AMA Journal of Ethics®

February 2022, Volume 24, Number 2: E154-159

VIEWPOINT: PEER-REVIEWED ARTICLE

Crisis Intervention Team Program Leadership Must Include Psychiatrists

Mark R. Munetz, MD and Natalie Bonfine, PhD

Abstract

Crisis intervention team (CIT) programs are partnerships between police and mental health community members developed with little involvement from psychiatrists. This article argues that psychiatrists should be one of the CIT program leaders to facilitate the transfer of persons in crisis from law enforcement to mental health care, make admission and civil commitment decisions, offer real-time telemedical support to officers or co-responders in the field, and collaborate with first responders in integrating responses to 911 and 988 calls.

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Origins

In 1987, a young Black man with a history of mental illness and armed with a knife was shot and killed by Memphis police officers when he refused to drop his weapon. Following public outcry and substantial community planning, the Memphis crisis intervention team (CIT) model emerged in 1988. CIT involves partnerships among police, mental health professionals, individuals living with mental illness, and their families to prepare volunteer police officers selected to become CIT officers. Trainings include 40 hours of the following content: overviews of mental illnesses and substance use disorders, local mental health service systems, contact with families of and individuals recovering from mental illness, verbal and nonverbal de-escalation strategies, and role playing. CIT programs motivate community safety and officer safety and enable prearrest diversion program development and implementation.[1,2,3,4]

Yet CIT programs have developed with little involvement from psychiatrists. This article argues that psychiatrists should be one of the CIT program leaders to facilitate the transfer of persons in crisis from law enforcement to mental health care, make admission and civil commitment decisions, offer real-time telemedical support to officers or co-responders in the field, and collaborate with first responders in integrating responses to 911 and 988 calls.

CIT Infrastructure

While CIT continues to evolve, concurrent efforts to improve and transform crisis response systems are underway: the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a toolkit of crisis care best practices,[5] the National Association of State Mental Health Program Directors and partners host the Crisis Now website with resources,[6] and both the Treatment Advocacy Center and the National Alliance on Mental Illness recommend that clinicians, not police, respond to crises.[7,8] Recent federal legislation established 988 as a dedicated alternative to calling 911 for crises involving a person with a mental illness,[9] which must be implemented by telecommunication service providers by July 16, 2022.[10,11] Finally, in 2021, $35 million was added to the federal Mental Health Block Grant to be distributed annually by SAMHSA to support states' crisis service integration, infrastructure, care, and implementation costs.[12]

Clinicians (eg, clinical social workers, psychologists, and counselors) have been key to CIT programs' successes. CIT police officers develop relationships with CIT trainers, who include clinicians in crisis centers, hospital emergency departments (EDs), and other mental health services organizations. CIT programs can help transform community safety cultures by forging solidarity among advocates and encouraging trusting relationships among police officers, clinicians, and families of and individuals with mental illness.[13] In the rest of this article, we try to show why psychiatrists' integration into CIT leadership would enable integration of clinical knowledge into CIT training and help more fully integrate CIT operations into crisis responses.

Psychiatrists' Roles

One reason for a lack of psychiatric leadership in CIT programs could be an overall shortage of psychiatrists in the US health care system. Yet as the number of community psychiatry fellowships increases nationally,[14] more psychiatrists may be exposed to and prepared for CIT responsibilities. In addition, a CIT program in Albuquerque, New Mexico, is now a potentially scalable model for how to embed psychiatrists directly within law enforcement to coordinate CIT responses and consultation to community partners.[15]

Psychiatrists can help teach CIT courses that train first responders to recognize a person with mental illness and should assist in CIT program development and implementation, especially in communities that lack psychiatrists. Police officers, specifically, can benefit from direct contact with psychiatrists in CIT program curriculum development, role play planning, and site visits. Trust among officers, psychiatrists, and other clinicians can make case work, field work, and quality assurance run productively and efficiently. Psychiatrists, specifically, can help in the following ways:

1. Implement early intervention programs to coordinate needed specialty care (rather than criminal justice system involvement) in cases involving, for example, persons with first-episode psychosis.
2. Implement evidence-based interventions (eg, assertive community treatment or assisted outpatient treatment) for individuals who should be treated as patients instead of as suspects or perpetrators.
3. Guide postcrisis evaluation, treatment, referrals, and care coordination for patients.
4. Facilitate information sharing as appropriate and educate stakeholders as appropriate about patients' postcrisis care needs, especially in cases in which

involuntary commitment or compassionate force protocols in clinical settings are needed to keep a patient or others safe.[16]
5. Give advice about state and federal policy that governs transportation and transfer of patients from correctional to clinical care environments.
6. Help CIT first responder colleagues navigate field-based or secondary trauma experiences.

Collaboration Promotes Safety

Because crises are complex and require individualized but well-coordinated responses, it's important to acknowledge that CITs might be only one part of an effective overall response to an incident in a community. For example, some crisis call responses require CITs to be augmented by mobile mental health crisis teams,[17] which typically include 2 clinicians (or a clinician paired with a specially trained person living in recovery from mental illness, referred to as a peer). Co-responder models tend to incorporate a CIT police officer and a clinician or peer in the field together[18] to respond to a call or follow up on a prior response to a call.[19,20]

Compared to police-only responses, having clinician partners in the field facilitates interagency collaboration and communication, improves de-escalation success, and increases the likelihood of a preferable outcome for an individual experiencing crisis.[21] Many crises can be resolved on scene, but some require transportation of patients to a crisis assessment center or hospital ED and therefore involve emergency medical system (EMS) personnel, such as paramedics or emergency medical technicians (EMTs), and nurses. Additionally, EMS personnel often work for fire departments or other local government units, are responsive to a medical director official, and follow well-established emergency response protocols that streamline transfers of patients to hospital EDs. For example, EMTs in the field are supervised remotely, make decisions based on protocols, and initiate transportation of a patient to an ED. Like emergency physicians' work with EMS personnel,[25] psychiatrists can help supervise field-based decision making to optimize CIT programs' contributions to effective crisis responses, by using innovative video technology either in real time[26] or to create a network for continuing education (eg, CIT ECHO) to respond to people in crisis.[27] Moreover, psychiatrists can help forge community trust and collaborative responses to 911 and 988 calls as implementation of 988 call centers, as well as service integration of 911 and 988, continues in the United States.

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Mark R. Munetz, MD is a community psychiatrist and professor and chair emeritus at Northeast Ohio Medical University (NEOMED) in Rootstown. Dr Munetz oversaw the Ohio Criminal Justice Coordinating Center of Excellence at NEOMED, which serves as a statewide technical assistance and training center for jail diversion alternatives, and was a founding board member of CIT International and a co-developer of the Sequential Intercept Model, a framework to assist communities in addressing the overrepresentation of people with serious mental illness in the criminal justice system.

Natalie Bonfine, PhD is a medical sociologist and associate professor of psychiatry at Northeast Ohio Medical University in Rootstown. Her primary area of research is the overrepresentation of people with mental illness in the criminal justice system and its impact at the individual and systems level. She also studies jail diversion alternatives for people with severe mental illness and is interested in interdisciplinary and cross-systems collaboration and coordination of care, services, and responses to meet the needs of people with mental illness.

Citation
AMA J Ethics. 2022;24(2):E154-159.

DOI
10.1001/amajethics.2022.154.

Conflict of Interest Disclosure
The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980