



# Practitioner perspectives

Onsite Visits, Case Histories, and State  
and Local Innovations From the  
Bureau of Justice Assistance

**BJA**

Nancy E. Gist, Director

*"I try to visit as much as I can, but Charlie Shift is really busy. There's a little boy, Bobby, 12 years old.*

*Sometimes he gets real angry at things and gets in fights with his little brother. I try to stop in every now and again and make sure things are good, if he's keeping with his medication and trying to work things out. It also shows somebody cares and wants to help him.*

*The parents are real cooperative. They like to see you coming. If there was ever a problem, I'm sure Bobby's mother would call and ask for me."*

—CIT Officer Carl Craig

## Memphis, Tennessee, Police Department's Crisis Intervention Team

By Betsy Vickers

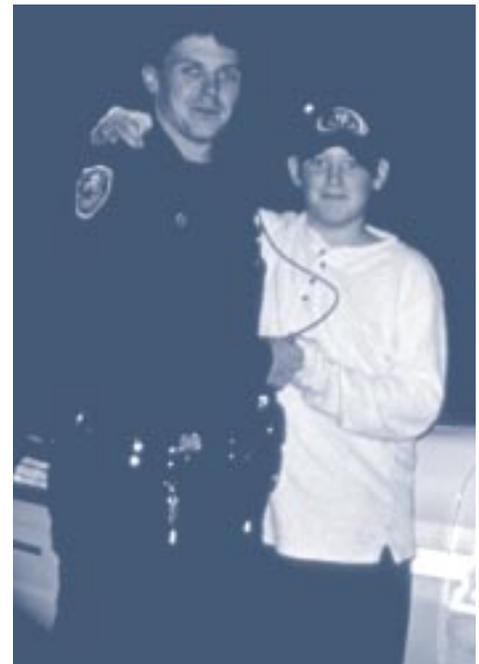
### January 2000, Memphis, TN—Delta Watch: 1700 to 0100: 911 Calls

#### 2100 Call

Three police officers, four firefighters, and two paramedics fill the modest living room that has been decorated with evident pride. Green overstuffed furniture and drapes in lavish folds and swags are accented by clusters of unlit red candles shaped like rose blossoms. Everyone's attention is focused on Eugene, an agitated 17-year-old who sits on the couch. His grandmother, whose perfectly kept house this is, moves about, volubly retelling her story.

#### 2315 Call

In an upper middle-class neighborhood, the front door of the house on a small rise from street level stands wide open, a glowing rectangle of yellow light. On entering, an expanse of polished hardwood and austere furnished rooms creates an



Officer Carl Craig and consumer.

ambiguous impression of a household in the process of becoming or undoing. The ominous stillness is broken by the bounding of a young black Labrador retriever, chased from the back of the house by a man in his midtwenties. Behind them, in the kitchen, a blond, 28-year-old woman, Helena, leans languidly against the

counter, flanked by two paramedics and faced by a police officer.

## The CIT Program

On a day's or night's routine patrol duties, Memphis police officers may respond to a number of dispatch calls before receiving one specifically for a member of the Crisis Intervention Team (CIT). CIT officers are regular patrol officers who have gone through an intensive 40-hour training program to learn how to respond to the mentally ill in crisis. The effective CIT officer is able to respond to and understand the needs of a *consumer*, as mentally ill people are called, and demonstrates sensitivity and caring.

The city of Memphis has seven precincts and nine wards. All 911 calls come into the police department's command center, from which officers are dispatched by precinct and ward. Paramedics and firefighters respond to 911 calls when there is a medical emergency. CIT officers respond to situations having a mental health component.

Because patrol officers are assigned to a specific ward, they know their sector intimately. They are familiar with both its law-abiding citizens and its lawbreakers. They can identify the substance abusers and the chronically mentally ill. Calming consumers in emotionally explosive situations that

could erupt into violence is their job. Sometimes a calming influence is all that is needed; other times a consumer must be hospitalized. The CIT program works because of the police partnership with the University of Tennessee Medical Center, referred to as The Med. At the discretion of CIT officers, consumers may be brought to The Med 24 hours a day, 7 days a week. With access to an organized reception facility, emergency medical and psychiatric units, and criminal medical/psychiatric treatment areas, CIT officers can leave consumers in capable hands and be back on patrol within 15 minutes.

