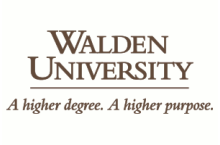

2020

Evaluation of the Impact of Virginia's Senate Bill 1294 on Crisis Intervention Team Cooperation

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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2020

Abstract

Evaluation of the Impact of Virginia's Senate Bill 1294 on Crisis Intervention Team Cooperation

by

Dennis Martin

MA, Central Michigan University, 2015

BS, Ferris State University, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Criminal Justice—General Studies

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May 2020

Abstract

In 2009, the Commonwealth of Virginia passed Senate Bill (SB) 1294 that directly involved the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services in the spread of the Crisis Intervention Team (CIT) program statewide. The purpose of this mixed-method study was to explore how the passage of SB 1294 affected the level of stakeholder cooperation within Virginia's statewide CIT program, through 11 interviews with Virginian CIT leaders and by the completion of 115 questionnaires by CIT members in a region of central Virginia. Findings indicated the most common way that SB 1294 affected CIT cooperation was that it provided increased funding for much needed programs such as mental assessment centers and that the best way to achieve and maintain cooperation was through regular meetings and communication between stakeholders. The most common participant response to the questionnaire statements was an agreement that cooperative CIT practices were being performed. However, many of the participants did not know enough about some of the practices that were affected by SB1294 to respond. A paired samples T test indicated there was a significant difference between how participants answered questionnaire statements that included cooperative CIT practices influenced by SB 1294 and those that included general cooperative CIT practices. Findings suggest that communities interested in having a successful CIT program must be willing to communicate, compromise, share resources, start small, map their mental health crisis system, respect all stakeholder perspectives, and develop a plan that could be put into practice right away but can be allowed to evolve as circumstances change.

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Chapter 1: Introduction to the Study

Problem Statement

Although scholarly literature has provided the frameworks for the main concepts of the Crisis Intervention Team (CIT) program (Dupont, Cochran, & Pillsbury, 2007) and how certain states, such as Georgia and Ohio (Oliva & Compton, 2008 & Munetz et al, 2006), had spread CIT statewide, there may be data about stakeholder cooperation that were missing that might better advise states newly exposed to CIT on how to successfully implement CIT statewide. In this mixed-method study, I examined how the passage of Virginia's 2009 Senate Bill (SB) 1294 affected the level of stakeholder cooperation within Virginia's statewide CIT program.

Background

During the turn of the 21st century, the mental health system of the Commonwealth of Virginia was in crisis. It suffered from a "revolving door" use of emergency rooms for mental health treatment, lack of funding and stakeholder coordination, and an unnecessarily high number of persons incarcerated due to behaviors induced by mental illness (McGarvey, 2007, p. 6). This point may be why jails have usually been overcrowded since 1985 (Joint Legislative Audit and Review Commission, 1996, p. 11).

One answer to relieving this crisis was the CIT program:

> CIT Programs… provide a community-supported, enhanced local law enforcement-based capability to respond to situations involving individuals with symptomatic behavioral issues. CIT brings together local stakeholders, including

> law enforcement, emergency dispatchers, mental health treatment providers, consumers of mental health services and other (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates), in order to improve and coordinated criminal justice and behavioral health system responses to persons experiencing behavioral health crises who come into contact with law enforcement. (DCJS & DBHDS, 2011, p. 6)

In 2001, CIT was first introduced to Virginia in the New River Valley region. This CIT became first successful, rural CIT program (DCJS & DBHDS, 2009b, p. 5). By 2008, three other regions in Virginia had pilot CIT programs. Because of the initial positive outcomes, Virginia's General Assembly passed SB 1294 to help the spread of CIT programs statewide with the assistance of the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS) (DCJS & DBHDS, 2014).

Purpose

The purpose of this study was to conduct a summative evaluation of how SB 1294 (2009) had affected cooperation between CIT stakeholders statewide for the greater understanding of those states who were novices in the CIT program. This was important because the level of cooperation among community stakeholders was often the key to a successful CIT program. Because I could not find a tool for measuring CIT cooperation in the scholarly literature, the benchmarks for measuring cooperation for this study were based on Deutsch's (1948) and Allwood's (2007) definitions of cooperation such as increased communication and dispute resolution.

Significance

This research study contributed to filling the gap in the scholarly literature regarding stakeholder cooperation within statewide CIT programs. I contributed to that knowledge by assessing the participants' perspectives about the level of CIT stakeholder cooperation in the State of Virginia both before and after the passage of Virginia's 2009 SB 1294. This evaluation may influence other states to adopt a similar system as Virginia to spread CIT statewide.

People within the CIT program used social-change tools including systems thinking, interagency and advocacy group collaboration, humane ethics, and civic engagement (Callahan et al, 2012) to attempt to solve both short-term and long-term problems involving mental illness and substance abuse disorders. They have attempted to empower the community by including representatives from law enforcement, mental health professionals, and advocates of people with mental illness into the CIT who worked together to develop strategies and promote positive social change. The findings from this mixed-method case study might lead to positive social change by allowing for the greater understanding and/or spread of CIT training, cohesive state laws and strategies, and shared resources.

Framework

Bertalanffy (1972) had studied both the individual organisms and processes of biological systems as well as how they worked together (p. 410). Because of the complex nature of CIT programs, I thought that CIT program system should be studied in the same way, particularly the coordination between agencies and other CIT partners. In addition,

it was important for me to study why law enforcement and mental health professionals traditionally do not understand each other's perspective and occupational duties (Vickers, 2000).

Because the CIT program involves people, I thought that using the human ecology systems theory was particularly appropriate. Although it was originally developed to understand the behavior of children (Bronfenbrenner, 1986), I found it useful during this study for explaining how different agencies and stakeholders within the CIT program work together to try to positively affect the behavior of people with mental illness.

Research Questions

I conducted a mixed-method phenomenological and correlational study about the level of cooperation among community stakeholders within the statewide CIT program of Virginia. The main research questions for this study were:

Research Question 1 (RQ1): How has the passage of Virginia's 2009 SB 1294 affected the level of stakeholder cooperation within Virginia's statewide CIT program?

Research Question 2 (RQ2): What was the relationship between what questionnaire participants perceived regarding questions about CIT stakeholder cooperation when stakeholders are performing CIT practices which were affected by the passage of Virginia's 2009 SB 1294 and those questions about CIT practice which were in effect before the passage of SB 1294?

Null Hypothesis: ($H_0$2): There would be no relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Alternative Hypothesis (H_a2): There would be a relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Research Design

I used a mixed-method design using both qualitative and quantitative methodologies for this study. I based the qualitative research on interviews with open-ended questions about cooperation among CIT stakeholders and the influence that the passage of SB 1294 had over that cooperation. I based the quantitative research on a questionnaire given to Virginian CIT officers which asked their perspective on the level of cooperation in their CITs using a Likert scale.

