



2014

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### Recommended Citation

Douglas, AV and AJ Lurigio. "Juvenile crisis intervention teams (CITs): a qualitative description of current programs" in *Police Journal: Theory, Practice, and Principles* 87(2), 2014.

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# Juvenile Crisis Intervention Teams (CITs): A Qualitative Description of Current Programmes

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**Keywords:** J-CITs; Crisis Intervention Teams; juveniles with mental illness; juvenile justice system; criminalisation of mental illness

**Abstract:** This article describes one of the newest, most specialised law enforcement programmes in the United States: Crisis Intervention Teams (CITs) for youth with mental illness. In response to the fragmentation of behavioural healthcare services in the educational, juvenile justice and mental health systems, Juvenile-CITs (J-CITs) have been implemented in a handful of jurisdictions to serve as an intervention for troubled and troublesome adolescents in need of mental health care. Information about J-CITs is limited; little has been written about such programmes, and no published studies have examined their effectiveness. Hence the present study was undertaken to identify all of the currently operational J-CITs in the United States. We conducted structured telephone interviews in order to gather qualitative data regarding the philosophy, origins, operations and components of each J-CIT. We afford an early look at several J-CIT programmes in diverse geographic areas. We conclude with observations concerning the role of such programmes in a law enforcement as well as the challenges that police departments are likely to face in the implementation and maintenance of such initiatives.

## Introduction

This article describes one of the newest, most specialised law enforcement programmes in the United States: Crisis Intervention Teams (CITs) for youth with mental illness. Such programmes are designed to ensure that youth with mental illness receive the assessment and treatment services necessary to prevent recidivism and further penetration into the juvenile and criminal justice systems. The failure to provide seriously distressed youth with coordinated, integrated and comprehensive assessment and treatment services exacerbates their psychiatric disorders and increases the likelihood that they will become entrenched in the juvenile and adult criminal justice systems (Boesky, 2002). J-CITs appear to offer a promising strategy for brokering effective care for delinquent or criminally involved juveniles with mental illness. The current study is the first to examine the nature of these programmes.

## Background

### *Mental Illness among Youth*

Since 1990, the number of juveniles diagnosed with mental illness has dramatically risen in the United States (Conrad, 2007). Despite increases in diagnosis and prescriptions for psychiatric disorders, a considerable number of adolescents with mental illness remain undiagnosed and untreated (Gruttadaro & Miller, 2004). Studies have shown that fewer than 20% of juveniles with mental illness receive any form of mental health treatment (US Surgeon General, 1999). Furthermore, the shift from public to private care facilities, a shortage of paediatric mental health practitioners and long waiting lists for psychiatric services have resulted in a lack of proper and timely treatment for

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young people with mental illness (Staller, 2008). The inadequacy of the mental health system to serve juveniles with mental illness has caused cases to ‘spill over’ from the psychiatric to the human services sector (Weithorn, 2005).

Overwhelmed by the challenge of diagnosing and treating students with mental illness, school administrators have summoned law enforcement personnel, particularly school resource officers (SROs), to respond to juveniles in mental health crisis (Wald & Losen, 2003). Both school personnel and adolescents’ family members have relied on the justice system for help in controlling the disruptive behaviours of emotionally disturbed adolescents (Rice, 2003; National Alliance for the Mentally Ill [NAMI], 2009). As a result, the juvenile justice system has recently been characterised as the ‘end of the road’ for juveniles with mental illness (Weithorn, 2005).

### ***Police Interactions with Youth with Mental Illness***

Youth with mental illness frequently interact with law enforcement officers because of the threatening, maladaptive and distressing character of their symptoms (Rich, 2009). Under the doctrine of *parens patriae*, law enforcement professionals are accorded the power to intervene in a mental health-related incident, determining the juvenile’s institutional trajectory (e.g. arrest, transportation or referral to mental health facility, or resolution of the matter on the spot) (Lamb et al., 2002). In this role, police officers become the primary gatekeeper for accessing mental health services in the community (Lamb & Weinberger, 1998). In reality, however, the police are greatly restricted in their options for care, because mental health professionals are frequently unwilling or unable to accept law enforcement-initiated mental health referrals (Rogers, 1990).