The Memphis CIT program is gaining recognition throughout the United States. Several cities—Albuquerque, New Mexico; Portland, Oregon; San Jose, California; Seattle, Washington; and Waterloo, Iowa—have already put in place response programs based on the Memphis model, and requests arrive daily from all over the United States for CIT training information.

The goals of the CIT are to provide immediate response to and management of situations where the mentally ill are in a state of crisis; prevent, reduce, or eliminate injury to both the consumer and the responding police officer; find appropriate care for the consumer; and establish a treatment program that reduces recidivism.

## 2100 Call

Eugene's grandmother explains that he has just spent 13 days in the Memphis Mental Health Institute (MMHI). CIT officers are trained to change a confrontation into a less hostile meeting. As a starting point, Officer Mike Schafer asks Eugene what medication he is taking. He is told Haldol (to treat schizophrenia and other types of psychoses) and Cogentin (to counter the effects of other drugs and help him sleep) for a 30-day trial period. Eugene is to take his medications right before bedtime. This evening he took them early and then wanted to go out with his friends. His grandmother said he couldn't because he had taken his pills, and an argument ensued.

"He was shouting and perspiring so much he soaked right through his clothes," she said. She had made the 911 call because, in the middle of the altercation, Eugene had suffered chest pains. The paramedics have found nothing physically wrong with him.

CIT Officer Schafer asks Eugene for his version of the events. At times, Eugene seems to lose connection, his eyes rolling. His grandmother repeatedly comments on his version until a police officer guides her away. As the crux of the dispute is reached, Eugene jumps up gesticulating and is told firmly to sit back down. He

This series is dedicated to the exploration of vital issues in criminal justice program development and management. Case studies highlight the work of progressive, innovative people and programs in state and local criminal justice systems. Although a case study may include a detailed description of the operational aspects of a program, it is not a scientific program evaluation. Rather, it is a document designed to explore the interaction of factors such as collaboration, politics, resources, culture, and others that play a part in successful public management.

complies and complains about the way the doctor at MMHI looked at him and was reticent about sharing information about his medications. Eugene is desperate for information about his illness.

"I want help," he cries, "but I don't like the medication. I don't feel good. I have chest pains. I need to play basketball so I can get a scholarship to Shelby State. What I want to know is, am I going to be able to run full court if I take the medication?"

Officer Schafer explains that he must take the medication before bedtime, because it will help him sleep. After 30 days his prescription would be reevaluated. As he speaks, he checks with Eugene to make sure he is listening and understands. He also advises Eugene to listen to his grandmother. He lives in her house, and she has his best interests at heart. Back in the patrol car, he shakes his head at the poignancy of Eugene's concerns.



*CIT Officer Mike Schafer in patrol car accessing computer.*

## 2315 Call

Sleepy, depressed, Helena responds slowly and with tonal flatness to Officer Schafer's questions as he establishes the chain of the evening's events. She had been out drinking at a neighborhood bar with her husband.

Arriving home, she took a large quantity of her husband's antibiotics, Cephalexin, washed down with vodka. The nearly empty bottle stands on the counter. Initially, her husband had no idea his wife was in distress, and he is still off balance. It is he who called 911. One of the other officers takes him to another room to ask about his version of events and allow Helena the privacy to speak her mind.

Officer Schafer asks Helena why she took the pills. She replies, "I'm tired of life. Life is so heavy."

"Did something happen between you and your husband?"

Helena shakes her head as Officer Schafer explains that she will have to be taken to The Med. She does not want to go and says she feels fine. He says evenly that it is no longer her choice, "Once the paramedics are called, you must go and be examined."

When The Med is the destination, a CIT officer will either take the consumer in the patrol car or meet the ambulance there. Put on the stretcher for the ride, Helena is rolled into the emergency room (ER). She is now shaking. Officer Schafer signs her in as a medical team takes over. Within 20 minutes he is sitting in the patrol car completing the paperwork.

