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Law Enforcement and Clinician Partnerships: Training of Trainers for CIT Teams in Liberia, West Africa

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Abstract

The crisis intervention team (CIT) model was developed in the United States to align law enforcement goals with those of mental health advocates and service users. Liberia is the first low-income country where CIT has been implemented. After preliminary training of law enforcement officers and mental health clinicians by U.S. CIT experts, the program is now entirely implemented by Liberian personnel. In this column, the authors describe topics addressed in the 5-day training-of-trainers process to prepare Liberian mental health clinicians and law enforcement officers to conduct the program, along with feedback received from participants. They hope that this model can guide future initiatives aimed at fostering collaboration of law enforcement and mental health services in global mental health.

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The crisis intervention team (CIT) model was developed in the United States in 1988 to improve collaborative efforts between law enforcement and mental health communities (1, 2). Since its inception, the program has demonstrated many benefits, including improved safety among officers, civilians, and service users; reduction in stigma toward people with mental illness; decreased response times by officers to mental health calls; and increased diversion of service users from the judicial system to the health care system (1–3). The positive outcomes of the program have led to its widespread uptake by police forces in the United States and other high-income countries (1, 2).

Despite its acceptance as a best-practice model (2), CIT has not been implemented in low- and middle-income countries (LMICs) until recently (4). This is a major shortcoming, because police are typically the frontline public service agents who encounter persons with mental illness. Recognizing the benefits of CIT and its potential utility in an LMIC setting, the Carter Center Mental Health Program and the Liberia National Police worked to adapt CIT according to local resources, law enforcement practices, and mental health services in West Africa (4). As members of these organizations, we have collaboratively implemented the model in the nation's police force, led several training sessions, and are presently seeking to sustainably transition the model to local ownership. In this column, we describe the implementation and structure of the first CIT training-of-trainers (ToT) program in an LMIC. We also discuss the feedback provided to us by program trainees (future CIT trainers).

The evaluation study of CIT training in Liberia was approved by the University of Liberia–Pacific Institute for Research Ethics. All facilitators and participants in the ToT activity completed a written consent form. Mental health clinicians were available throughout the entire training to support persons in distress and make referrals for more intensive care if necessary. No adverse events occurred during the ToT program or follow-up interviews.

ToT in Liberia

The Liberian ToT program was developed to be a 40-hour, 5-day course. Program structure and materials were developed by CIT experts from U.S. institutions, the Carter Center, and Liberian mental health clinicians. All ToT participants first completed a CIT training in 2016, employed CIT skills in their daily activities for approximately 9 months, and expressed a commitment to training others in the model.

The ToT program was intended to reemphasize and build on core CIT knowledge and skills, including reviewing topics in mental health, deescalation, and police officer first-aid and also providing didactic and practice-based classes on principles of andragogy (adult learning), leadership, and feedback techniques. Program classes were modeled after the National Alliance on Mental Illness (NAMI) Georgia CIT ToT program. NAMI Georgia is a state affiliate of the U.S.-based grassroots mental health organization dedicated to improving the lives of people affected by mental illness. [Please follow the links for more information on the Carter Center Mental Health Program (cartercenter.org/health/mental_health/index.html), our NAMI Georgia partners (namiga.org), and CIT international (citinternational.org)].

Liberia ToT program instructors included two Liberian mental health clinicians (including WG), a U.S. psychiatrist (BK), a U.S. psychiatric resident (MB), two Liberian mental health advocates, and a U.S. mental health advocate (PS). Trainees included 16 law enforcement officers (including police, corrections officers, and immigration officers), 10 mental health clinicians, and four mental health advocates.

The training schedule is described below. A training manual is available for distribution. [A chart listing the topics and schedule is available in an online supplement to this column.]

Day 1.

The first day was dedicated to CIT training pretests, introductions, and CIT curriculum content review. After the knowledge and attitudes pretest, trainers were taught and practiced personal introduction techniques that promoted collaboration between law enforcement officers and mental health clinicians. Next, participants shared what they remembered and how they used their skills from their initial CIT training. The goal of this activity was to ground CIT trainers in the real-life applications of these skills. In the afternoon, participants were introduced to the teaching approach and methodology for CIT courses. The concept of the “sandwich method” of feedback was introduced in which facilitators start with actionable positive feedback; follow with specific, timely, actionable areas for improvement; and conclude with a positive summary statement tailored to the individual. The day concluded with a presentation on common, culturally tailored myths and facts about mental illness and how to teach a class on myths and facts about mental illness to their (the current trainees’) future trainees.

Day 2.

The second day focused on reinforcing CIT trainers’ communication and deescalation skills and providing them with techniques to teach these skills to other officers. The adaptation process for CIT in Liberia indicated that officers had limited training in conflict-reduction communication skills and no training on to how to speak with persons in mental health crises (4). Therefore, basic communication skills (verbal communication, nonverbal communication, active listening, empathy, and rapport building) needed to be taught in CIT training. In addition, communication skills specific to issues such as psychotic episodes with delusions and hallucinations were covered.

Teaching de-escalation is a keystone for the CIT trainer’s skill set. A number of role-plays were developed specific to Liberia for participants to practice by using de-escalation skills. In addition, the future trainers were introduced to using structured role-plays for assessing competency in de-escalation. Enhancing Assessment of Common Therapeutic Factors (ENACT) (5), a tool developed to measure the competency in global mental health of nonspecialist workers, was modified to assess de-escalation skills (ENACT-CIT). In the afternoon, CIT trainers were taught to facilitate a module on suicide precautions. Because suicide is viewed as a criminal act in Liberia, persons with suicidality are often taken to jails and housed there. Therefore, working with individuals in acute suicidal distress and their families is an important skill for CIT officers.

Day 3.

