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Abstract

Following the murder of Joseph Dewayne Robinson in 1987 by Memphis, Tennessee police, community and civil organizers collaborated with the Universities of Memphis and Tennessee and the Memphis Police Department to organize Memphis PD's Crisis Intervention Team (CIT). Similar modes of the CIT model have been deployed nationally as a law enforcement-based crisis intervention strategy aiming to reduce lethality in police response to mental health crises. At least 2,700 communities around the United States utilize CIT methodology to provide mental health education and training for police officers, yet statistical evidence of police-related response, injury, and use of force with individuals experiencing mental illness crises undermines the CIT mission and goals. While systematic analyses of CIT training support officer-level outcomes, national police incident data confirms parallels between use of force and injury and individuals experiencing a mental health crisis. As a nationally deployed and largely unstandardized methodology, the CIT model seeks to reduce the risk of injury or death for people experiencing mental illness during emergency police interactions, yet its objective improvements in arrests, officer and citizen injury, and use of force during de-escalations remain unclear.

Introduction

Memphis, Tennessee police responded to a 911 dispatch from Joseph Dewayne Robinson's mother on September 24th, 1987. She reported that her son, who had a history of mental illness and substance abuse, was using drugs, engaging in self-harm, and threatening others (Rogers et al., 2019, p. 2). According to Memphis police on the scene, Robinson did not respond to their verbal cues and lunged at the officers. The officers proceeded to shoot him multiple times. Joseph Dewayne Robinson died on September 24th. He was 27 years old.

In response to Mr. Robinson's murder, community organizers and civil administrators collaborated with the Universities of Memphis and Tennessee and the Memphis Police Department, organizing Memphis PD's Crisis Intervention Team (CIT). Memphis's CIT model sought to reduce lethality in police responses with those experiencing mental and substance abuse disorders. Over 30 years later, similar modes of the CIT model have been deployed nationally as a law enforcement-based crisis intervention strategy. At least 2,700 communities around the US utilize CIT methodology, affirmed to provide mental health education and training for police officers (National Alliance on Mental Illness, n.d.).

University of Memphis researchers within the School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, and CIT Center document the CIT Model's foundations within their 2007 report, "Crisis Intervention Team Core Elements," stating the model's basic goals to "improve officer and consumer safety" and "redirect individuals with mental illness from the judicial system to the healthcare system" (Dupont et al., 2007, p. 3). The report similarly outlines CIT functional roles, training, and curriculum guidelines, stressing the collaborative involvement of external mental health, law enforcement, and social justice advocacy groups in training officers for crisis intervention. Specifically, the sample CIT curriculum encompasses a 40-hour patrol officer training for self-selected officers with lectures, scenario-based and on site de-escalation and mental health training, as well as separate dispatch training (Dupont et al., 2007, p. 14-17). Still, statistical evidence of police-related response, injury, and use of force with individuals experiencing mental illness crises undermines the CIT model mission and goals. Nationally deployed and largely unstandardized, the CIT model seeks to reduce the risk of injury or death for people experiencing mental illness during emergency police interactions, yet its objective improvements in arrests, officer and citizen injury, and use of force during de-escalations are unclear (Rogers et al., 2019).

Counter Arguments

Within longitudinal law enforcement incident studies, the CIT model parallels positive effects on pre-booking jail diversion. One such study analyzed the outcomes of 1,063 incidents involving 180 officers across multiple police departments, with approximately 50% of officers receiving the 40-hour CIT training curriculum. Participating officers demonstrated "increased verbal negotiation" as the highest level of force used during mental health de-escalations; their outcomes also involved higher rates of mental health unit referral and lower rates of arrest (Rogers et al., 2019, p. 5). Despite these positive outcomes, the study found no disparities in use of force between CIT-trained and untrained officers. Without objective evidence of reductions in injury related to CIT training, the incident study fails to affirm CIT efficacy.

When statistically analyzed alongside the "liaison and diversion" and "street triage" interventions within mental health crisis response, the CIT model similarly presents as the best program in reducing re-offending and improving mental health outcomes (Rogers et al., 2019, p. 5). While the "liaison and diversion" approach focuses primarily on diverting individuals to mental health-trained staff, the "street triage" method involves prompt access to mental health services with localized "mobile crisis units" (Rogers et al., 2019, p. 5). Despite their differing interventions and goals, all three programs produce variable positive effects on policing incidents when compared to the untrained control groups within their studies. This study of mental health interventions utilized a screen of 29 databases, allowing researchers to focus their study and narrative synthesis on 23 studies. While researchers found a "positive impact" within the varying interventions, the lack of randomized controlled trials fitting their criteria made further conclusions impossible (Kane et al., 2018). Due to the lack of standardized reporting and measuring tools to assess intervention model efficacy, none of the above models provide objective evidence of improving criminal justice and health outcomes in their specified populations. Without quantitative comparisons demonstrating these outcomes, including reduced arrests and early mental illness identification, the CIT model cannot be accurately assessed as superior to other specialized interventions. Further, the CIT model likely received this positive reputation because it was the only model in the study offering both initial call and response and emergency patient assessments alongside specialized officer and mental health professional intervention (Rogers et al., 2019, p. 6). Within the context of modern police brutality, crisis intervention mechanisms and law enforcement responses must be analyzed longitudinally in their intent, population outreach, and outcomes. Perpetuating positive or ambiguous narratives regarding mental health crisis response overshadows continuous use of force against people experiencing mental health crises.