## Why the CIT Was Born

The deinstitutionalization of the mentally ill in the 1960s, requiring the release of nonviolent patients was laudable in theory. Release back into the community, the resultant downsizing of mental health institutions, and

the development of drug therapies were heralded by rights advocates. The money saved by hospital closings was to be put into outpatient community programs.

Unfortunately, the money did not end up in the community. Instead, states rebudgeted the savings, and many mentally ill people found themselves without appropriate social services and support systems. Without monitoring, many stopped taking their medication, while others continued with medications that had severe side effects and quickly became outmoded. This resulted in many unstable individuals living in the community with their families who were unprepared for the role of caretaker, or in the too few halfway houses and group homes, or on the street.

When people with mental illness became psychotic, quality-of-life initiatives in the community led to some rough handling. The police were most commonly called and, as Mary Zdanowicz of the Treatment Advocacy Center (TAC) observed, "Officers were serving as frontline mental health workers."

As is often the case, it took a crisis, a shocking incident, and the ensuing public outcry to crystallize existing efforts into solutions in Memphis. The city, with a population of 630,000, demonstrates enormous civic pride. Evidence is everywhere of a small town still trying to recover from the devastating effects of the flight of middle-class whites by trading on its tradition of Delta blues, the music and watering holes of Beale Street, the reputation of its regional cuisine, and the ongoing attraction of its favorite son, Elvis Presley.



*Police Director Walter Crews with CIT Coordinator Lt. Sam Cochran.*

As part of its contemporary face, Memphis is involved in business attraction efforts. A number of downtown office and bank buildings, including a new police headquarters and courthouse, have been built and others are being renovated. Parts of downtown have a barren quality, suffering from the wrecking ball of urban renewal before new construction comes in to fill the gaps.

Another Memphis fans out from the downtown restoration. Half of the city's population is African American, the majority living at the poverty level. There is little neighborhood integration, and black and white residential areas are insular and separated.

In September 1987, against this polarized backdrop, some white Memphis police officers answered a 911 call. A young African-American man with a history of mental illness was cutting himself with a knife and threatening suicide. Police officers are trained to respond with deadly force when they perceive their lives are in danger. At the outset of the

incident, it appeared that the only life in danger was the young man's from self-inflicted wounds. As they were trained to do at the time, officers at the scene confronted the man and demanded he drop his weapon. At this, he became more upset and ran at the officers who, in fear for their own safety, opened fire and killed him.

Although the welfare of both officers and the mentally ill in situations of confrontation had been a concern for some time, this death, with its racial overtones, was the catalyst that resulted in the creation of CIT a year later.

## **CIT's Formation**

The public outcry in the aftermath of the shooting caused the mayor to establish a task force. He enlisted the input of the police, the heads of the psychology department and the medical center at the University of Tennessee, the head of the psychology department of the board of education, representatives from the University of Memphis and the National Alliance for the Mentally Ill (NAMI), the managers of mental health facilities in Memphis, and local citizens. This group was charged with finding ways to prevent such tragedies in the future.

"The mayor was really smart by making it a community thing and keeping it simple," said CIT Coordinator Lt. Sam Cochran. "He said he wanted the task force to come back with a program that would provide safety for the officers, for the mental health consumers, and for their family members. That was generic, mutual ground. Who could be against that?"

When you are talking about system changes—government and private institution changes—you are going to need some political clout. The mayor gave that to the task force. As this thing grew, partnerships grew. At some point money was going to come into it, but it was clearly put down that this was not to be about money, but about the community."

At the time of the shooting, Police Director Walter Crews was in charge of hostage negotiation and was asked to join the task force. He recalled, "Back then if a mentally ill person was violent when the police arrived, it usually ended up with the consumer and the police being injured. What we tried to do was look at a plan that would allow us to insert a tool that would help us, as a police agency, bring the consumer under control, which was a diversion from our normal tactic. I knew immediately that education and technology would be the keystone."

## **A Partnership Program**

Without a committed partnership among the constituents affected by the needs of the mentally ill, no program will get off the ground, much less succeed. In Memphis, those constituents are the families of the mentally ill, law enforcement agencies, emergency medical/psychiatric services, regional short- and long-term receiving hospitals, and the consumers themselves.

