and he felt intimidated by the guy's size, so one time they came—I had this house about two or three times. One time they came and…what is he doing? Well, he's down in the basement asleep. Well, that's not against the law. That's not harming himself. He's not killing himself in his sleep. He's not doing nothing to you while he's sleeping, you know, so I went down there and talked to him. I said, "Well, I—he doesn't qualify to be sent to the hospital." "Well, he needs to go back wherever he came—." I said, "Okay, well, then give him some car fare and send him back." But this [individual] is not the issue.

Once CIT trained officer indicated that in cases where CIT trained officers do not feel a person is in need of hospitalization, but the family member, social worker, or doctor who placed the call disagrees, he/she can request the officer transport the individual regardless.

Many of the interviewed CIT officers believe the number of arrests has decreased as a result of the CIT training, as the training provided the tools necessary to identify when mental illness is involved and distinguish who is at risk of harming oneself and/or members of the community. CIT trained officers provided examples by which arrest or force might have been used prior to the training; however, with the tools from the training, officers are more capable of making assessments of individuals with a mental illness. A CIT trained officer discussed an event in which a man with a known history of schizophrenia was on a public bus. He pulled out a pen and began yelling that he was going to stab everyone on the bus with it. The bus driver pulled over, called the police, and evacuated the bus. The CIT trained officer was dispatched to respond to the call and reported:

> But it was one of those situations where she [the sergeant] could have gotten there and maced him, or some people could have shot him because he basically was like this with the pen at you. We just backed off. There was nobody in the bus so there was no reason to rush in. You know, let him come down. But the thing with him was you couldn't tell him he was under arrest. He just didn't want to go the

> hospital, period. And he let you know he wasn't going anywhere. That's why we waited for the wagon to get there. Three more officers got there and a sergeant. One of the sergeants had a Taser, but we had a good game of keeping him looking over here. And then, the guys grabbed him on the side, threw him down, and we cuffed him, and took him over there. And he was fine once he got to the hospital.

In contrast, non-CIT trained officers discussed unease with assessment of individuals with a mental illness as "you don't know what is gonna make them—what is gonna make them just fly off the handle," one non-CIT officer reported. "They're dangerous…they can snap in a minute," reported a non-CIT trained Lieutenant.

Finally, CIT trained officers also discussed an increased ease in distinguishing mental illness symptoms from the influence of drugs or alcohol. One CIT trained officer reported that she thought a woman from the neighborhood that she saw all the time was just intoxicated but after the training, the officer was able to distinguish when she'd been drinking and when she was off her psychiatric medication.

> But the mentally ill people, it's just—it's their behavior more or less or the things that they're doing. Even when we try to conversate [sic] with them and talk to them we'd be like, "Okay, is something else going on here? Is something wrong?" You can kinda pick up on basically this is not drugs. This is not alcohol. This is something else going on in the head.

Response Tactics

Most non-CIT officers in the sample did not identify techniques that they use in calls involving mental illness beyond the command and control techniques that are provided in basic police trainings. One non-CIT officer reported that the CIT training simply offers skills and techniques that officers will naturally pick up on the job as a result of experience. When he responds to calls involving mental illness, he reported

> Yeah, well, you can't get angry, and you can't tell them what to do as if they're, you know, just a regular person. I mean, it's just—go along with the program, humor them, agree with them, "Yeah, okay, whatever you say."

This same officer further reported that in order to gain control of a situation involving an individual with a mental illness, Tazer guns, leg shackles, and handcuffs are most helpful because they immediately make the situation unpleasant for the individual. While he may have picked up this approach over time with experience, this is not the strategy encouraged in CIT training. CIT trained officers, however, identified a number of response tactics that they use specifically for calls involving mental illness which non-CIT officers did not discuss. Specifically, CIT officers identified talking to the individual as a de-escalation technique, making an effort to listen to the individual's stated needs, and taking extra care to allow sufficient time to resolve issues rather than using traditional forceful strategies. The information provided by CIT trained officers suggests that CIT trains officers with response tactics that are specific to individuals with mental illnesses that officers may not necessarily learn from on-the-job experience.