Nature of the Study

The nature of this study was qualitative and quantitative. I used phenomenological and correlational studies to evaluate the level of stakeholder cooperation within statewide CIT program in the State of Virginia through the theoretical lens of the human ecology system theory. I reviewed the history of Memphis-style CIT and what prompted Virginia to adopt the program. I analyzed how Virginia implemented the program within its state. I questioned whether the level of stakeholder cooperation has remained constant before and after the passage of Virginia's 2009 SB 1294 and what strategies were involved in obtaining stakeholder cooperation within Virginia's CIT programs.

Chapter 2: Literature Review

The success of the CIT model has depended heavily on the cooperation between the agencies, organizations, and individuals who have regular interactions with people with mental illness. Because many of these populations have not normally interacted in the past, I used ecology systems theory to describe how the history and culture of the United States may have affected people with mental illness and how the different agencies and organizations in Virginia had interacted with people with mental illness in the past and present.

In 1979, Russian psychologist, Urie Bronfenbrenner introduced the ecology systems theory (Word Press, 2013), also known as the human ecology system theory (Sincero, n.d.). Bronfenbrenner (1986) used the theory to describe how different levels of environmental systems influenced individual children. Those systems included: (a) the macrosystem, (b) the exosystem, (c) the microsystem, (d) the mesosystem, and (e) the chronosystem.

According to Paquette and Ryan (2001), a macrosystem consisted of "cultural values, customs, and laws" (p. 2) and all the other systems. An exosystem was a larger social system that indirectly influences an individual through the individual's contacts within a microsystem, such as a family member's workplace and employer (p. 2). A microsystem included any people or environments that regularly interacted with the individual, such as family members and the individual's school environment (p. 2). A mesosystem happened when two or more separate microsystems interacted with each other, such as a parent-teacher conference (p. 2). Finally, the Word Press (2013)

described a chronosystem as a period of time that was significant to the individual, such as a divorce or the cumulative experience of being a student (p. 4).

Duke Trinity College of Arts and Sciences (n.d.) described the study of ecology as the study of the interaction of living things with each other and the environment. When the ecological system is in balance, it is in ecosystem homeostasis (Wood, n.d.), otherwise known as dynamic equilibrium (Abedon, 2016).

If an ecological system is stressed, attack-avoidance behavior may be unconsciously used by its inhabitants to reestablish the system's balance (Morning Earth, n.d.). This behavior is characterized by organisms fighting, threatening, fleeing, and/or ignoring each other. Frequently people with mental illness seem to either have exacerbated attack-avoidance behavior themselves or induce enhanced attack-avoidance behavior in others. The CIT model is a conscious, community effort to moderate attack-avoidance behavior, especially during mental health crises.

In this literature review, I considered CITs and other relevant agencies and organizations within the State of Virginia to be the social system underlying an ecological systems theory framework. I considered persons with mental illness who reside in Virginia to be the individuals who might be influenced either positively or negatively by the social system.

Macrosystem: Cultural Values, Customs, and Laws

According to Baxter (n.d.), a macrosystem includes all the other systems of the human ecology system theory as well as "culture, political systems, economic patterns, laws, customs, society and nationality" (p. 5). Furthermore, a macrosystem can change

over time as the culture and environment changes (p. 5). Because the laws and culture of the United States affect people with mental illness in Virginia and because CIT did not develop in isolation in Virginia, I included the historical social control of people with mental illness in the United States and the development of the CIT model as important aspects of the macrosystem which influences the lives of people with mental illness within Virginia.

Historical Social Control of People With Mental Illness in the United States

Federalist era:1789–1801. The Federalist era was a vulnerable time for the United States because it was a newly formed government. It was named for the Federalist Party which was the dominant political party at the time (Lumen Candela, n.d., p. 1). According to Lumen Candela (n.d.), the Federalists favored a strong, centralized government versus state sovereignty. They also exhibited anxiety and suspicion regarding refugees and subversives from the French Revolutionary War and foreigners in general, as exhibited by the Alien and Sedition Acts of 1798 (p. 2).

During this time, people with mental illness may have been cared for in a segregated ward or private hospital (Barton, 1996 & Harvey, 2012). However, since these hospitals and facilities required payment for the care that was given, many people with mental illness were living in poorhouses, jails, or on the streets instead (Barton, 1996, p. 241). In some circumstances, the mental wards and hospitals were used as detainment centers for political insurgents and inconvenient wives who did not have a genuine mental illness (p. 194).

Legally, those who were confined due to a mental illness went through civil death (Barton, 1996, p. 82). They lost their voting rights and ability to participate in politics (p. 82). In fact, they lost the ability to have any self-determination at all and were disciplined with humiliation (p. 82), as well as, pain and isolation.

The medical treatment of mentally ill persons during the Federalist Era seemed to take the form of mind control tactics (Barton, 1996) because the physicians used coercive methods to change the behaviors and beliefs of their patients (Singer, n.d.). Strong patient-physician relationships were formed by isolating patients from society and sometimes from each other while the only kindness allowed to patients was given solely by the physician (Barton, 1996, p. 96). Other treatments included ice water baths, restraints, and electric shocks (Harvey, 2012).

Antebellum era:1817–1857. The Antebellum Era was the time between the War of 1812 and the American Civil War (History Net, n.d.). It was characterized by increased transportation, manufacturing, and diversity (pp. 1–7). The increased stress caused by society transforming from rural, agricultural environments to more dense, urban, industrial centers made it more likely for mental health crises to occur (Norbury, 1999).

People with mental illness who could not afford private care and did not behave civilly were frequently kept in basements, closets, and barns and beaten into submission (Smark, 2008, p. 162). Most often, they were confined to poorhouses and jails (Norbury, 1999). Reverend Louis Dwight observed these practices and founded the Boston Prison

Discipline Society in 1825 to help improve conditions for prisoners with mental illness (Torrey, 1997, p. 26).

Institutional era:1833–1982. During the beginning of the Institutional Era, there was a growing acknowledgement that correctional facilities and poorhouses were improperly being used to house people with mental illness. Because of Reverend Dwight's advocacy, the Worcester State Hospital was opened in 1833 to help treat people with mental illness who could not afford to pay for private care (Kirsch, n.d. & Torrey, 1997). In addition, he inspired the Massachusetts legislature to appoint a committee to inspect the state's jails environmental conditions and inmate population (Torrey, 1997, p. 26). The committee confirmed that many people with mental illness were often being held in cruel and humiliating settings (p. 26).