## **Families of People With Mental Illness**

The concept of CIT was formed in 1983 when NAMI Memphis, a local

division of the National Alliance for the Mentally Ill, held its first meeting. The initially small group consisted of parents of mentally ill children who found they could not get the help they needed for their children and themselves from the police, state agencies, or mental health facilities. They became activists and had a hand in revising the Tennessee state code covering mental health. Today, some family members regularly assist instructors teaching the 40-hour CIT officer training program.

### **Law Enforcement Agencies: Memphis Police Department CIT**

The Memphis Police Department employs some 900 uniform patrol officers. Of that total, 213 are CIT patrol officers. Efforts have been made to have a diverse staff: 112 officers are white men, 11 are white women, 62 are black men, 27 are black women, and 1 officer is an Hispanic male.

As well as overseeing the Hostage Negotiation Team and Critical Incident Services, Lt. Cochran coordinates the Crisis Investigation Bureau. He has held this position for the past 10 years, and his leadership has shaped the program. For Lt. Cochran, the CIT program is so close to a calling that his evangelical zeal galvanizes the officers who work in the program.

Because the financial incentive to be a CIT officer is small (\$45 a month extra), Lt. Cochran does everything he can to encourage and reward his people. He is in regular contact with the officers, both in person and through a newsletter that offers the

latest information on dealing with consumers, points them to published recognition of CIT activities, and notifies them of upcoming inservice training. Other rewards are a CIT identifying pin, an annual NAMI awards dinners, written commendations for outstanding service, and a chance for a promising officer to assist Lt. Cochran for a few months and learn the administrative side of the program. This sort of attention sets CIT personnel apart from their fellow officers, promotes camaraderie, and allows them to see themselves as a specialized unit.

### **Emergency Medical/Psychiatric Services Staff: The Med**

#### **The University of Tennessee Medical Center Psychiatric Unit**

Dr. Kendall Vitulli, Medical Director

Dr. Marie Tobin, Staff Psychiatrist  
Psychotropic Medicines

Dr. Randy Dupont, Head of  
Psychiatric Services

- ◆ 400–500 psychiatric ER admissions for evaluation per month.
- ◆ 350 brought in by CIT officers.
- ◆ 40–50 percent new patients.

Without The Med's open-door policy, the CIT program would not work. The synergistic system is designed to admit within 15 minutes whoever is brought in by the police. The quick transfer from officers to the mental health facility is considered the key

to the program's success. It is also noteworthy that without the agreement of all entities in the health services on The Med's clearinghouse role, turf wars could break out among hospitals looking for their share of regional patients requiring care.

Guided by state statute, CIT officers make the judgment in the field whether a consumer is dangerous to himself or others and if transport to The Med is appropriate. At The Med, the consumer is placed in protective custody with no charges, after which the doctors decide if the consumer should be transferred to the state hospital or guided to another solution. These solutions involve referral to various community resources, such as medical detoxification programs, mental health centers, rehabilitation programs, and social service agencies.

The medical component serves the following critical functions:

- ◆ It ensures cooperation among the advocates; the medical, psychological, and psychiatric communities; the police department; and the state hospitals.
- ◆ It protects against dumping—misrepresenting the situation to off-load the consumer in trouble.
- ◆ It gives doctors the time to assess patients—extremely important with co-occurring substance abuse and mental health disorders.
- ◆ It provides appropriate patient care:
  - Treating medical problems.
  - Restarting medication and releasing to current living situation or finding a new one.

- Placing in a short- or long-term care mental hospital.
- Offering rehabilitative care.
- Arranging for continuous care services.
- Assigning a case manager.

“All parts of the system encourage the flow to come through here and not the jail, and that’s the bottom line,” said Dr. Randy Dupont, head of The Med’s psychiatric services. “If this doesn’t turn out to be mental illness, but turns out to be alcohol or drugs, or dementia in the elderly, that’s our problem. This is still a health-care issue, but we are not going to try to figure that out at the door.”

Dr. Dupont observed, “Most crisis facilities’ failings happen because they are underfunded, so they tend to start to restrict the doorway. Pretty soon there are facilities that will not take the handicapped, will not take the blind, the mentally ill, or those under the influence of alcohol and drugs. If I were a police officer, I would be asking, ‘Well what do you take?’ We are going to take all comers, and will sort it out. If it turns out to be a complicated medical problem which needs surgery, we can take that too. I think our ability to take care of the range of needs is what is impressive.”