The third day began with training on how to tell your personal story as a CIT trainer. On the basis of models of attitudinal change in mental health training (6), we assumed that officers who communicated how CIT skills affected their lives and work would more effectively motivate their future trainees. For many officers, the CIT training was their first opportunity to openly discuss family members and close friends who were living with mental illness. Therefore, it was important to create a safe space for CIT trainees to share their stories. Many officers also disclosed their own psychological distress during the training—in particular, their symptoms of posttraumatic stress disorder associated with their experiences during the Ebola crisis. Thus it was important that future CIT trainers be equipped to respond to distress among officers in training. To prepare them to do so, the future CIT trainers were trained in psychological first aid (PFA), an evidence-supported strategy that was developed for use in humanitarian settings and other crisis situations and adapted for use in West Africa during the Ebola crisis (7). CIT trainers were expected to integrate PFA into training in collaboration with mental health clinicians.

Day 4.

CIT trainers reviewed the legal and rights-based frameworks applicable to persons with mental illness and psychosocial disabilities. Liberian law enforcement officers did not have exposure to the national and international guidelines on respect for persons with psychosocial disabilities. Therefore, it was important that the CIT curriculum include an overview of legal rights and protections in Liberia as well as the United Nations *Convention on the Rights of Persons With Disabilities*. In future training sessions, this session would be facilitated by a legal expert who collaborates with law enforcement. This was followed by a series of exercises on de-escalation training and communication exercises on empathy.

Day 5.

Working with service users and advocates is a hallmark of effective CIT programs. Therefore, the CIT trainers were trained to cofacilitate sessions with service users from a Liberian service user organization, Cultivation for Users Hope. Future CIT trainers then reviewed the processes for collaborating with the only psychiatric hospital in the country—E. S. Grant Mental Health Hospital. Because persons requiring inpatient psychiatric hospitalization have limited options in Liberia, Grant Hospital is often the receiving center for persons in severe psychiatric distress from anywhere in the country. The CIT trainers reviewed what types of persons could and could not be referred to Grant Hospital, appropriate transportation, involvement of family members for admissions, and follow-up procedures. The remaining time was dedicated to planning and coordinating a CIT training and management of pre- and posttest information to ensure ongoing quality improvement of the training sessions.

Lessons Learned

During the ToT program, we held daily group discussions to evaluate CIT and ToT program effectiveness and sustainability and to continue adaptation to the local context. Discussion groups ranged from small groups of five or six individuals to the entire class of 29

participants. The future CIT facilitators provided recommendations for modifications, supplementation, and ongoing engagement with CIT law enforcement officers after the course.

Regarding the CIT and ToT curriculums, relatively close adherence to current training approaches, including didactic instruction on the basics of mental health and mental illness and opportunities for practice-based learning, was well accepted. The group valued culturally specific material, with many participants emphasizing a desire to continue discussions related to myths of mental illness contagion. Trainees reported that the material was too dense. Therefore, differences between trainees from LMICs and those from high-income nations in regard to literacy and cultural exposure to information on mental health may necessitate dedicating more time to administer the courses in LMICs. In our group's case, because of resource limitations, we elected to maintain the 40-hour CIT and ToT programs, actively auditing for class comfort with content and adjusting time spent on topics as appropriate. However, given the concern that the material was too dense, where resources allow, others may find benefit in increasing the program's length. Conversely, other discussants had different thoughts about the setting and length of CIT training, with some favoring 2-hour in-service training sessions to make it easier for officers to attend. We are concerned that 2-hour classes would not be sufficient to affect police practices and improve outcomes, especially considering participant reports that the 5-day training was too dense.

The CIT trainers reported reluctance to engage with police supervisors on the topic of CIT administration. The group suggested that the Carter Center act as a mediator on this point. Although in the short-term mediation is appropriate, such an approach would impair independence. Instead, we believe that the concerns related to CIT trainer engagement with supervisors warrant incorporating further training on this matter into subsequent ToT refresher sessions. In addition, CIT trainers requested the involvement of law enforcement leadership in future CIT and ToT programs. Such involvement is consistent with one of the 10 core elements of CIT—specifically, partnership within law enforcement agencies includes command staff (8). Involving leadership early in CIT training will increase program support, particularly in LMICs, where mental health literacy is limited (4).

Through discussions, CIT trainers provided feedback that raised concerns about possible stigmatizing immigration policies. We followed up on this and found that the Aliens and Nationality Law of 1974 advises exclusion from entry into the country based on "feeble-mindedness, insanity, one or more attacks of insanity … epilepsy or mental defect, narcotic drug addicts or chronic alcoholics" (9). We discussed this with the Ministry of Justice and were advised that a new bill, excluding this clause, is under consideration by the cabinet and the legislature. From the perspective of CIT training, policies that are in clear contradiction to CIT efforts stand to undermine program objectives. As suggested by the CIT trainers, open communication with supervisors is needed to ensure that policies are modified and do not discriminate against vulnerable populations.

Finally, many of the challenges raised by discussants led to the identification of a need for a Liberian CIT association. CITAL (CIT Association of Liberia) was thus established and has since been active in continued CIT program development and advocacy. The development of

similar organizations would benefit implementation of the CIT model in LMICs to foster community buy-in and commitment to program success. Ultimately, the work in Liberia demonstrates that the local law enforcement institutions have interest in equipping their officers with mental health–related knowledge and skills, and that this commitment can be channeled into development of local, sustainable cadre of CIT trainers and advocates.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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HIGHLIGHTS

- The Carter Center Mental Health Program and the Liberia National Police worked to adapt the crisis intervention team model according to local resources, law enforcement practices, and mental health services.
- The model is now entirely implemented by Liberian personnel using a training-of-trainers approach.
- This column describes topics addressed in the 5-day training-of-trainers process, along with feedback received from participants.