Limitations in space and staff have reduced the capacity of mental health facilities to accept large numbers of adolescents who the police transport to emergency rooms and other psychiatric facilities. In light of the shortcomings of the mental health system, police officers have turned to the juvenile justice system to obtain psychiatric services for juvenile arrestees (Lamb et al., 2002). With a lack of viable mental health options, police officers have relied increasingly on the juvenile justice system as the best and only mental health care resource for troubled youth (Bostwick, 2010).

### ***Need for Specialised Services***

Juveniles with mental illness are often unresponsive to police officers’ directives because of cognitive and emotional deficits, fear, paranoia, anxiety and a host of other symptoms (NAMI, 2009). Coming into a crisis situation with a traditional law enforcement mindset, police officers can unwittingly aggravate the symptoms of juveniles with mental illness (Strauss et al., 2005; NAMI, 2009). As the distraught youth stubbornly resists complying with the police officer’s orders, the situation can escalate, thereby increasing the likelihood of the use of physical force. The combination of law enforcement personnel without mental health-specific training and the instability of juveniles with mental illness can elevate the risk of bodily harm or death for either the juvenile or law enforcement officer or both (NAMI, 2009). Despite the strong possibility that they will have contact with people with mental illness, law enforcement officers have long recognised that they are unqualified to diagnose or treat psychiatric disorders effectively (Borum, 2000). Police officers’ duty to protect public safety and maintain public order has consistently eclipsed the need to deliver immediate care to people with emotional disturbances (Teplin, 2000).

### ***The Memphis Model***

As a means to bridge the gap between the mental health and criminal justice systems, the Memphis Police Department created and implemented the first CIT programme in the United States in 1988 (Memphis Crisis Intervention Team, n.d.). In collaboration with the University of Tennessee Medical School, the University of Memphis, NAMI and local mental health agencies, the Memphis Model strove to improve police responses and procedures to calls for service that involve people with mental illness, protecting the safety of the officers and civilians in the encounters. The

Memphis Model relies on three key components: community collaboration among mental health providers, law enforcement personnel, family and consumer advocates and other stakeholders; a 40-hour training programme to cultivate the therapeutic skills of law enforcement personnel (e.g. de-escalation and active listening); and consumer and family involvement in the programme's continued development and improvement.

Memphis CIT provides no direct services to people with mental illness; rather, its goal is to refer people with mental illness to appropriate services in the community (e.g. 24/7 drop-offs). Therefore, in incidents that involve minor crimes, Memphis CIT officers divert emotionally disturbed subjects from the criminal justice system and into the mental health system. The overarching goal of the programme is to decriminalise people with mental illness. Indeed, the Memphis CIT's arrest rate of approximately 2% is significantly lower than the average national arrest rate of 20% (Steadman et al., 1999, 2000). In addition, since its inception, Memphis CIT has increased the number of police referrals to mental health centres (Strauss et al., 2005), reduced jail time by an average of two months for people with mental illness and lowered the rates of officer injuries and use of force in calls for service involving the mentally ill (Borum et al., 2000).

Although the Memphis Model has produced consistently positive results in several jurisdictions, to date such programmes have predominately (or exclusively) served adults. Research suggests that effective diversion programmes could also reduce the number of youth with mental illness who enter the juvenile justice system (Cocozza & Skowrya, 2000). Only recently have CIT programmes been created and implemented specifically to serve youth with psychiatric disorders. These programmes take the adult CIT model a step further by establishing the presence of police officers in schools and communities as a mental health resource for emotionally troubled youth. In summary, the role of the trained CIT officer is to assess youth with mental illness, divert them from juvenile and criminal justice processing and refer them to a mental health treatment facility for services.