Talking—Nearly every CIT trained officer reported that talking to the individual is their most helpful response tactic. One officer reported, "You've gotta talk somebody down…to get to the bottom of what's going on." CIT officers reported that when they explain that they are there to help and to listen to what the individual needs, the police responder is no longer seen as a threat to the subject. One officer provided an example of how he talked through a situation with an individual with a mental illness that he responded to a month prior to the interview:

> We come in. He said, “Hey, I didn’t call the police…I don’t need the police. ….And so I’ll say, “Well, do you think somebody might’ve called the police?” And they’ll say, “Yeah, it could be my brother who lives in Wisconsin called the police.” And, “Why might your brother have called the police?” “Well, ‘cause he thinks I’m trying to kill myself.” “Why would he think [you] are trying to kill yourself?” “Well, because I got fired from my job, and I told him I was gonna take all these pills, but I’m not really serious about it,” and –“well, where are the pills?” And, you know, all that kinda stuff. And then in that case, as an example, the discussion with ‘em, a lot of times, because of our lack of expertise, we’ll say, “Well, you know, what we’d really like is—” you know, “Why don’t you let us help you get to the doctor and get an evaluation from the doctor?”

Several CIT trained officers reported they find it helpful to say, “We know you‘re in crisis.” One CIT trained officer said he likes to ask the individual to sit down and talk to him about what’s wrong. He might ask if the individual wants to take a walk or get some fresh air as a de-escalation technique. Another CIT trained officer replied with the following in response to a question about how CIT influences how she interacts with a person with a mental illness:

> I mean as far as knowing that this person has a mental illness, how to treat them; not to be so much, “Let me just slap some cuffs on this person and get them in the wagon, and get them out of here.” More or less talking to the individual. Some people are coherent enough to say, “Okay, I need to go to the hospital.” Some people have to be involuntarily admitted into the hospital. Knock on wood, I think our success rate has been pretty good. We haven’t had any injuries to the subject or ourselves so that’s how I gauge it.

Effort to listen—Another technique commonly reported by CIT trained officers is making an effort to listen carefully to what the subject is saying. Numerous officers suggested that it is crucial to give individuals with mental illnesses their undivided attention. One officer said, for example, that when she questions a subject who seems uncomfortable sitting, she will invite the subject to adopt a more comfortable position and makes an effort to listen even if the subject is pacing or leaning against the wall. Another CIT trained officer explained that since the CIT training and through his experiences working with individuals with mental illnesses in the community, he learned the value of listening to people’s needs as not only a de-escalation technique but also to know what action to take. He often relays this knowledge to family members of the individuals with mental illnesses. The individual referenced in the example below was a young man that the officer had responded to multiple times.

> Well, I had talked to him before. I had prior dealings. See, I had prior dealings with him, so they know you and I say, “Listen to him.” That’s the main thing you don’t do to people with mental illness. You don’t listen to. If you’re hollering at them, you’re not—you’re so busy running your mouth that your ear’s not open.

CIT officers also recognized that, as one officer put it, “…a lot of times what people want is company or someone to vent to.” Although officers are not able to stay with subjects indefinitely, CIT officers did report that they stay a little longer on calls if needed, in part because they made listening to what the subject had to say such a high priority.

Allowing for sufficient time—One of the biggest differences between CIT and non-CIT trained officers was their discussion surrounding the amount of time appropriate for responding to calls involving mental illness. One CIT officer reported, “we take as long as necessary.” Another CIT trained officer said, “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." CIT officers find that taking their time is necessary in safely and effectively responding to calls involving mental illness as is evident in this example given by a CIT officer.

> At that point, she grabbed a vase and like threatened to throw the vase at us, so we kinda have—we backed off a little bit and after about five minutes she finally calmed down enough that we were able to get in the apartment and I say she calmed down.