### ***The Consumers***

Officer Stacey LaMondue, 1998 CIT Officer of the Year, exemplifies the dedication and caring for consumers required of CIT work. She perceives herself as a first responder whose job is meeting people, learning their needs, and acting as a referral source. When her regular duties allow, she

visits the consumers in her ward. Because she works the 0700 to 1500 Bravo Watch, she is better situated to do this than officers on nighttime shifts. One of the reasons she visits is that regularly interacting with “her” consumers allows them to feel comfortable calling her if they have a question, need help obtaining a service, or sense they are about to have an episode.

“A lot of people think they can only call us when it is totally out of control,” said Officer LaMondue. “I would rather come when things aren’t full blown. Many consumers do have presence of mind. I hadn’t seen Alvin in a couple of years and last week, he calls and says the voices are coming back up on the TV, telling him to walk here and there. They can call a police officer in their area and this is someone with whom they’ve established rapport and might be readily available. If they call the hospital they’ve got to leave a message, be put on hold, or hear an unfriendly or strange voice on the phone.”

A fellow CIT officer reported to her that he had seen one of her



*CIT Officer Stacey LaMondue visits a group home.*

consumers wearing a bottle cap pretending it was a CIT pin. When she heard this, she stopped by police headquarters to pick up a CIT pin, drove out to the group home where he lives, and ceremoniously pinned on the badge. That same visit, she helped another consumer negotiate with the head of the home over how much spending money he should have from his disability check and waited while he telephoned his case-worker for information.

When asked if she ever felt fear around consumers, Officer LaMondue replied, “If an officer tells you they are never afraid, they’re lying. You need some fear to survive. With some consumers, the delusion has taken over and you can’t break through. This person doesn’t see you as you but as whoever the aggressor is in their delusion, and may attack you. So I can be in control of the situation where I have total compliance one second and lose it the next just because of a delusion. You have to be aware and prepared. I can’t have bad days because I have to be responsible for myself, my coworkers on the scene, and the consumer. And we all have to get in and out safely. If it goes wrong, it’s my fault.”

### **Success Depends on Training**

#### ***CIT Training at the Memphis Police Training Academy***

Lt. Cochran insists there is no magic to the training program he helped devise for his CIT officers. He is proud that officers readily complete the 40-hour training program in

addition to the annual week of inservice training required for all police officers. After that, CIT officers receive another 8 hours of specialized training.

Perhaps the most important aspect of the program is that the instructors' involvement is on an in-kind basis. Each partner agency donates instructional staff. Because of the instructors' volunteer status, the sense of ownership of and investment in the success of the program is enhanced.

The training consists of fundamentals in recognizing mental illness; instructions on psychotropic medications; small-group visits to Veterans' Administration and state mental hospitals facilitated by NAMI members; visits to patients' homes; a tour of Lowenstein House, where consumers learn job skills; crisis deescalation skills; and defense weapons training. There are more than 9 hours of role playing, with distinctive goals and objectives, in which seasoned CIT officers participate.

### **Health Professionals**

It was not smooth sailing in the early days. The task force had developed a training program, but Lt. Cochran said that when the health professionals came in to teach, "it was like cats and dogs. We thought what they said about how to handle the mentally ill and people who were acting out high on drugs was the stupidest stuff we ever heard. We were saying, how are you going to handle these big men? And they just [heard police ignorance of the consumers' reality]. The truth of the matter is we didn't know each other. We were polite, but when it came down to it, both sides had their

prejudices and preconceived ideas about how the others did or didn't do their duties. We said, 'We gotta get these health people into the cars so they can see, so the officers can have some credibility.' " Mutual education took place, and understanding and a sense of partnership grew.

Dr. Dupont starts the training week by introducing some rudimentary diagnostic concepts and showing videotapes of consumers with diagnostic mental illnesses—such as depression, bipolar disease, schizophrenia, and obsessive compulsive disorder—to teach the officers how to recognize the illnesses. He discusses acting out on delusions and how alcohol/drugs exacerbate behavior.