## **Current Study**

Descriptions of J-CITs are limited; little has been written about such programmes, and no published studies have examined their effectiveness (Douglas & Lurigio, 2010). Hence the present study was undertaken to identify all of the currently operational J-CITs in the United States through an exhaustive Internet search and snowball sampling techniques. After identifying these programmes, we conducted structured telephone interviews in order to gather qualitative data about the philosophy, origins, operations and components of each J-CIT. We afford an early look at several J-CIT programmes in diverse geographic areas. We conclude with observations regarding the role of such programmes in law enforcement as well as the challenges that police departments are likely to face in the implementation and maintenance of such initiatives.

## **Method**

### **Participants**

We obtained the study's data from representatives of all current J-CIT programmes in the United States, which we identified through an exhaustive Internet search and snowball sampling techniques. Respondents were each involved in the programming of one of the eight identified J-CITs, which provide services expressly to juveniles with mental illness. In order to be considered eligible for participation in the research, the J-CIT programme had to be free-standing in its operations; that is, the programme could not be an ancillary unit of an adult CIT programme. The programmes included the Connecticut Alliance to Benefit Law Enforcement (CABLE) in Wallingford, Connecticut; the Children's Crisis Intervention Training (CCIT) programme in San Antonio, Texas; the Child and Adolescent CIT programme in President, Minnesota; the CIT programme for Youth in Denver, Colorado; the CIT programme for

Youth in Salt Lake City, Utah; the Montgomery CIT in Montgomery County, Maryland; the Juvenile CIT programme in Chicago, Illinois; and the Kansas CIT programme in Topeka, Kansas.

As noted above, we identified interviewees by engaging in an exhaustive Internet search and snowball sampling procedures. We asked them to review and sign an informed consent form, which they returned to the research team via email or post. On the informed consent form, interviewees selected one of three levels of confidentiality: identified as the source of the information and listed as the contact person for the programme; identified as the source of the information but not listed as the contact person for the programme; or participated in the survey but not identified as the source of information or listed as the contact person for the programme. The official, programme-related titles of the study participants included executive director, director, coordinator and operations manager.

## ***Survey Instrument and Procedures***

We collected data through semi-structured telephone interviews, which lasted an average of 40 minutes. All identified interviewees participated in the study and completed the interviews, for a 100% participation and completion rate, respectively. We asked a series of 20 open-ended questions that covered the following content domains: the philosophy, mission, development and jurisdiction of the programme; programme implementation, operations, resources and calls for service; programme participants and services; the role of the consumer's family members in the programme; programme training, staffing and volunteers; the characteristics of programme participants; and the evaluation and future of programme operations. Responses to each item were coded into common categories for purposes of description and comparison.

## **Results**

### ***Programme Features and Philosophy***

The basic philosophy and operations of J-CIT programmes are inextricably linked. Their structure and operations are based largely on the original Memphis CIT Model. At the heart of J-CITs are training modules for law enforcement officers, which focus on effective communication techniques (i.e. de-escalation and active listening). The primary purpose of the training is to enhance the safety of both the police officers and juveniles involved in crisis situations and to ensure that adolescents with psychiatric disorders receive follow-up mental health care. As one respondent explained, J-CIT programmes espouse the philosophy that, 'people with serious mental illness need to be treated with dignity and respect'. This philosophy permeates all aspects of the programme and is predicated on the medical model of mental illness, which views psychiatric disorders as chronic but treatable brain diseases. Training prepares programme officers to understand differences between adults and juveniles with mental illness; the essentials of adolescent development; and the policies and procedures of the local mental health system (see below).

