

Statewide Implementation of the Crisis Intervention Team Program: The Ohio Model

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This column discusses ways that states can implement community-based best practices statewide, by using the crisis intervention team (CIT) model as an example. Although state mental health authorities may want to use a top-down approach to ensure uniform, high-quality implementation, programs may be more likely to succeed if they arise as bottom-up, grassroots innovations. Programs like CIT are especially challenging to implement because they involve collaboration between complex systems and affect multiple stakeholders. The column describes lessons learned in Ohio in hopes of assisting other

states in implementing this and other innovations. (*Psychiatric Services* 57:1569–1571, 2006)

It is challenging for states to implement community-based best practices statewide. Although state mental health authorities may want to use a top-down approach to ensure uniform, high-quality implementation, programs may be more likely to succeed if they arise as bottom-up, grassroots innovations. It may be that the most effective way to implement innovation is to combine elements of unplanned or spontaneous diffusion with directed and managed dissemination of a program (1). Ohio has effectively blended these two approaches to spread evidence-based and other promising practices throughout the state by using Coordinating Centers of Excellence that are spread out throughout the state.

In this column we describe how this approach has led to widespread adoption of the crisis intervention team (CIT) model. Programs like CIT are especially challenging to implement because they involve collaboration between complex systems and affect multiple stakeholders. We will share some lessons we have learned in hopes of assisting other states in implementing this and other innovations.

The CIT program

The CIT program, started in Memphis in 1988, is a partnership between law enforcement, the mental

health system, and consumers of mental health services and their families (2). Police officers volunteer for the program and are trained about mental illness, the mental health system, and how to deescalate a crisis situation involving a person with mental illness. Once trained, CIT officers are first responders to calls involving people with mental illness. The promotion of this program by founders Cochran and DuPont led to early adoption in the 1990s in a few large cities. Recently there have been statewide efforts at dissemination in Colorado, Connecticut, Florida, Georgia, Illinois, and Ohio. The benefits of the CIT program are discussed in the Council of State Governments Mental Health Criminal Justice Consensus Project (3). The National Alliance on Mental Illness (NAMI) is promoting the CIT program as a best practice and has staff dedicated to assist its affiliates nationally in CIT development (4). Emerging evidence of its effectiveness (5,6) may further facilitate adoption of the program.

Beginnings of CIT implementation in Ohio

The Ohio Department of Mental Health saw CIT as a promising program and invited Cochran and DuPont to make a presentation at its 1998 Annual Forensic Conference. Because of Ohio's diverse, decentralized mental health system, the Ohio Department of Mental Health hoped

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one or more counties would become interested in initiating the CIT program. Two counties, Summit (Akron) and Lucas (Toledo), sought additional consultation from the Memphis leaders and began implementing the CIT program in 2000. Akron subsequently began to assist other counties in implementing CIT programs.

In Akron the CIT program started because stakeholder groups came together and planned its development. However, implementation of the program would not have succeeded without leadership in both law enforcement and the mental health system. Both the Akron Police Department and the Summit County mental health authority supported the request of an experienced member of its organization to lead the CIT implementation, which led to a role now known as the CIT coordinator. Coordinators were personally committed to work together to help the program succeed. We have come to believe that without such “champions,” the CIT program is unlikely to succeed.

Ohio's Coordinating Centers of Excellence

Shortly after the CIT program was in place in Akron, the Ohio Department of Mental Health became interested in a method to promulgate and support promising practices. The Ohio Department of Mental Health created a number of Coordinating Centers of Excellence that were to “serve as expert resources providing technical assistance and consultation to improve quality by promoting Best Clinical Practices” (7). The Coordinating Centers of Excellence identify and work with local opinion leaders to shape these practices. The Ohio Department of Mental Health contracted with universities, medical schools, and county mental health boards across the state to develop Coordinating Centers of Excellence that promoted practices such as integrated dual disorder treatment, multisystemic therapy, and supported employment. To promote jail diversion efforts, including CIT, the Ohio Department of Mental Health contracted with the Summit County Alcohol, Drug Addiction

and Mental Health Services Board in May 2001 to develop a Criminal Justice Coordinating Center of Excellence. The center is operated by the Northeastern Ohio Universities College of Medicine.

The Criminal Justice Coordinating Center of Excellence contracts with a law enforcement liaison (MW), whose main role is to assist communities around the state in the planning, implementation, and maintenance of CIT programs. The credibility that an experienced police officer brings to the table appears to be critical in overcoming the inherent skepticism of law enforcement leadership. Once communities decide to adopt the CIT program, in a “train the trainer” model, they are invited to send a team representing law enforcement, mental health, and advocacy groups to the 40-hour CIT course. There is no charge for the course, but local county agencies are responsible for other expenses, such as transportation and lodging.

These efforts have been remarkably successful and involve a relatively small investment of state funds. As of June 2006 there are approximately 1,831 trained CIT officers in Ohio—representing officers in 47 of Ohio's 88 counties—in 151 police departments, 37 county sheriff offices, and 16 Ohio college and university police departments.

The Criminal Justice Coordinating Center of Excellence had two valuable partners who accelerated its efforts. One partner was expected, NAMI Ohio; the other was unexpected, Justice Evelyn Lundberg Stratton of the Ohio Supreme Court. As the Criminal Justice Coordinating Center of Excellence was beginning, Justice Stratton formed the Advisory Committee on Mental Illness and the Courts to encourage the development of mental health courts. Quickly Justice Stratton came to understand the advantage of prearrest diversion programs like CIT and became a strong advocate for collaborations between criminal justice and mental health generally and for CIT programs specifically. Using the bully pulpit afforded a supreme court justice, Justice Stratton advocated statewide for community develop-

ment of CIT programs (8). Also, with Justice Stratton's help, Ohio increased the minimum training on mental health issues in basic police training from two to 16 hours. Although a supreme court justice with such passion may be rare, local judges with an interest in mental health issues can be found and are effective at bringing stakeholders together and advocating for programs like CIT. As Justice Stratton has pointed out, when a judge invites people to a meeting, they usually come.