Unfortunately, the Worcester State Hospital became overcrowded shortly after it was opened (Kirsch, n.d., p. 1). The overcrowding forced the overflow population from the hospital to be placed back into a correctional facility (Smark, 2008, p. 161).

In 1841, a schoolteacher by the name of Dorothea Dix volunteered to teach Sunday school to prisoners at the Middlesex County House of Correction where the overflow population from Worcester State Hospital were placed (Smark, 2008, p. 164). While she was there, she witnessed how people with mental illness were confined along with prisoners. She began to document the abuses and neglect of people with mental illness which she had witnessed at the Middlesex facility as well as at other jails, prisons, and poorhouses (p. 164).

Because Dix was a woman, she was not allowed to address Congress directly, so she enlisted the help of male cohorts who sympathized with the mental health cause to present her testimony at state congressional sessions (Smark, 2008, p. 165). Her first success was Massachusetts' Congress voting to fund the expansion of the Worcester State Hospital (p. 165). Later, she helped start 32 state hospitals throughout the United States (p. 161).

Dix had intended for these hospitals to treat their patients with moral treatment which was more humane than the standard treatment provided to mentally ill persons during that era (Norbury, 1999). Norbury (1999) defined moral treatment in the following ways:

> Moral treatment consisted of removing mentally ill persons from a stressful environment and family conflicts and placing them under a rather benign but autocratic system of organized living. There were regular hours and habits, and the patients were kept occupied with crafts, gardening, and other works of this kind. Everything was under the close supervision of the superintendent, a physician, and his word was law. The physicians prescribed some sedatives, tonic, and later hydrotherapy. Restraint was used as seldom as possible. It was believed that given time under this system cure would occur. Many of these institutions were at least loosely affiliated with church groups and encouraged chapel services and other religious activities. (pp. 15–16)

It was apparent to Dix and her supporters that insufficient funding for state mental hospitals was a common problem (Norbury, 1999). Dix's solution to this problem was the

proposition of the Ten Million Acre Bill (p. 25). The passage of the bill would have allowed states to fund hospitals through federal land grants that could be developed or sold for a profit (p. 25). Although Congress passed the bill in 1854, President Pierce vetoed it on the basis that it was unconstitutional because it would interfere with state government responsibilities (p. 25).

Because of the chronic problem of poor financial support for mental health, state mental hospitals could not afford the staff and space that was necessary for moral treatment. There was also doubt about the ability of any treatment to cure insanity (Norbury, 1999, p. 26). Eventually there was a reversion back to the old ways of controlling people with mental illness through violence, fear, isolation, and restraints (Bly, 1887, Norbury, 1999, Shapiro, 2009, & Smark, 2008). In addition, many people with mental illness were kept in perpetual nakedness, seemingly due to their unpredictable behavior and/or their questionable hygienic practices.

During the turn of the 20th century, the American public was made aware of some of the shockingly common abuses committed within state mental hospitals through the *New York World* newspaper story written by undercover reporter Nellie Bly (1887). In *Ten Days in a Mad-House,* Bly referred to Blackwell's Island as a human rat trap (p. 57). This statement was probably written because Bly had spoken to several women who were mistakenly placed in the asylum and could not prove their sanity once they had entered the asylum system.

Along with false imprisonment, Bly (1887) experienced forced drugging with an opiate; nurses requesting sexual favors on behalf of doctors; communal baths in ice-cold,

dirty water followed by containment in unheated cells; verbal and physical abuse by nurses; and malnourishment. For all the abuses Bly suffered, she knew that it was far worse for those who became violent or suicidal (p. 51).

Occasionally, the nurses would take disobedient patients to the "Retreat" (Bly, 1887, p. 52). The following excerpt was told to Bly by a fellow patient who was sent there:

> The beatings I got there were something dreadful. I was pulled around by the hair, held under the water until I strangled, and I was choked and kicked. The nurses would always keep a quiet patient stationed at the window to tell them when any of the doctors were approaching. It was hopeless to complain to the doctors, for they always said it was the imagination of our diseased brains, and besides, we would get another beating for telling. They would hold patients under the water and threaten to leave them to die there if they did not promise not to tell the doctors. We would all promise, because we knew the doctors would not help us, and we would do anything to escape the punishment. (Bly, 1887, pp. 52-53)

Ten days after being committed, Bly's (1887) release from the asylum was orchestrated by Attorney Peter A. Hendricks (p. 57). Soon after being discharged, Bly testified about her experiences to New York's Grand Jury and then accompanied them on an inspection of the asylum (pp. 57–58). Although no one was supposed to have known about the inspection, Blackwell's Island Insane Asylum was given advanced notice while the Grand Jury was inspecting Bellevue (p. 58). This occurrence caused the worst of the

offenses to be covered up while the rest were blamed on lack of funding and being understaffed.

About the same time in which Bly's story was published, an ideology emerged which compounded the stigma against people with mental illness. This ideology was eugenics. History.com (2017) described eugenics in the following manner:

> Eugenics is the science of improving the human species by selectively mating people with specific desirable hereditary traits. It aims to reduce human suffering by "breeding out" disease, disabilities, and so-called undesirable characteristics from the human population. Early supporters of eugenics believed people inherited mental illness, criminal tendencies and even poverty, and that these conditions could be bred out of the gene pool. (History.com, 2017, p. 1)

Eugenics had many influential supporters including Teddy Roosevelt, Andrew Carnegie, and John D. Rockefeller (Lenz, 2017, p. 2). It also inspired the inception of several state marriage and sterilization laws (History.com, 2017). Around this time, Connecticut prohibited marriage to people with epilepsy or intellectual disabilities (p. 2). Likewise, California allowed about 20,000 forced sterilizations of people being treated in state mental hospitals (p. 3).

Even the U.S. Supreme Court had cause to rule on the matter of eugenics. In the ruling of *Buck v. Bell* (1927), the Court upheld a 1924 Virginian law which stated that forced sterilizations were legal in certain cases involving people with intellectual disabilities (Supreme Court of United States, 1927, p. 1). Those cases included patients committed to institutions such as mental hospitals and colonies who had been found by

the superintendent to have hereditary intellectual disabilities (p. 1). The gravity of that ruling was emphasized by the following statement of Justice Oliver Wendell Holmes regarding the reasoning behind the ruling which is still in effect today (National Public Radio, 2016, p. 20):

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination [*Jacobson v. Massachusetts* (1905)] is broad enough to cover cutting the Fallopian tubes. (Supreme Court of United States, 1927, p. 2)

Along with forced sterilization, many people with mental illness were required to participate in medical experimentation and/or treatments. Some of those treatments were helpful while others have been debilitating. The more common treatments included lobotomies, insulin shock, electroconvulsive therapy (ECT), and Thorazine. Shock treatments, in particular, were based on the observations that many doctors had had over the centuries that seizures and head injuries seemed to improve mental illness (Sabbatini, n.d., p. 1).

