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Introduction
In this practice brief, we provide research-based information from two rural communities, Orange and Lawrence counties, regarding the development and implementation of Crisis Intervention Teams (CITs). Our goal is to promote shared understanding of the CIT implementation process in these two counties, including the challenges and opportunities for members of the CIT working groups.

Key Audience
Partnership members responsible for the development and support of CITs in Southern Indiana.

Background
CITs are reliant upon a partnership of mental health providers, community advocates, and law enforcement. Together, these partners continually work to evaluate the program to achieve a more nuanced response to mental health care throughout the community. Currently, over 3,000 CIT programs in 49 states have been established, with the Memphis Model serving as the “gold standard” (Strassle, 2019; Watson et al., 2017). However, there is a lack of evidence regarding CIT implementation in rural areas despite the fact that rural communities have unique characteristics which may affect CIT implementation. For example, while the prevalence of mental health conditions is similar in urban and rural areas, rural residents have lower access to mental health providers and resources, and face increased stigma (Crumb et al, 2019; Lyons et al., 2015). In addition, high turn-over in law enforcement and constraints on economic and human resources serve as barriers unique to rural communities. The two selected counties have a current and pressing need to implement CITs, as identified by the Orange County community health improvement plan (Barnes et al., 2019) and current implementation of training in Lawrence County.
What We Learned from Lawrence County
A total of 10 individuals from Lawrence County participated in the study. Six of these individuals participated in semi-structured interviews, which lasted an average of 35 minutes. A 30-minute focus group was also conducted with four new participants. The professions included law enforcement (n=3, 30%), mental health provider (n=3, 30%), community activist (n=2, 20%), criminal justice director (n=1, 10%), and citizen with lived experience (n=1, 10%).

Participants familiar with the CIT model mentioned their desire to adapt the CIT training model (40 hours of training during a one-week course) to accommodate small law enforcement departments. Participants also were concerned about the lack of a mandate to make long-term change as well as the lack of community leadership to make long-term changes to the justice system, despite the desire for improvements in jail crowding, for example. There was also a concern for the systemic stigma around mental health, including substance use disorder, rooted in the perception that it is an individual choice. While Lawrence County did implement one CIT training, there was no follow-up with data collection, evaluation, or established plan for sustained support. Mostly, this was attributed to the lack of administrative support, planning, and unclear mandate.

What We Learned from Orange County
A total of 13 individuals from Orange County participated in the study. All of these individuals participated in semi-structured interviews, which lasted an average of 30 minutes. The professions/roles consisted of community activist (n=6, 46%), school official (n=3, 23%), EMS/nurse (n=2, 15%), and mental health provider (n=2, 15%).

There were many facilitators identified in Orange County, including an active health coalition dedicated to implementing CITs. However, the participants acknowledged that there is a shortage of mental health providers that makes it difficult for people to receive treatment during a crisis, or to have someone dedicated to work with law enforcement. The fact that the towns that make up the county do not have mayors was seen as a potential barrier since a top-down approach is not feasible. However, since business owners and other community stakeholders fill the role of leadership, this could be a positive influence on implementation if CIT champions are identified through education and awareness efforts.
Study Limitations

• Difficult to initiate participation (partly due to constraints on face-to-face meeting during COVID), lack of professional sector and community stakeholder diversity in participation.

Summary and Next Steps

The focus for CIT working groups should be to design, develop, and implement a comprehensive crisis response program (identifying partners, creating jurisdiction-specific content, helping to identify local trainers, building deployment strategies, a review of existing policies and procedures, etc.) that addresses county-specific barriers and facilitators and are built upon the core elements of CIT.

Primary

• Conduct Phase II data collection, analysis, and dissemination using CFIR to examine barriers and facilitators to implementation during the strategic planning process.

• Plan and deliver CIT training from February 14th – 18th.
  ○ Apply for grants to cover February training for law enforcement.
  ○ Invite community and regional partners

• Develop a preliminary CIT data collection plan before February training (see https://bja.ojp.gov/program/pmhc/ measuring-performance).

Secondary

• In partnership with the relevant COS coordinator, continue to deliver Mental Health First Aid trainings as a mechanism to identify and recruit business leaders and school leaders as champions for CIT as well as to address pervasive stigma in the community.

• Develop regional CIT strategy.
  ○ Long-term planning with the Hoosier Uplands Economic Development Corporation and NAMI to address high turnover rates and job creation/training in the mental health service sector as part of a regional strategy.

Resources


Prepared by the Indiana University School of Public Health and the Center for Rural Engagement.