Dr. Maria Tobin, a staff psychiatrist, lectures on psychotropic medicines. She said, "Most students' eyes kind of glaze over after you mention the first medicine, but I give it a shot. We use Dr. Dupont's videos of particular diagnoses that they have seen before. Afterwards they know what medicines you might find lying around when they go into a consumer's house. I think the officers quite like having this knowledge; it empowers them."

Speaking a common language with the doctors gives officers the ability to report on the medications prescribed and to assess and describe a consumer's condition. When they arrive at The Med, this information is invaluable to the doctors.

"If, for instance, the officer reports the consumer has said, 'I have the devil riding on my back,' this indicates psychosis to us," said Dr. Tobin.

### **Weapons**

Sometimes reasoning alone cannot diffuse a crisis. A consumer in the grip of a psychotic episode can be surprisingly powerful. Officers are trained to keep their distance. If a deadly weapon is in the hands of the person in crisis, the danger is magnified.

Over time, police have tried various methods to subdue consumers from a safe distance. The taser gun shoots two darts that provide high-voltage but low-amperage shock on contact and cause the person to fall to the ground. At times, someone in the grip of psychosis will have an unusual resistance to shock and a high tolerance for pain. In addition, an individual living on the street may be wearing many layers of clothing, which the darts cannot penetrate.

Pepper spray also has proved to have limited effectiveness in the same circumstances and must be sprayed at a close range. Pepper foam is more concentrated, but again must be discharged at a possibly unsafe distance, particularly if the consumer has a weapon. Given the goals of using the minimum amount of force necessary for officers to accomplish their duties and ensuring that neither the officer nor consumer be injured while the situation is brought under control, a better method had to be found.

The solution was the Impact Delivery System (IDS), specifically the Sage Less-Lethal Launcher (SL-6). The IDS is designed for a contained situation, one in which negotiation has failed and the consumer, in danger of harming oneself or others, must be immobilized in a nonlethal way.



*IDS training officer Lt. Joe Ruff on firing range.*

Police have rarely had to fire it. The visual intimidation factor when the IDS is produced is often enough to convince someone to be reasonable.

IDS is an imposing 10.6-pound rifle with a large ammunition canister, giving it the appearance of a modern-day Tommy gun. The IDS' cartridge is a 37mm rubber baton that travels at 140 miles per hour when launched and has both near- and far-firing impact capabilities. Each launcher costs \$1,500. The need for IDS is what involved the Bureau of Justice Assistance (BJA) in the CIT program. The Memphis Police Department applied to BJA under the Local Law Enforcement Block Grants Program. The department received money for 12 IDS launchers and cases, a number of rubber projectiles, and baton reloaders. The police department has since purchased more launchers, providing two IDS per precinct.

Police officers who show up at a volatile scene follow a use-of-force

continuum. CIT officers must not only know the stages of the continuum, but also learn and use communication techniques designed to keep a situation from escalating up the continuum. These stages of the use of force are spelled out in training and are learned in practice. Officers develop their own methods and find an area of specialization in which they feel most skilled.

“The reason all officers can't be CIT trained and certified is that not all have it in them to be compassionate, especially with the mentally ill,” said Officer Schafer. “If somebody's just completely out of this world, you've got to learn how to talk them down, talk them into the handcuffs and into the back seat of the squad car. A police officer in uniform wearing a gun and a badge can look intimidating. I begin by telling them I am Officer Schafer and to call me Mike.”

A recent incident in which IDS might have been used illustrates the value of CIT training. Officer Schafer tells of a man, upset over a relationship, who had gotten a gun and was threatening to kill himself. “It's really dark. I am behind a 7- or 8-foot fence looking through a little crack, and he's on the back porch. I was scared to death. He could have shot through the fence. First he didn't want to talk. He was asking for a police officer he knew, and I continually said, ‘I will try to get in touch with him, but will you do me a favor and lay down the gun?’ But he didn't want to get separated from it. I told him we could not locate that officer, but we were trying. You never want to lie, because not only could that particular situation go bad if you lie, but you may have to answer a call there again. I don't care

## Use-of-Force Continuum

1. Physical presence.
2. Verbal warning.
3. Verbal command.
4. Chemical weapon.
5. Hands-on control (soft hands/hard hands).
6. Impact weapons.
7. Deadly force.

if they are paranoid schizophrenic, manic, it doesn't matter—that is in the training.”