In 1935, Portuguese neurophysiologist António Moniz performed the first lobotomy on a human being after being inspired by observing the surgical removal of the frontal lobes of two chimpanzees (Lenz, 2017, p. 4). The next year, neurosurgeon Dr. James Watts and neurologist Dr. Walter Freeman performed the first lobotomy in the United States (Hilchey, 1994, p. B00007). During the lobotomies, Watts would first sedate a patient and then drill holes into his or her skull (p. B00007). A knife was inserted

into the hole and rotated to sever the thalamus (the emotional brain) from the prefrontal lobes (the thinking brain) (p. B00007).

Ten years after participating in the first lobotomy in the United States, Dr. Freeman began experimenting with a faster way of doing a lobotomy and conducted the first transorbital lobotomy using an instrument like an ice pick (National Public Radio, 2005). His colleague, Dr. Watts disapproved of this method and dissolved their professional partnership a few years later (Hilchey, 1994). Over the course of his career, Freeman performed over 3,400 lobotomies (Kuroski, 2017).

Freeman's transorbital lobotomies were performed as follows:

> The doctor would first administer a local anesthetic, leaving the patient conscious and alert for what was to come (if the patient did not respond to anesthesia, doctors would use electroshock). Next the doctor would position a sharp steel pick of seven or so inches with its point underneath the eyelid and against the bone atop the eye socket. Then, with a swing of a mallet to the butt of the pick, the doctor would drive the point through the bone, past the bridge of the nose, and into the brain. Once the point was about two inches deep into the frontal lobe, the doctor would rotate it, severing the connective white matter between the prefrontal cortex—the executive center that makes decisions, informs personality, and makes you who you are—and the rest of the brain. The entire procedure took the doctor less than ten minutes, and the patient would never be quite the same again. (Kuroski, 2017, p. 1)

Although lobotomies had a “14 percent fatality rate” (Kuroski, 2017, p. 2) and some severe side effects including paralysis, seizures, and loss of personality (Lenz, 2017), some studies stated that between one fourth and two thirds of patients had some improvement of their mental illness (Engber, 2013). In all, there were about 50,000 lobotomies performed in the United States, particularly during the 1940s and 50s (Tartakovsky, 2011, p. 3).

Insulin shock therapy was the practice of injecting insulin into schizophrenic, psychotic, or drug-addicted patients to induce hypoglycemic shock in the body (Sabbatini, n.d.). About 45 minutes after being injected by insulin, the brain became deprived of glucose and seizures began (Chem Europe, n.d.). Soon after the seizures began, a coma commenced. After one hour of being in a comatose state, the patient was given an injection of sugar (p. 1) to counteract the insulin.

This therapy was first developed in 1927 by Dr. Manfred Sakel (Sabbatini, n.d., p. 3). It began to be practiced in the United States in 1934 until the 1950s (p. 3). According to two studies (p. 3), approximately 63% of patients had some improvement in mental health following insulin shock therapy, but that improvement rarely lasted longer than two years (p. 3).

In 1937, Italian neurologist Ugo Cerletti developed electroconvulsive therapy (ECT) after watching pigs being shocked before they were slaughtered (Sabbatini, n.d., p. 6). Cerletti and two colleagues (Lucio Bini and L.B. Kalinowski) experimented with animals and developed an instrument to supply brief shocks to a subject (p. 6). During

their human trials with acute-onset schizophrenics, most patients showed some improvement (p. 6).

ECT was introduced to the United States in the year 1940 (Bakalar, 2015). It produced seizures in patients by allowing a limited amount of electric current to flow into electrodes placed on the head (Goldberg, 2017). It is still one of the best treatments for depression, mania, or suicidal tendencies (p. 1). It also tends to induce amnesia in patients regarding the treatment itself (Sabbatini, n.d., p. 6). According to Mandell (2010), "memory loss… [can be] massive, and memory may not return" (p. 53).

Thorazine was invented by French researchers looking for a cure for malaria (Scott, 2011, p. 1). However, instead of curing malaria, they discovered that it acted as a strong sedative which created "a medicinal lobotomy" (p. 1). In 1954, Thorazine was first drug approved by the FDA to treat mental illness (p. 1).

> Scott (2011) described the effects of Thorazine in the following statement:
>
> Thorazine works by blocking dopamine receptors in the brain. In response, the presynaptic neurons release more dopamine into the synaptic cleft, stimulating the postsynaptic neuron to increase dopamine receptor density…. But, after three weeks, the feedback mechanism that regulates dopamine release based on the activity of the post-synaptic neuron (which is suppressed because Thorazine blocks its receptors) begins to fail. This means that the neurons begin to fire in irregular patterns or stop firing all together…. [The problem with this is that] dopamine doesn't just make you psychotic; it makes your muscles move. (p. 2)

The overabundance of dopamine in the body which the use of Thorazine (chlorpromazine) and the other major tranquilizers such as Haldol (haloperidol) causes may produce some troubling side effects. In about 20% of cases, major tranquilizers caused tardive dyskinesia (Bibeau, 1994). According to Scott (2011), "tardive dyskinesia is irreversible and characterized by repetitive involuntary movements like grimacing, tongue protrusion, lip smacking, puckering and pursing of the lips and rapid eye blinking" (p. 2).

Even more troubling than tardive dyskinesia is the side effect of akathisia. Bibeau (1994) described akathisia as "a drug-induced inability to sit still comfortably" (p. 46). Furthermore, Van Putten, May, and Marder (1984) conducted a study and found that akathisia was exhibited in 40% of "newly admitted schizophrenic patients" (p. 1036) within six hours of Haldol administration and in 75% of patients within seven days of receiving Haldol therapy.

Symptoms of akathisia include restlessness, pacing, hostility, aggression, agitation, and anger (Bibeau, 1994) which were not previously exhibited by patients prior to tranquilizer use. In a Canadian study, researchers found that akathisia was the root cause of increased violence among inmates who were given psychiatric medications (p. 47). In extreme cases, akathisia has been attributed to brutal, homicidal assaults and suicidal attempts (p. 47).

While most of the previously mentioned, psychiatric treatments were being developed, the state mental hospitals were suffering financially (Joint Commission on Mental Illness and Health, 1961, p. 12). Before they could recover financially, many of

the psychiatrists and staff who worked in the state mental hospitals were drafted into the war effort of World War II. According to Shapiro (2009), the staff shortage became so severe that in one incidence "three men [were assigned to take] care of 350… patients" (p. 2).