As we noted above, J-CITs were spawned from adult CITs. In their basic composition, each J-CIT is highly similar to its adult CIT counterpart, sharing the same goals, operational model and core training components (e.g. diversion, de-escalation and collaboration with mental health providers and the families of consumers). The overarching goal of J-CIT programmes is to divert youth with mental illness from the juvenile justice system and into the mental health system where they can receive treatment and other services that will address their immediate and long-term clinical needs. J-CIT officers view themselves generally as liaisons, spanning the boundaries of the juvenile justice, educational and mental health systems.

### ***Programme Jurisdiction***

The jurisdictions of J-CITs vary in size, scope and authority. One J-CIT programme operated at only the municipal or local level; four J-CIT programmes provided their services statewide. Three programmes were county-wide in their

scope of operations; these J-CITs also accepted into their training programmes police officers, SROs and school administrators from other counties. The directors of the J-CITs that were then operating at a local or county level expressed an interest in expanding their programmes throughout the state. However, many of these programmes lacked the funding or political support needed to do so.

### ***The Origins of the J-CITs***

All respondents reported that no specific incident or tragedy led to the creation of their programme. However, one interviewee noted that the programme was implemented after the police chief observed several instances in which police officers with no training or expertise in mental illness or CIT tactics had ineptly handled encounters with people with mental illness. These incidents resulted in injuries and no mental health treatment referrals for the civilians involved, which prompted the chief to rectify the situation through the development of a J-CIT programme.

Another J-CIT was created as part of a state-wide initiative in juvenile justice reform. To handle the influx of mentally ill youth into the juvenile courts, the state launched a J-CIT programme to divert youth with mental illness away from courts and detention centres and to obtain for them access to psychiatric treatment. The most common reason for programme development – cited by six of the eight respondents – was the pressing need for a mental health training programme for police officers. The law enforcement personnel in these jurisdictions simply recognised that they were unprepared to intervene in crisis situations involving juveniles with mental illness.

The interviewees also observed that police officers on J-CITs were genuinely invested in the well-being of youth and motivated to foster more opportunities for deflecting them from the juvenile justice system. In particular, the SROs wanted to serve students with psychiatric disorders better, and they were aware of the potential of the CIT model to benefit such youth. Due to the nature of their jobs, SROs believed that they were the best law enforcement professionals to serve juveniles in crisis but they had neither the training nor resources to do so. Furthermore, SROs were often unsupported in their diversionary efforts. Hence, a common impetus for the programmes was recognition of the need for mental health services among juveniles with school problems as well as the inability of police officers to address those needs with current training and resources. The creation of J-CITs was also envisioned as a mechanism for decriminalising youth with mental illness.

### ***Reasons Police Officers Join the J-CIT***

Although all J-CITs targeted SROs for training, the programmes are open to all types of law enforcement officers as well as to school administrators, teachers, mental health professionals and community members. All respondents indicated that the majority, if not all, of the J-CIT officers were self-selected and volunteered to undergo specialised CIT training. The majority of respondents also reported that the J-CIT programme attracts law enforcement personnel who are highly suited for the programme because it solicits volunteers instead of assigning officers to the team. Many police officers are drawn to J-CIT training because they have family members with mental illness. Another motivation is that officers felt that they had failed to help juveniles in previous crisis situations and wanted to avoid such failures in the future. The J-CIT provides officers with the knowledge and expertise necessary for handling these situations more effectively and successfully. In short, all respondents reported that their J-CIT officers ultimately underwent training because they have a personal desire to assist juveniles in crisis.

Focusing on the fragile relationship between the criminal justice, mental health and educational systems, three interviewees stated that J-CIT officers desired to undergo training so that they could better educate school administrators and teachers about the importance of diversionary services for troubled students thereby creating a more collaborative and therapeutic atmosphere for responding to adolescents with psychiatric problems. These officers wanted to cultivate a positive relationship between the police department and schools, so that the latter

would be more open to diversionary options and less likely to demand legal action as the only avenue for dealing with youth in crises.