One CIT officer did not allow for sufficient time prior to receiving the training. "I think the main thing I've learned is just to give the person more time to kind of assimilate what we're trying to tell them, so I'm a little bit more patient with them than I was initially."

In contrast, a non-CIT trained Lieutenant described a situation she recently had with a man with a mental illness that illustrates his understanding that taking time is less of a priority relative to other response tactics.

> We wanted to get out fast because it [the apartment] was so small but he didn't want to go [to the hospital] …But then there comes a point where you can see it's like beating your head against a brick wall, and you're just going to have to do it [arrest or transport] or you're going to be there all day.

Another non-CIT trained Lieutenant shared that he conducted an investigation of an incident in which one of his CIT trained officers was involved, wherein a man with a mental illness was in a parking lot breaking windshields with his head. The CIT trained officer responded to the call, which took more time than usual because the CIT officer injured himself chasing the subject on foot as he fled the original scene. The non-CIT trained Lieutenant, baffled, asked the CIT officer why he had expended such time and effort, even putting himself in jeopardy in the process. The Lieutenant specifically reported to researchers, "Now in my mind, being non-CIT trained. I couldn't understand why you would chase this person. And the officer explained to me, 'Well, you know, this guy maybe is not really a threat to other persons, but he's definitely a threat to himself; I mean look what he's been doing. Look what he was doing right in from of me. He's running his head through car windows'." In response to the Lieutenant's inquiry, the CIT trained officer explained his concern that the subject was at risk of further harming himself and the officer felt that regardless of time, it was his duty to help the individual because he was in crisis. Persuaded by this reasoning, the Lieutenant reported he now supports the additional time and effort his subordinate officers spend on calls involving mental illness. This example suggests that through diffusion, CIT training may potentially affect the policing practices of not only the trained officers, but their fellow officers and even their commanders.

Disposition

Finally, CIT trained officers identified more options beyond hospitalization and arrest when responding to calls involving individuals with a mental illness than non-CIT trained officers identified. CIT trained officers reported that they not only transport people to the hospital in emergency situations, but that they also respond to non-emergencies by providing people with referrals to community agencies, transportation to the hospital or his/her doctor, and information about helpful programs or services that he/she might benefit from. One CIT trained officer reported:

> You gotta tell them about doing stuff. You're doing that so [you're] referring all the time. It's a referral thing. You keep the peace, but I would say 80% of the time you're referring them to somebody else that can help them. If I can't help directly, I can refer them to somebody else who can.

Non-CIT officers were more likely to find that their options were limited to hospitalization. One non-CIT officer said:

> They [responding officers] have a few options. Your option is you call a wagon, throw them in back of the wagon and take them to the nearest hospital. It's bare minimum, but that's what we have to do because of just the volume of calls. It's outrageous. You can't spend any time with any one person….when they come to the station, it's difficult to know what to do. We take them to [hospitals] …they're back the next day…they don't seem like they're getting any treatment…If just seems like it gets to the point where—I can't say hopeless, but it is hopeless.

Discussion

Individuals with mental illnesses may not respond well to traditional police tactics like verbal commands and use of verbal and/or physical force (Engel et al., 2000). The CIT model utilizes techniques, knowledge, and skills to train officers with alternative response tactics to increase safety, respectful interaction, and to divert people with a mental illness away from the criminal justice system and into mental health treatment (Watson et al., 2008). Little research, however, has investigated the impact the CIT training has on police response to calls involving mental illness. The current study addressed this gap by interviewing CIT trained and non-CIT trained police personnel.