Because of the severe staff shortage at state mental hospitals, 3,000 drafted pacifists, otherwise known as conscientious objectors (COs), were appointed to the task (Shapiro, 2009, p. 1). One CO by the name of Charlie Lord was assigned to work at the Philadelphia State Hospital (Shapiro, 2009). It had two wards which were particularly difficult to work in: the "incontinent ward" and the "violent ward" (Shapiro, 2009, p. 2).

Shapiro (2009) described the wards in the following statement:

> The incontinent ward… was a large open room with a concrete slab for a floor [where] hundreds of men—most of them naked—walked about aimlessly or hunched on the floor and huddled against the filthy bare walls…. The violent ward… [housed] angry men [who] sometimes violently attacked one another. In one room, rows and rows of men were strapped and shackled to their bed frames…. Many of the regular attendants were drunks who'd get fired at one state hospital and just move on to a job at the next. Some kept control by hitting patients with things like sawed-off broom handles or a rubber hose filled with buckshot…. One of their tricks was to use a wet towel and put it around their neck and squeeze it. It… choked them…, but it didn't make any mark… [that might cause a] state inspector… [to] catch up with them. (pp. 2–4)

Lord secretly took 108 photographs of the two wards' patients to produce proof of the many inhumane conditions at the hospital (Shapiro, 2009, p. 5). In 1946, the American public was once again exposed to some of the abuses which occurred in state mental hospitals when the photographs were published in *Life* magazine (Shapiro, 2009, p. 6).

After World War II, there was a political campaign for national funding for psychiatric research and programs to help veterans to return to civilian life (Herman, 1995, p. 246). The emphasis was to be on mental health instead of mental illness because it was thought that preventative mental health would be more cost-effective than treating mental illness (p. 246).

In 1946, the National Institute of Mental Health (NIMH) was established (National Institutes of Health, 2017, p. 1). Its purpose was to research mental illnesses to find cures, to prevent illness, and to promote recovery (p.1). It was hoped that more research might uncover additional preventative treatments for mental illnesses such as when Joseph Goldberger discovered that pellagra was caused by the lack of niacin in the diet (Joint Commission on Mental Illness and Health, 1961, p. 38) or when penicillin was found to successively cure acute cases of syphilis (Bienaimé, 2014, p. 1).

Although NIMH was studying causes and possible cures for mental illness, there was a need to assess the state of mental hospitals and treatments around the country. In 1955, the Joint Commission on Mental Illness and Health was established to conduct a national study of mental health facilities and treatments (Amadeo, 2018, p. 2). The

Commission's report was published in 1961 under the name of *Action for mental health* (Joint Commission on Mental Illness and Health, 1961).

According to the Joint Commission on Mental Illness and Health (1961), there were three universal problems with mental health: "manpower, facilities, and costs" (p. vii). Their recommendations for solving these problems included (a) diversification of research; (b) immediate mental health treatment for people in a mental health crisis; (c) converting state mental hospitals into comorbidity treatment centers; and (d) reducing hospitalization time for mental health treatment to specialized acute care only (pp. vii–xix). In general, the Commission urged that mental health treatment should be provided in an outpatient, community setting.

The *Action for mental health* report seemed to influence future federal policy and law such as with the enactment of the Community Mental Health Act of 1963. However, it was also likely that state governments may not have been ready to reconstruct their mental health policies to included community mental health programs. The federal government responded with cuts to mental hospital funding, first with the Social Security Amendments of 1965 and second with the Omnibus Budget Reconciliation Act of 1982.

In 1965, President Johnson began the Medicare and Medicaid programs by amending Social Security (LBJ Presidential Library, 2012, p. 1). These amendments reduced federal funding to cover mental hospital stays in three main ways: (a) Medicare medical insurance only covered psychiatric hospitalization for a total of 190 days within a patient's lifetime (Cohen & Ball, 1965, p. 10). (b) It stopped the federal program designated in Public Law 565 of 1954 that paid for half the cost of treating elderly

patients with tuberculosis or mental illness within a state institution (Hollister, 1959 & Cohen & Ball, 1965). And (c) Medicaid cannot be used to pay for inpatient mental health or substance abuse treatment in facilities with more than 16 patients who are between 21 and 64 years old (Legal Action Center, 2014, p. 1).

In 1981, the Omnibus Budget Reconciliation Act was passed which cut funding to NIMH and further reduced the amount of federal money given to states to fund mental health programs (MIWatch.org, 2011). Federal grants that had previously been given directly to state hospitals were thereafter given to States as block grants to be divided among several different programs (pp. 4-5). With this vast reduction of funding, state mental hospitals began to close nationwide at a large scale (Torrey, 2013).

Community mental health era:1963–present. The community mental health era was influenced by economy, familial advocacy, the Civil Rights Movement, and the Joint Commission on Mental Illness and Health's (1961) report *Action for mental health.* The Commission had found that long-term residency in a mental health hospital was harmful for recovery. They recommended that existent mental hospitals either be exclusively used for acute care of persons having mental health crises or for comorbidity treatment facilities (xvi).

Congress was inspired by the Commission's report to introduce the Community Mental Health Act. The act was meant to make federal grants available to State and non-profit organizations to construct community mental health centers and facilities to help children with intellectual disabilities (Stephens, n.d.). In 1963, President Kennedy ratified the act and an amendment to Social Security to provide federal funding for preventative

measures that reduced accidents during childbirth and fetal malnourishment (Lenz, 2017 & Eighty-eighth Congress, 1963). Because of the language of the legislation, Kennedy was likely inspired by his sister, Rosemary, when he signed them into law.

Rosemary had mild to moderate mental retardation and behavioral problems that were attributed to her forcibly delayed birth that had caused severe oxygen deficiency (Lenz, 2017). Because of JFK's and his brothers' political careers, their father, Joseph Kennedy Sr., sought to correct Rosemary's behavior with a lobotomy when she was 23 years old (p. 5).

Lenz (2017) described the results of the lobotomy in the following statement:

> After the lobotomy, Rosemary was no longer able to walk or talk. It took months of therapy before she regained the ability to move on her own, recouping only the partial use of one arm. One of her legs was permanently turned inward. Months after the surgery, when she regained her ability to speak, it was a mix of garbled sounds and words. (p. 6)

Later, Joseph Sr. placed Rosemary in an institution and did not tell anyone where she was, not even her mother (Lenz, 2017). It was not until after Joseph Sr. suffered a stroke in 1961 that anyone else in the family knew what happened to Rosemary (p. 6). In early 1962, Rosemary saw her mother for the first time in 20 years (p. 6).