### Training Focus and Topics

As shown in Table 1, J-CIT programmes cover similar training topics, such as mental illness among juveniles and its treatment. Based on the Memphis model, trainees are instructed on how to access services in collaboration with mental health providers and consumers’ families. Unlike the adult model, J-CITs emphasise the programme’s critical connection to schools. Programmes train officers on the basic CIT techniques of de-escalation, family intervention and resource brokerage. Several programmes include unique training topics in their curricula. For example, one J-CIT teaches trainees about returning veterans and post-traumatic stress disorder as well as ‘suicide by cop’. A couple of programmes provide exercises to help officers understand at first hand the emotional and cognitive harm caused by auditory hallucinations. Other programmes include the topics of trauma in juveniles; one J-CIT focuses specifically on urban trauma. Another programme discusses Taser protocols, while still another teaches about a condition known as ‘excited delirium syndrome’ as well as the stigma surrounding mental illness.

**Table 1 Reported Training Topics for J-CIT Training Programmes**

CABLE	CCIT	Child and Adolescent CIT	CIT for Youth, Colorado
<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Developmental disorders</li> <li>• Juvenile development</li> <li>• Adolescent brain and normal development</li> <li>• Trauma and trauma in youth</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Working with families, school, mental health system and other resources</li> <li>• Community resource panel</li> <li>• Issues surrounding school protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Behavioural Problems</li> <li>• Developmental Disorders</li> <li>• Juvenile development</li> <li>• Adolescent brain development</li> <li>• Suicide and self-injurious behaviour (QPR)</li> <li>• Substance abuse and co-occurring disorders</li> <li>• Psychotropic medications</li> <li>• Issues surrounding medication</li> <li>• Stigma surrounding MI</li> <li>• Jail diversion and Juvenile diversion (TCLOSE lesson plan)</li> <li>• Juvenile justice issues</li> <li>• Issues surrounding school protocol</li> <li>• Remerging juveniles into school</li> <li>• Juvenile civil commitment laws and emergency detention</li> <li>• Excited delirium</li> <li>• Cultural competency, poverty, diversity awareness</li> <li>• Stages of crisis</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Student role play session</li> <li>• Working with families, school, mental health system and other resources</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Substance abuse</li> <li>• Psychotropic medication</li> <li>• Differential effects of medication</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Working with families, school, mental health system and other resources</li> </ul>	<p><i>4-hour programme</i></p> <ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Juvenile development</li> <li>• Treatment</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Working with families, mental health system and other resources</li> </ul> <p><i>24-hour programme</i></p> <ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Juvenile development</li> <li>• Substance abuse</li> <li>• Treatment</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Working with families, school, mental health system and other resources</li> </ul>

CIT for Youth, SLC	Kansas CIT	Juvenile CIT	Montgomery CIT
<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Developmental disorders</li> <li>• Juvenile development</li> <li>• Adolescent brain development</li> <li>• Developmental influences</li> <li>• Suicide, self-injurious behaviour and intervention strategies</li> <li>• Substance abuse and co-occurring disorders</li> <li>• Treatment</li> <li>• Juvenile civil commitment laws</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Working with families, school, mental health system and other resources</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Personality disorders</li> <li>• Development disorders</li> <li>• Returning veterans and PTSD</li> <li>• Drug trends in juveniles</li> <li>• Illicit and abused drugs</li> <li>• Psychotropic medication</li> <li>• Treating juveniles with severe emotional disorders</li> <li>• Bullying and psychological aspects of bullying on juveniles</li> <li>• Detention centre</li> <li>• Intake protocols</li> <li>• Suicide by cop</li> <li>• Juvenile civil commitment laws and emergency detention</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Working with families, school, mental health system and other resources</li> <li>• Helping families cope</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Developmental disorders</li> <li>• Adolescent brain development</li> <li>• Aural and visual hallucination simulation</li> <li>• Violence and urban trauma</li> <li>• Risk assessment</li> <li>• Substance abuse</li> <li>• Co-occurring disorders</li> <li>• Suicide, self-injurious behaviour, intervention strategies</li> <li>• Psychotropic medications</li> <li>• Department adolescent procedures</li> <li>• JICS project</li> <li>• Remerging juveniles into school</li> <li>• Legal issues</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Working with families, school, mental health system and other resources</li> <li>• Parents and Teachers as Allies</li> </ul>	<ul style="list-style-type: none"> <li>• Juvenile MI</li> <li>• Personality disorders</li> <li>• Developmental disorders</li> <li>• Traumatic brain injuries</li> <li>• Out-of-control adolescents</li> <li>• Distressing voices exercise</li> <li>• Suicide, self-injurious behaviour and intervention strategies</li> <li>• Psychotropic medications</li> <li>• Taser protocol</li> <li>• CIT techniques</li> <li>• Accessing community resources</li> <li>• Community resource panel</li> <li>• Working with families, school, mental health system and other resources</li> </ul>