The results of the study suggest that CIT is in fact providing officers with specialized tools to use in calls involving mental illness. The analysis uncovered three specific areas that CIT trained officers demonstrated specialized procedures in comparison to non-CIT trained officers: assessment, response tactics, and disposition. In contrast to non-CIT trained officers, CIT trained officers discussed ways of assessing for potential danger in mental health calls with techniques specific to mental illness. In addition, they reported a broader understanding of the various meanings of exhibited behaviors. CIT trained officers also reported using a number of salient response strategies in practice including the use of talking as a de-escalation technique, listening to the individual's stated needs, and being patient and allowing enough time for the call. Finally, CIT trained officers identified more options when deciding the outcomes of calls. Although most officers found the availability of mental health resources to be limited in their community, CIT trained officers discussed the availability of options beyond arrest and involuntary hospitalizations whereas non-CIT trained officers felt disposition options for individuals with a mental illness were much more limited.

Officers participate in CIT training on a voluntary basis. Thus, some of the effects of CIT training on officer behavior found in the larger study (Watson, et al 2010) might be attributed to self selection into the program. That is, officers who elected to take CIT training may have been motivated to do so by their sensitivity to and concern about mental health issues, and this preexisting difference in motivation may be more important in determining how they approach mental health crises than the actual CIT training itself. However, the findings from this study indicate that officers perceive that CIT training modified the manner in which they respond to mental illness-related calls relative to their non-CIT trained counterparts, and thus suggests specific ways in which the training is effective. Further research is needed to parse out the relative contributions of self selection and CIT training to CIT effectiveness.

The findings have implications for both police practice and policy. The implications of these findings in practice are important for improving safety in police encounters and reducing unnecessary arrests. Specifically, police officer fear of injury and lack of understanding of mental illness are linked to aggressions in police encounters (Peirson, 1976). Research also

shows that the manner in which the police approach and interact with individuals with a mental illness can impact the disposition, use of force, and safety of all parties involved in the call (Ruiz, 1993). CIT provides officers with a training that not only increases their knowledge of mental illness but also gives them tools that can be used in calls to improve their assessments of danger, respond more appropriately to a person who is potentially symptomatic, and determine the appropriate action for the individual. Having increased knowledge and skills is likely to give officers more confidence in their ability to mange calls involving mental illness and improve safety for officers and civilians. The findings from the current study also provide support to continue funding specialized response programs like CIT. As police departments continue to be first responders, there is a political obligation to ensure officers have tools to utilize when responding to individuals in crisis.

Limitations

This study was a small scale, qualitative investigation designed to identify specialized response tactics utilized by CIT trained officers. The findings might not generalize to districts outside of Chicago. Further, the approach to analysis utilized does not allow for researchers to make causal conclusions that CIT caused trained officers to respond in specialized ways. The current investigation asserts that CIT trained officers discussed specialized responses that were not discussed by non-CIT trained officers. Although the current study is useful for contextualizing an intervention, investigations with small samples require replication and further testing using a range of research designs. In addition, it is possible that the four districts chosen for study were unusually receptive to a training innovation. Thus, additional work is needed to determine how the CIT intervention would impact officer response in districts with lower motivation to find strategies for working more effectively with people who have serious mental illness.

Conclusions

Our findings suggest that CIT training influences the ability of police officers to resolve encounters with citizens with mental illness using force less frequently and to appropriately link these individuals with services rather than unnecessarily arresting them. By collaborating with police departments in the development and implementation of such programs, social workers, treatment providers, mental health professionals, other stakeholders possess a unique opportunity to influence whether and how their clients with serious mental illness are treated within a system that has an increasingly prominent role in determining whether they access appropriate treatment.

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Table 1

Sample Demographics (n=20)

Interviewee Characteristics	Type	Percent of Total Sample
Sex	Male	60%
	Female	40%
CIT Trained	Yes	60%
	No	40%
Rank	Officer	50%
	Sergeant	15%
	Lieutenant	25%
	Captain	10%
Watch	1st- Midnights	15%
	2nd- Day	70%
	3rd- Evening	15%
Tenure on police force (in years)	Less than 5	10%
	5 to 10	5%
	11 to 20	35%
	More than 20	50%