Rosemary's condition became a rallying point for her family (Lenz, 2017). In 1968, her sister Eunice established the Special Olympics (p. 6). And her brother, Senator Ted Kennedy campaigned for the passage of the American's with Disabilities Act of 1990 (p. 6).

Because the Community Mental Health Act provided a grant opportunity and was not a federal requirement, there was not a lot of follow through on States' development of community mental health centers (Stephens, n.d.). However, since the Social Security Amendments of 1965 reduced federal funding to State mental hospitals when Medicare and Medicaid were established (Cohen & Ball, 1965), many hospitals had little choice but to transfer some of their patients to nursing homes, adult foster care homes, or to low-cost boarding homes (Gargan, 1981) where they may or may not have had access to community psychiatric care.

When these patients were released from State mental hospitals, several of them began to talk about their experiences and to fight for their civil rights. This campaign became known as the psychiatric survivors' movement (Alvelo, 2009). It began in the 1960s in the large coastal cities of the United States and spread inward (p. 4). According to Chamberlin, Rogers, and Ellison (1996), the survivors advocated "for empowerment, choice, and self-determination" (p. 40).

In lieu of traditional psychiatric treatment, psychiatric survivors preferred self-help programs (Chamberlin, Rogers, & Ellison, 1996, p. 40). Some programs had drop-in centers while others had scheduled meetings like alcoholics anonymous. Within these programs, survivors helped each other to acclimate back into communities along with financial and legal assistance (p. 40).

Two of the most famous activists of the psychiatric survivors' movement were Judi Chamberlin and David Oaks. Chamberlin was a founding member of the Mental Patients' Liberation Front (MPLF) who wrote prolifically about her experiences as a

psychiatric patient and the psychiatric survivors' movement (Mandell, 2010). Likewise, Oaks was the executive director of Mind Freedom International and spent nearly a lifetime protesting forced psychiatric drugging (Mind Freedom International, n.d.).

A forerunner of the psychiatric survivors' movement was Clifford W. Beers (Parry, 2010). In 1908, Beers published *A mind that found itself* which included a description of his experiences of being institutionalized for three years for mental illness (p. 2356). He promoted mental health care reform to reduce the physical and mental abuse that he and other patients had experienced (p. 2356). However, instead of joining with other ex-patients, Beer combined forces with a psychiatrist, a physician, and a philosopher to establish the National Committee for Mental Hygiene, now known as Mental Health America (p. 2357).

Another type of advocacy group was started in 1977 by two mothers who had sons with schizophrenia, Harriet Shetler and Beverly Young (NAMI Wisconsin, n.d., p. 2). This was the Alliance for the Mentally Ill (AMI), now known as the National Alliance on Mental Illness (NAMI), which mainly consisted of the family members of mentally ill persons (p. 2). NAMI Dane County (n.d.) reported that NAMI "has been the largest grass roots organization supporting, educating, and advocating for individuals and families affected with mental illness" (p. 1).

Along with offering educational and emotional support, advocacy groups have made significant legislative and judicial contributions for the benefit of mentally ill persons. These included the Individual with Disabilities Education Act (IDEA), *Rogers v.*

Okin (1979), the Civil Rights of Institutionalized Persons Act (CRIPA) of 1980, and *O'Connor v. Donaldson* (1975).

Public education for children with severe disabilities became possible in 1975 with the passing of IDEA (Disability Justice, 2018). Between 1971 and 1975, there were 28 federal court cases which influenced its development and passage (p. 4). The first case involved the Pennsylvania Association for Retarded Children (PARC) fighting for the right of intellectually disabled children to have free public education within Pennsylvania (p. 3). In *P.A.R.C. v. Commonwealth of Pennsylvania* (1972), it was argued that the exclusion of children from school who had a mental capacity of less than an average five-year-old by the time that they started the first grade violated the Fourteenth Amendment (p. 3).

Rogers v. Okin (1979) was a class action suit sponsored by Chamberlin and the MPLF against the Boston State Hospital (Mental Illness Policy Org., 2017, p. 1). They argued that patients should not be forced to take medication or be in isolation unless it was in an emergency situation (p. 1). Judge Tauro ruled that since patients in mental hospitals still retained legal rights to property (p. 2), they should retain the right to refuse psychotropic medication. Therefore, except in cases of patients committing extreme harm to themselves or others, a court had to decide if a patient could be forcibly medicated (p. 3).

The passage of the CRIPA was largely influenced by the American Civil Liberties Union (ACLU) class action suit against Willowbrook State School (ACLU, n.d.). Willowbrook was an New York state institution for children with intellectual disabilities

(DeBello, n.d.). Many of these children had been neglected and abused in a very unsanitary environment (p. 2). For three years, children were injected with hepatitis for a study in which participation was virtually involuntary (p. 2). The justification for the forced participation was that most of the children were already contracting hepatitis and that it would be beneficial to infect them in a controlled setting (p. 2).

According to the National Council on Disability (2005), CRIPA allowed the U.S. Attorney General to represent people residing in state or local institutions in cases of widespread abuse. The institutions included correctional and long-term health facilities in which residents had little contact with the outside world (p. 9).

O'Connor v. Donaldson (1975) was a pivotal case that has affected civil commitment cases ever since. Donaldson was committed under the insistence of his parents even though he denied being mentally ill (Mentally Illness Policy Org., n.d.). After 15 years of refusing treatment and petitioning to be released from the hospital, Donaldson's case was judged by the U.S. Supreme Court with the help of the ACLU (p. 1). The Court decided in his favor and judged that non-violent individuals cannot be confined indefinitely in state institutions if they are able to safely reside in communities with or without the support of family and friends (p. 2). This ruling has influenced how long people with mental illness can be committed and has made it extremely difficult to commit people unless there is proof that they are a danger to themselves or others (p. 2).

Similarly, California's Lanterman-Petris-Short (LPS) Act of 1967 has also affected civil commitments and has influenced the policy of the rest of the United States. It was meant to limit inappropriate commitments for people with mental illness,

intellectual disabilities, or alcoholism (Shields, 2013) by limiting most involuntary commitments to 72 hours (California Legislature, 2018). However, the act has made it difficult for any person with mental illness to obtain civil commitment (Friedman, 2018).

Currently, there has been an effort to amend the LPS Act with AB 1971. This bill would temporarily affect Los Angeles County until the year 2024 (California Legislature, 2018). It would allow people to be civilly committed who are non-compliant regarding medical treatment (p. 2). To obtain the civil commitment, a medical doctor would be required to provide his or her written, professional opinion that the failure to be compliant might result in death in the near future (p. 2).