All but one of the J-CITs have training programmes that are independent from those implemented in the adult CIT programmes. The lone J-CIT that adopts the adult training programme begins each training module with a general overview of mental health issues and then differentiates between juveniles and adults in terms of mental health problems and treatments. J-CITs educate participants regarding juvenile-specific community resources and mental illness by using experts in juvenile mental health problems and services and by conducting training programmes that target SROs and law enforcement personnel who work primarily with juveniles. Nonetheless, these J-CITs also allow other types of law enforcement officer to participate in the training. In addition, two J-CITs programmes invited young actors to play roles in the scenario segment of their training programmes. The decision to include juveniles in the training was controversial because of the highly intensive and realistic nature of the scenarios, which officers thought might be too stressful for young people.



All respondents reported that their training staffs are composed of highly qualified professionals in the juvenile mental health field. The J-CITs' training components are co-led and -delivered by mental health professionals and law enforcement personnel. The mental health professionals primarily specialise in juvenile mental health topics. Training programmes also recruit professionals to teach highly specialised topics. One interviewee indicated that the J-CIT mental health instructors must be approved to teach by the directors of the local Crisis Centre.

The J-CIT training models and materials focus on juveniles with mental illness who are in crisis. Law enforcement officers are instructed on how to work with juveniles in both school and community settings; however, the vast majority of J-CITs' materials are tailored toward the duties and responsibilities of SROs. Interviewees also reported that sessions on cultural competency and awareness – prerequisites in all CIT training programmes – are provided through the J-CIT's or the police academy's training agenda.

The J-CIT programme operations are taught by seasoned CIT police officers. The officer-trainers typically have extensive experience working with juveniles in a school or community setting. Additionally, these instructors have specialised knowledge in a particular training module, as well as proven teaching abilities, which are vetted by the J-CIT coordinators. Respondents indicated that having experienced law enforcement officers on the training staff is greatly appreciated by the programme's trainees. Experienced law enforcement officers are able to relate the usefulness and practicality of J-CIT tactics and apply them to actual situations. In order to provide the best possible instruction to trainees, one J-CIT distributes an evaluation tool to rate each instructor in order to determine which trainers and topics should be retained in future training sessions.

### ***Client Characteristics***

Interviewees provided mostly impressions about the 'typical' juvenile in contact with the J-CIT programme. Nearly half of them reported there was 'no common type' of juvenile. One interviewee noted that the demographic and personal characteristics of juveniles in crisis simply reflect those of the adolescents living in the community. However, it appears that officers are more likely to work with boys than girls. The ages of juveniles who have contact with J-CIT officers ranged from 10 to 17. One interviewee reported that programme officers also encounter young adults in their early twenties because J-CIT personnel are assigned to the local community college. All interviewees agreed that youth in the programme have different clinical and juvenile justice histories. Another interviewee stated that officers were mostly involved in crisis situations with juveniles who have experienced trauma and are now suicidal. This interviewee also stated that due to the school system's recent mainstreaming policy, police officers are interacting increasingly with juveniles who have autism.