Officer Schafer continued, “He was concerned that I was going to have to handcuff him like a criminal. I said, ‘Anyone, I don't care if it's the President of the United States, my policies and procedures say if you are in my back seat, I've got to handcuff you.’ But because he was embarrassed, I agreed to cuff him in front. Finally he put down the gun, I put him in the car, and was gone. I let other officers handle the gun. I took him to The Med because he had been talking suicide. With people like that, it feels good because you made a difference.”

## Effects of the Program

### *Jail*

Before the CIT program, officers responding to disturbing-the-peace or misdemeanor calls would take the citizen directly to jail. This cast the homeless, mentally ill, alcoholics, and drug abusers together; created an unsafe mix; and clogged the court

system. Now, people with mental illness who have committed a misdemeanor or caused a disturbance go to jail only if they are considered by the officer to be responsible for their own behavior. Otherwise they are transported to The Med.

The jail accommodates between 400 and 700 prisoners. In Dr. Dupont's view, screening by the medical service at the jail is not the best place to establish if someone is mentally ill. They lack the resources to track those with a past history of mental illness. When someone is brought to jail drunk or on drugs, that condition may mask serious mental illness. When the person regains sobriety, he or she may be in full psychosis and dangerous to other prisoners.

With CIT training, officers are able to recognize mental illness and provide transport to The Med for triage. As a result, conditions have improved at the jail by reducing the number of mentally ill individuals arrested. Dr. Dupont acknowledges the importance of diverting additional individuals under the influence to The Med instead of bringing them directly to jail because of the increase in alcohol and drug use.

"I am not going to tell you that everything is wonderful in Memphis," said Lt. Cochran. "We have all the problems of other cities. We are making great efforts in getting people into The Med. And even if it is only 72 hours, that 72 hours of care is better than 72 hours in jail."

There is a separate locked facility for injured or ill prisoners at The Med. In the case of less serious crimes,

## Confronting Mental Illness

- ◆ Deinstitutionalization of the mentally ill resulted in many being abandoned.
- ◆ Quality-of-life initiatives often led to mentally ill individuals being arrested to get them off the streets.
- ◆ Jails have become mental hospitals. Nationally there are 250,000 mentally ill prison inmates.
- ◆ 3.5 million Americans are afflicted with severe mental illness.
- ◆ 20 percent of Americans with severe mental illness are also mentally retarded.
- ◆ Mental illness is a disease, not a crime.

Updated statistical information may be found on the NAMI Web site ([www.nami.org](http://www.nami.org)).

once aware of the consumer's psychiatric history, the decision to press charges is often left to the victim.

### New Detox Center

Memphis is close to funding a detoxification unit at The Med. This facility is intended to provide the missing link in the CIT network. It is being put in place for both police and jail personnel who have difficulty making an accurate preliminary diagnosis when alcohol or drugs are involved. The 300 intoxication arrests made each month will be rerouted from the

jail, helping to move the jail out of the role of health-care provider.

### Critics

The Memphis CIT program has few critics, owing largely to its genesis from community action. When all the constituents involved participate in creating the program, they become invested in its success. Funding is always an issue, but it does not have to be an impediment. People who support the CIT program may be protective of funding for their own programs; those whose programs are not funded can be resentful. The CIT program works because it is not about money, but is about belief, ownership, and commitment among the partners.

Although some regular officers may feel that the CIT is a favored group within the department, for the most part they seem to welcome CIT officers' intervention in volatile, emotional situations involving someone not entirely "in reality." When police have been called to a confrontational scene, they clearly see the difference between cases appropriate to CIT handling and commonplace law-breaking confrontations.

### The CIT Program and New Initiatives

When asked what kept the momentum going as the CIT program was evolving, Police Director Crews explained, "We had excellent leadership. Success motivates success. Right now we make about 7,000 calls a year on the mentally ill. And we have seen a dramatic decrease in injury (consumer and police) since 1988. It's not hard to multiply 7,000

by 11 years. CIT has just about put our hostage negotiation team out of business. We've had only two or three hostage situations in the past several years. That's not many if you consider that we make over 73,000 police service calls a month overall."