With so many limits on civil commitments and the lack of community mental health resources, many states have had difficulty getting people with mental illness who refuse to acknowledge that they are ill the psychiatric treatment that they need. The States of New York and California responded to these limits with Kendra's Law of 1999 and Laura's Law of 2002 (Davis, 2012). These laws allow a judge to order outpatient psychiatric treatment for mentally ill persons who refuse treatment (p. 1). If the person is non-compliant about accepting treatment, the person may be involuntarily committed (p. 1). However, the court can only be petitioned if certain criteria are met regarding the person's history and risk to themselves or others (p. 2).

Although mental health care has primarily been a state issue, this issue has come up in the federal government several times. In 1977, President Carter signed an executive order to have a President's Commission on Mental Health advise him about the conditions of mental health services at the time (Carter, 1977). Carter acted on that

information by enacting the Mental Health Systems Act of 1980 which would have made federal funding available for community mental health programs (Hart, 2016). However, President Reagan cut much of the available mental health funding with the Omnibus Budget Reconciliation Act of 1982 (MIWatch.org, 2011).

On July 17 of 1990, President George H.W. Bush (1990) declared the 1990s as the "Decade of the Brain" (p. 2). There were great hopes that research into the brain would help cure brain injuries, mental illnesses, and drug addiction. Nine days later, Bush signed the Americans with Disabilities Act (ADA) (ADA.gov, n.d.).

ADA.gov (n.d.) described ADA's impact in the following statement:

> The ADA… is one of America's most comprehensive pieces of civil rights legislation that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life—to enjoy employment opportunities, to purchase goods and services, and to participate in State and local government programs and services. (p. 1)

The past three presidents: President Clinton, President George W. Bush, and President Obama have signed mental health parity acts to extend health insurance coverage for mental health and substance abuse treatments (Hart, 2016). Bush also signed the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) to help divert people with mental illness away from the criminal justice system (p. 2). Likewise, Obama signed the Frank Melville Supportive Housing Investment Act of 2010 to increase housing for people with mental illness (p.2).

On July 6, 2016, the U.S. House of Representatives passed U.S. Representative Tim Murphy's Helping Families in Mental Health Crisis Act (H.R.2646) (U.S. Congress, 2016). The following week, the bill was given to the U.S. Senate and the Committee on Health, Education, Labor, and Pensions (p. 1). Some highlights of the bill include increased federal financial support for mental health care, clarification of when confidential patient information may be disclosed, and providing more grants for programs that bring multiple agencies together to help de-escalate mental health crises (p. 4).

Shortly after President Trump came into office, he repealed an administrative rule (Kodjak, 2017) that automatically added people who received Social Security disability benefits for mental illness or intellectual disabilities to the National Instant Criminal Background Check System (NICS) in an effort to prevent them from purchasing firearms (Vitali, 2017, p. 1). Several senators supported that decision because they felt that the rule had stigmatized people with disabilities (Gorman, 2017, p. 2).

President Trump has also shown that he was concerned about the mental health of military veterans and law enforcement officers. On January 9, 2018, he made an executive order to make mental health treatment easier to obtain for people from the military returning to civilian life (Bushatz & Sisk, 2018, p. 1). The next day, he signed the Law Enforcement Mental Health and Wellness Act into law (Borelli, 2018). The law made more federal grants available for programs that improved the mental health of law enforcement officers (p. 1).

Development of the CIT Model

Los Angeles, CA. In several ways, California has modeled prototypes in technology and legislation for the rest of the United States. In 1984, Los Angeles, California became one of the first cities to address mental health crises (Finn & De Cuir, 1988). Two separate homicide cases involving perpetrators with mental illness caused community officials to question how these types of tragedies might be avoided (p. 2). The police chief brought in executives from most influential law enforcement, mental health, and social service agencies to discuss strategies for reducing the negative impact of mental health crises (p.2). This discussion group became known as the Psychiatric Emergency Coordinating Committee (PECC) (p. 2).

On April 1, 1985, PECC came to a formal agreement called the Memorandum of Agreement (Finn & De Cuir, 1988, p. 5). It stated that each partnering agency within the mental health emergency network would have mandatory responsibilities and that the Los Angeles Police Department (LAPD), the Los Angeles County Department of Mental Health, and District Attorney's Office each make high-level administrators available 24-hours-a-day to answer telephone calls regarding disagreements during a mental health emergency and legal advice (pp. 5–7).

In addition, the California state law was amended to help the effort to reduce mental health crises (Finn & De Cuir, 1988). One amendment made it illegal for mental health facilities to refuse to evaluate and treat someone in the custody of a police officer (p. 5). The other amendment made it mandatory that the time needed for transfer-of-custody procedures be reduced as much as possible (p. 5).

The LAPD's Mental Evaluation Unit (MEU) was created to help achieve law enforcement's responsibilities required by the Memorandum of Agreement (Finn & De Cuir, 1988, p. 6). Essentially the MEU was used to screen mentally ill persons before placement in a mental health or correctional facilities, to provide advice to patrol officers regarding mentally ill persons, to respond to calls for assistance during mental health crises, and to provide mentally ill persons with referrals to various mental health facilities and services (p. 6). The MEU also shared information with mental health facilities regarding mentally ill persons with known violent tendency, weapons, and martial art abilities (p.7).

Unfortunately, confidentiality laws, similar to the Health Insurance Portability and Accountability Act (HIPAA), restricted the information that mental health professionals could share with law enforcement officers. Exceptions were made for cases when there was a credible threat of serious injury towards a potential victim such as police officer who was transporting a patient (Finn & De Cuir, 1988). These exceptions were made possible due to a California State Supreme Court decision in *Tarasoff v. Regents of the University of California* (p. 7).

Memphis, TN. In 1986, the future president of the NAMI Memphis, Helen Adamo proposed a new kind of law enforcement training for officers responding to service calls involving mental illness (NAMI, 2013). The proposal was written in response to how her son and the current NAMI Memphis President Ann Dino's son had been treated by police officers inexperienced with people with mental illness (p. 1). The

proposal was modeled after the LAPD's PECC and MEU and focused on reducing injuries to both people with mental illness and police officers (p. 1).

Memphis Police Director John Holt accepted the proposal and assigned an officer to research training techniques (Bayne, 1987, B1). The research included identifying community assets and emergency commitment laws (p. B1).