Systematic analyses of CIT training remain most effective when supporting officer-level outcomes. Qualitative surveys conducted within CIT-trained police bureaus affirm both

officer satisfaction and self-perception of a reduction in use of force. Such surveys reveal that CIT-trained officers perceive themselves as "less likely to escalate to the use of force in a hypothetical mental health crisis encounter" (Rogers et al., 2019, p. 6). Yet, these subjective surveys fall short of evidencing the CIT model success because they bear no greater statistical influence on recorded incidents and outcomes of police de-escalation.

Main Argument

Despite the intentions of the CIT model and its adoption across the country, US police incident data confirms an ugly reality: people with serious mental illnesses constitute a statistically significant percentage of suspects injured in police interaction and involved in use-of-force cases. One study examined a nonrandom sample of nine police departments in moderately sized US cities to understand disparities in experiencing police force and injury for people affected by serious mental illnesses using novel police use of force and suspect injury data from 2011 to 2017. Researchers found that people affected by serious mental illness are 11.6 times more likely to experience police use of force, and 10.7 times more likely to experience police-related injury than those unaffected by mental illness (Laniyonu & Goff, 2021).

While the CIT model sought to improve upon this reality, its implementation continues to elicit underwhelming results. A group of researchers examined the efficacy of the CIT model as implemented by the Portland Police Bureau by utilizing a three-year period of data from 2008 to 2011. 4,211 use-of-force incidents within Portland Police Bureau records revealed that people perceived to have behavioral health disorders are statistically more likely to experience police use of force, despite all responding police engaging in the bureau-wide CIT curriculum (Morabito et al., 2017). Why did the CIT model fail to improve use-of-force outcomes within the Portland Police Bureau? And how are people affected by serious mental illness 10 times more likely to experience this force, despite the rapid uptake of CIT training across the country?

Despite national CIT popularity, larger system and policy-level challenges undermine the model's successful implementation. Insufficient dispatcher training and regulation, inadequate access and availability of psychiatric emergency facilities, and CIT resistance within rural settings are some of the many obstacles presently affecting CIT efficacy throughout the country (Compton et al., 2010). Apart from limited state-wide police forces and their systemic flaws, United States police power resides with individual states.
Testimony recorded in the President's Task Force Report on 21st Century Policing further relayed difficulties with training and equipment for smaller police departments. Small, localized police departments employ the majority of US police officers, and these departments

exhibit limited standardization of protocols and resources. Local municipal boundaries and traditions interfere with the agendas of law enforcement agencies; community outreach to strengthen models like the CIT remains widely overlooked (Rogers et al., 2019, p. 3). The majority of small US police departments seem unable to deploy and operate under a CIT model that aligns with core elements of the Memphis approach, leaving mental health crises de-escalation in the background of policing response.

Meanwhile, both mental health and police militarization stand in the foreground of national politics and culture. Rising police brutality cases throughout the country parallel an increasing demand for universal mental health education and outreach. As these demands go unanswered, individuals affected by serious mental illness live in measurable danger. Regardless of its origins and intentions, the CIT model continues to fail this singular, targeted demographic.

Conclusion

Systematic analyses of the CIT support officer-level outcomes, including officer satisfaction and self-perception of a reduction in use of force. But the CIT model is not intended to appease its police officers. The CIT's foundation seeks to reduce lethality in police response with individuals experiencing mental health crises; the CIT model is meant to protect its citizens (Dupont et al., 2007). On a national level, people affected by serious mental illnesses constitute a statistically significant percentage of suspects both injured in police interaction and involved in use-of-force cases. Police incident data provides evidence suggesting that individuals experiencing severe mental illness are at higher risks for sustaining police-based injury and use of force than people with no perceived mental health disorders. This mixed evidence regarding CIT efficacy inherently concerns the ability of law enforcement to intervene and de-escalate situations involving a mental health crisis.

To see tangible improvements in crisis response, crisis intervention training and reform may take priority in law enforcement and healthcare communities alike. Police officers struggle to serve the individuals of their communities experiencing mental health crises, and use of force and injury statistics bear witness to this struggle. Radical crisis intervention training reform and standardization may address the disparities in police use of force for people experiencing serious mental illness, and training reform necessitates both communal engagement and longitudinal analysis of CIT educational outcomes. Alternative community-based responders can offer collaborative care in crisis intervention and healthcare-oriented insight within educational and training contexts. Responders within emergency response teams, composed of licensed counselors, clinical social workers, physicians, and EMTs, can offer specialized de-escalation with the necessary background in mental health crisis response.

Similarly, 911 diversion programs and mobile crisis teams can offer immediate stabilization, support, and treatment referrals for people in crisis, all without imposing risks of physical force and injury. Publicly advocating for and funding crisis intervention reform can prioritize the safety of individuals in mental health crises.

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