The Memphis CIT program has had highly beneficial results including:

- ◆ Reduced stigma and perception of danger attached to mental illness.
- ◆ Increased involvement of officers on calls related to mental illness.
- ◆ Reduced use of deadly force.
- ◆ Reduced use of restraints.
- ◆ Fewer injuries to officers and citizens.
- ◆ Greater flexibility in the use of misdemeanor charges.
- ◆ Lower arrest rates.
- ◆ 2½- to 3-percent decline in number of consumers sent to jail.
- ◆ Relief to an overburdened criminal justice system.

The benefits for The Med ER include:

- ◆ Officers' initial report of medical history better prepares doctors and nurses.
- ◆ Officers spend less time in ER.
- ◆ Patient violence has been reduced.
- ◆ The need for acute hospitalization has decreased from 40 to 25 percent.
- ◆ Health-care referrals have increased dramatically.
- ◆ Recidivism has decreased to less than 15 percent after 1 year.



*Drs. Marie Tobin and Kendall Vitulli of The Med.*

All the members of the Memphis partnership believe the program is replicable but must be tailored to the needs of the local community. Dr. Dupont noted, "In larger cities there is so much ingrained heterogeneity in the systems that it's hard to give the police a single source of entry as with The Med. You have to adapt for that. In the smaller city you'd have to create a constellation of municipalities to network into something where you have enough available for a facility, perhaps a countywide draw."

To project success, a community wishing to create a Crisis Intervention Team needs organizational intervention; sufficient political will to change the existing public/governmental mindset and police culture; a mental health emergency system capable of responding to the needs of police; a safe place for consumers that is not jail; and a full understanding of the crisis team concept.

Currently, Lt. Cochran and Dr. Dupont are helping at least 50 other sites nationwide assess their needs. Representatives of law enforcement

agencies from all over the country have been to Memphis, and requests for site visits from scores more come in every day.

## Epilogue

A month after the visit to Memphis for this Bulletin, an incident occurred that received national news media attention. Responding to a 911 fire call, two firefighters and a sheriff's deputy were shot and killed by a man who had murdered his wife. In a telephone conversation about the incident, Lt. Cochran was asked if CIT officers had been involved.

"No, they weren't," Lt. Cochran said. "It was an ambush situation; the whole thing happened in a matter of seconds."

"I'll tell you what though," Lt. Cochran continued, "last night CIT was called to a Kroger's grocery store. A man who had refused to leave was by the bakery section shouting. His attention was all over the place. When the police arrived, he pulled out two pairs of long-bladed scissors. Holding a pair in each hand, he started yelling, 'Kill me, Kill me!' at the officers. They tried talking to him, and that didn't work. They tried pepper spray, and that didn't work. Finally when he started coming at them waving the scissors saying, 'If you won't kill me, I'll kill you,' from about 8 feet an officer shot him in the leg with one of the IDS lesser energy rounds. He fell down, and they were able to subdue him and get him to The Med. Now that's the way the Impact Delivery System is supposed to work. It saved a life."

*Consumers' names have been changed.*

## For More Information

For more information about the CIT program, contact:

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Treatment Advocacy Center  
3300 North Fairfax Drive, Suite 220  
Arlington, VA 22201  
703-294-6001  
Fax: 703-294-6010  
World Wide Web: [www.psychlaws.org](http://www.psychlaws.org)

National Alliance for the Mentally Ill  
Colonial Place Three  
2107 Wilson Boulevard, Suite 300  
Arlington, VA 22201-3042  
1-800-950-6264  
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World Wide Web: [www.nami.org](http://www.nami.org)

For more information about the Bureau of Justice Assistance and its programs, contact:

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Clearinghouse staff are available Monday through Friday, 8:30 a.m. to 7 p.m. eastern time. Ask to be placed on the BJA mailing list.

U.S. Department of Justice Response Center  
1-800-421-6770 or 202-307-1480

Response Center staff are available Monday through Friday, 9 a.m. to 5 p.m. eastern time.

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