Coincident with the start of the Criminal Justice Coordinating Center of Excellence and the Advisory Committee on Mental Illness and the Courts, NAMI Ohio enlisted funds from Ohio's Office of Criminal Justice Services to promote CIT programs. NAMI's funding was used to support planning meetings, usually luncheon programs, to help develop the community partnerships needed to successfully initiate a CIT program. NAMI worked closely with the Criminal Justice Coordinating Center of Excellence, whose law enforcement liaison made most of the stakeholder meeting presentations. Working in concert with Justice Stratton, the NAMI network of grassroots advocates was more successful than leaders in either mental health or law enforcement at quickly gathering stakeholders to an initial meeting. In communities where law enforcement and mental health have not begun to collaborate, each may be suspicious of the other and be reluctant to come to the table. NAMI's clear agenda cuts through such skepticism. NAMI's coordinator of this effort understood the nature of the CIT partnership and was able to lay the foundation to obtain the necessary commitment from all parties.

As CIT programs quickly spread to major cities across the state, the Criminal Justice Coordinating Center of Excellence enlisted the help of emerging CIT champions. NAMI Ohio and the Criminal Justice Coordinating Center of Excellence matched counties that had implemented CIT programs with nearby counties interested in starting such programs. CIT programs in central

Ohio and all four quadrants of the state became centers of CIT promulgation for their neighbors, so that teams no longer needed to travel to Akron for training. This process facilitated even more rapid spread of CIT programs.

Success and sustainability in Ohio's statewide program

The emerging CIT leadership recognized the need to address long-term sustainability of CIT programs. Also, there was concern within the Ohio Department of Mental Health, the Criminal Justice Coordinating Center of Excellence, and NAMI that with rapid promulgation, programs might drift from fidelity to the CIT model. There was particular concern that CIT programs might be just police training programs rather than meaningful community partnerships.

To address such concerns, the center and NAMI convened a statewide group now known as the Ohio CIT Coordinators group. A growing and dynamic group of CIT leaders from the law enforcement, mental health, and advocacy communities, the CIT Coordinators group meets several times a year and communicates regularly through e-mail. An early task of the group was to develop a consensus document about the core elements of an effective CIT program. This process included several face-to-face meetings and extensive debate before reaching consensus on nearly all elements of CIT (9). The Ohio document has been shared with other statewide CIT groups and is being used as part of an effort to develop a national CIT core element document. The CIT Coordinators group continues to meet regularly and focuses on helping new communities develop CIT programs, main-

tain the core elements of the programs, and recognize ways to enhance existing programs. Publication of a CIT newsletter and an extensive Criminal Justice Coordinating Center of Excellence Web site provide additional resources and promote continued training opportunities for CIT officers.

Summary

CIT programs are now spreading rapidly across the country, with an estimated 100 to 300 CIT programs nationally (personal communication, Schwartzfeld M, 2006). All the partners take ownership of an effective CIT program. There is a risk that with a major push by the various CIT advocates, top-down efforts will be made to impose CIT on a community. We believe such mandated programs are unlikely to be effective. We believe Ohio's model of assisting communities to embrace CIT programs has been effective in large part because of the partners involved in that effort.

Although other states may not establish an equivalent to Ohio's Coordinating Centers of Excellence, state mental health leadership may identify and support local champions who can partner with counterparts in law enforcement and the advocacy community to promote CIT statewide. Combining the efforts of leaders in the mental health, criminal justice, and advocacy communities mirrors the partnerships needed to establish an effective CIT program. The emergence of CIT champions from those groups across Ohio accelerated the spread of CIT programs. The CIT Coordinators group is a forum that allows local adaptation and innovation and promotes adoption of and sustainability of new ideas while retaining consis-

tency with the identified core elements of the program essential for maintaining effectiveness (1).

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References

1. Rogers EM: Diffusion of Innovations, 5th ed. New York City, Free Press, 2003
2. DuPont R, Cochran S: Police response to mental health emergencies—barriers to change. *Journal of the American Academy of Psychiatry and the Law* 28:338–344, 2000
3. Criminal Justice/Mental Health Consensus Project. New York City, Council of State Governments, June 2002
4. Crisis Intervention Team Resource Center. Alexandria, Va, National Alliance on Mental Illness. Available at www.nami.org/template.cfm?section=cit2&template=/taggedpage/taggedpagedisplay.cfm&tplid=62&contentid=29917
5. Steadman H, Deane M, Borum R, et al: Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services* 51:645–649, 2000
6. Teller JLS, Munetz MR, Gil KM, et al: Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services* 57:232–237, 2006
7. Tools for Transformation: A Guide to Ohio's Coordinating Centers of Excellence and Networks. Columbus, Ohio Department of Mental Health, Office of the Medical Director, spring 2005
8. Munetz, MR, Stratton EL: What is a CIT? Why does your community need one? *For the Record* (Ohio Judicial Conference Newsletter), first quarter, 2002, pp 18–20
9. Expert Consensus Document: Core Elements for Effective Crisis Intervention Team (CIT) Programs. Rootstown, Ohio CIT Coordinators Committee, Sept 2, 2004. Available at www.neoucom.edu/cjc/coe/support/citcoreelements9204.pdf