### ***Mechanics of Intervening in Crisis Situations***

In or out of school settings, J-CIT officers are most often called to a scene in response to a juvenile who is uttering threats of violence or engaging in violent acts, who is perceived to be uncontrollable. All J-CITs instruct law enforcement officers in a specific crisis intervention protocol. The first step in the crisis intervention process is the emergency dispatch screening of the call to ascertain if the incident involves a juvenile with mental illness. The second step in the crisis intervention process involves dispatching a J-CIT officer to the scene. The third step in the crisis intervention process is to evaluate the juvenile and assess the dangerousness of the situation, which is especially critical in school settings. At this step, the CIT techniques of de-escalation and active listening are imperative. The fifth step in the crisis intervention process, known as follow-up, differs among the programmes. Nonetheless, law enforcement officers are generally instructed to fill out paperwork regarding the aftermath of the incident and recommendations for future interventions.

## ***Role of Family Participation and Services***

Respondents reported that the parents or guardians of juveniles with mental illness play a significant role in the J-CIT panel discussions and role-playing modules that are part of police officer training curriculum. Many of the respondents had participated in the 'Parents, Teachers as Allies' component of NAMI's educational programme in order to gain insight into parents' perspectives and experiences with their children with mental illness. All respondents agreed that the NAMI programme was an invaluable educational resource for law enforcement officers. As we noted above, in order to foster immediacy and verisimilitude in J-CIT training courses, one J-CIT uses students, with the permission of their parents/guardians, to participate in role-playing scenarios.

The majority of respondents indicated that parents and mental health treatment providers are instrumental in the implementation of their J-CIT programmes. For juveniles who have already been diagnosed with a mental illness, these parties collaborate with a programme officer to formulate a tailored intervention plan before a crisis situation escalates into a more serious problem. Although law enforcement officers exercise discretion in crisis situations, the plans provide clear guidance on how to respond to the youth, including specific information on the best placements for services and means for diversion. The overarching goal of implementing crisis intervention plans is to prevent juveniles from experiencing a full-blown crisis and being unnecessarily processed through the juvenile justice system.

J-CIT programmes offer no direct mental health services to juveniles or their families. Rather, J-CITs officers indirectly provide services through a referral process that directs youth and their families to community resources. By educating law enforcement officers, J-CIT programmes are preparing them to educate the wider community about juvenile mental health problems and services. Due to limitations in programme funding and training, these indirect services are usually available only during and immediately following the juvenile's crisis situation.

## ***Obstacles to Programme Implementation***

In general, respondents were hesitant to characterise their programme's challenges as 'obstacles'. As stated by a J-CIT coordinator, 'There were several difficulties, but not obstacles.' The three most commonly cited difficulties were finding time for police officer training; identifying community agencies and referral services, which were willing to coordinate their efforts with the J-CIT; and weaving J-CIT activities into the law enforcement culture. Many J-CITs use SROs, which limits their ability to schedule training sessions. Although summer break is the ideal time for J-CIT training for SROs, participants indicated that they wanted to host more training sessions throughout the year. Restrictions in the number of training sessions were also attributable to the dearth of funding from both the State government and local law enforcement agencies. In hosting the training sessions during the school year, many jurisdictions would have to pay their law enforcement officers overtime to attend the training.

A few respondents explained that police officers are initially hesitant to accept their new roles as service providers for juveniles in crisis situations. A respondent acknowledged that 'A lot of time, police officers think that [a crisis situation] is part of normal development.' Therefore, programme coordinators need to create a programme that is compatible with the prevailing law enforcement culture because, ultimately, this 'is a police diversion programme'. In addition, interviewees reported that it was sometimes difficult to obtain from community agencies, referral services or school administrators a firm commitment to work with the J-CIT programme. Finally, participants reported that their states generally lacked mental health facilities, making it difficult to refer youth and their families to already overcrowded facilities.

## ***Programme Evaluation***

Only two respondents reported that an outside entity was conducting an evaluation of their programmes. Another respondent reported that her J-CIT participated in an external investigation of the programme by supplying

researchers with qualitative information about the programme's operations and participants. Three respondents stated that no evaluation was currently being conducted on their programmes, but they were in the process of collecting data for the informational needs of their police departments or for the accreditation of their programmes. The purpose of these data analyses was to track the outcome of the J-CIT trainees in crisis situations, as well as the effectiveness of the actual training components on trainees' behaviour in the field.

## **Future Goals**

The majority of the participants stated that the future goal of their J-CITs was to continue conducting training sessions, adding more modules to their training curriculum and expanding the model to other jurisdictions in the state. Three respondents reported that programme sustainability is one of their major goals; for all programmes, grant funding is limited in both amount and duration. In addition, three respondents reported that they wanted to expand the number of their training topics and include other professionals who could benefit from J-CIT training (e.g. juvenile probation officers). One programme director reported that he was searching for an outside agency to conduct a process and outcome evaluation of his J-CIT programme.

## **Discussion**

J-CITs are a new police innovation designed to divert youth with mental illness from the juvenile justice system and into the mental health system. Unlike other specialised police programmes, they are aimed at achieving outcomes that are decidedly therapeutic rather than law enforcement-oriented. Historically, the relationship between youth and police officers has been largely hostile and confrontational (Friedman et al., 2004). In contrast, J-CITs consist of police officers *qua* advocates or case managers for adolescents with emotional struggles; the police in these initiatives serve as a bridge that links schools, mental health agencies and police departments in an effort to keep juveniles with mental illness from falling through the interstices that separate these institutions. Without a police presence to direct troubled youth to appropriate service providers, such youth are often arrested, suspended from school and placed in detention centres, where they might receive treatment but at the cost of a criminal or juvenile record that can adversely affect future contacts with law enforcement and court authorities.

Following the lead of other programmes for criminally involved people with mental illness, such as mental health courts and CITs for adults, J-CIT programmes are responsive to the increasing number of mentally ill juveniles who are entering the justice system and require treatment and ancillary services. Such interventions can lower recidivism and slow the progression of chronic, untreated mental illness, which can damage the brains of those afflicted, especially young people with serious psychiatric disorders (Kramer, 2005). Similar to other approaches for dealing with mentally ill people in the criminal justice system, J-CITs programmes recognise the critical need for collaboration with community-based providers and families (Council of State Governments, 2002). Unlike the overwhelming majority of programmes for criminally involved people with mental illness, J-CITs are focused on adolescents and, as such, involve schools and family members in intervention plans.

Although CITs are touted as an effective practice, little controlled research has been conducted to examine their implementation or their impact on rearrest rates. The few studies that have been done on the Memphis Model suggest that it has great promise as a diversionary mechanism for mentally ill adults (Compton et al., 2008) and is effective in changing the mental health-related knowledge, attitudes and perceptions of police officer participants (Wells & Schafer, 2006). Hence, CIT training is valuable in its own right and must be the centrepiece of such initiatives. Nonetheless, the long-term effect of J-CIT interventions on clients has not been established, which is critical because of the chronic nature of serious mental illness and its high co-occurrence with substance use disorders, which leads people to churn through the criminal justice and mental health systems (Lurigio & Swartz, 2000).

Crisis intervention training is a necessary but insufficient condition for the success of J-CIT programmes. To work best, J-CITs must consist of several other components. These include the capacity to assess psychiatric and substance use disorders, medical conditions and educational deficits; dispatcher involvement in screening and evaluating calls; numerous, geographically dispersed drop-off points for services; 'police-friendly' policies in the local mental health system, such as no refusal and a streamlined, rapid intake protocol that allows officers to return quickly to their regular patrol duties; and adequate treatment and other services in the community, which are usually in short supply because of state budgetary shortfalls (Steadman et al., 2001).

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