Almost one year after the presentation of the proposal, there was a mental health crisis which became the catalyst for its implementation in the form of the CIT Program (Bayne, 1987, p. B1). Twenty-seven-year-old Joseph Robinson (Bayne, 1987) was threatening to seriously harm himself with a knife (Vickers, 2000, p. 4). His mother called the police for assistance (NAMI, 2013, p. 1). When the officers arrived, they ordered him to drop the knife. Robinson became visibly agitated because of the order and ran toward the officers. The officers then shot and killed him because he had presented a serious threat to their safety (Vickers, 2000, p. 4). As a result, Robinson's death brought up extreme racial tensions because he was African American and the officers who shot him were Caucasian (Dupont & Cochran, 2000, p. 339).

During the public protest of Robinson's killing, the mayor and police chief collaborated to find a solution to preventing similar incidents (Bayne, 1987, p. B1). Memphis Mayor Dick Hackett decided to implement Adamo's proposal as soon as possible (p. B1). Lieutenant Walter Crews was assigned to recruit and coordinate the community taskforce needed to bring perspective and ideas for the new training (NAMI, 2013, p. 1).

According to Dupont and Cochran (2000),

> The task force set out four basic goals…. These were: (a) the need for advanced training; (b) immediacy of the crisis response; (c) emphasis on safety of the officer and consumer involved in the crisis; and (d) delivery of proper care for the individual in crisis. No model available at the time focused on these four elements. Addressing these goals set into motion a dynamic relationship between community policing, mental health service delivery, and advocacy that focused on issues of police use of force and jail diversion. (p. 339)

The Memphis community taskforce formed an alliance network after meeting for several months (Gilliland & James, 1997, p. 626). The alliance network did not just consist of law enforcement and mental health agencies; it also included the city government, NAMI, neighborhood emergency rooms, the University of Tennessee, the YWCA, and the University of Memphis (Gilliland & James, 1997, p. 626).

Initially, the taskforce looked at other cities' mobile crisis team model (Moore, 2008). However, because of the limited number of team members traditionally involved in a mobile crisis team program, the response time was often too long with a wait up to two hours (p. 61). Later, the taskforce decided to train police officers with good judgment on how to respond to calls for service involving people with mental illness (p. 61).

In 1988, Major Sam Cochran became Memphis' CIT training coordinator and remained the coordinator until retiring in 2008 (CIT International, n.d.-a). Cochran was deeply passionate about the CIT program and has been instrumental in its endurance and expansion across the world (NAMI, 2013). According to CIT International (n.d. A), he

adopted NAMI's viewpoint that "mental illness is a brain illness, and respect and dignity are necessary components within hope and recovery" (p. 1).

CIT officer training had three basic parts: (a) lecture-discussions by mental health professionals, legal professionals, and experienced CIT officers; (b) de-escalation role-playing and critiques; and (c) in-person, group discussions with mentally ill persons about their viewpoint regarding law enforcement (James, 2008, p. 84).

Lecture-discussions were made by mental health professionals, legal professionals, and (after the initial training in 1988) experienced CIT officers. The topics were focused on basic mental health education such as symptoms and behaviors of major types of mental illnesses, basic pharmaceuticals used to treat mental illnesses, and civil commitment procedures (University of Memphis, n.d., p. 2).

The role-playing training techniques were based on University of Memphis Professors Burl E. Gilliland, Ph. D. and Richard K. James, Ph. D.'s crisis intervention strategies (Woody, 2005, p. 59). These strategies were devised from the authors' experience and from their interviews with first responders (James, 2008, p. xx). Gilliland and James (1997) identified "listening and responding skills… [as] critical to everything else… [done] in crisis intervention" (p. ix). Role play combined with peer and mentor critiques was found to be the best way to safely learn de-escalation techniques (p. ix).

In-person, group discussions with mentally ill persons about their perceptions of the police were important for helping officers to develop empathy for mentally ill persons (Gilliland & James, 1997). Sometimes these discussions could take place on site visits to mental health facilities.

Because the majority of CIT officers had no extensive training in mental health and it was important to make CIT officers readily available, it was crucial that there were consistently expedient and efficient transfers-of-care for people with mental illness into the mental health system. To find a solution, Cochran partnered with Dr. Randolph Dupont who was the Program Director for Psychiatric Services at the Regional Medical Center, otherwise known as the MED (Dupont & Cochran, 2000, p. 338).

Dupont and Cochran (2000) came up with a single-entry point system in which the MED's emergency room screened people brought in by officers for medical conditions such as intoxication or exacerbation of a mental illness (p. 343). They accepted all police referrals and kept the time needed for transfer-of-care procedures to a maximum of 15 minutes (Cochran, Deane, & Borum, 2000 & Vickers, 2000).

Akron, OH. Cochran and Dupont first presented the CIT program to Ohio at the was first introduced to CIT at the 1998 Annual Forensic Conference (Munetz et al, 2006, p. 1569). Their presentation influenced Summit and Lucas counties to adopt the CIT program in 2000 (p. 1570). Thereafter, the largest city in Summit County, Akron, Ohio, became the center for CIT training and innovation in the State of Ohio (p. 1570). Lieutenant Michael Woody of the Akron Police Department became the State CIT Coordinator and helped the CIT program spread across Ohio (CIT International, n.d.-b, p. 1).

As CIT spread across the State, two main concerns emerged which were how to maintain CIT programs for long-term periods and how to prevent the possible deviation from community stakeholder collaboration which was the basis of the original CIT model

(Munetz et al, 2006, p. 1571). To address these concerns, the Ohio CIT Coordinators was formed (p. 1571).

The Ohio CIT Coordinators developed a document that listed the basic strategies needed for a successful CIT program (Munetz et al, 2006, p. 1571). Later, the Ohio's *Core Elements* document was the model for the national CIT program document (p. 1571). Likewise, Ohio's statewide program became a model for other States to follow.

In 2005, Ohio held the first national CIT conference (Woody, 2017, p. 1). Some of the participants of that conference formed the CIT National Advisory Board in 2006 (p. 1). Three years later, the Board became known as CIT International Inc, and Lieutenant Woody became its first president (Woody, n.d.).

In addition to educating representatives from other counties, states, and countries about the CIT program, Akron became a center of CIT research. A team of researchers led by Munetz and Griffin (2006) built upon Dr. Gerald Landsberg's plan for diverting people with mental illness away from the criminal justice system of New York City (p. 544). Their work resulted in the development of the sequential intercept model (Munetz & Griffin, 2006, p. 544). The model was made in an attempt to prosecute only mentally ill persons who deliberately committed crimes and to divert those whose criminal behavior was caused by their mental illness away from the criminal justice system and into treatment (p. 544).

The sequential intercept model introduced a framework of five interception points within the criminal justice system (Munetz & Griffin, 2006, p. 544). These points were diversion to treatment by police officers or other first responders before an arrest is made;

diversion to treatment post-arrest but pre-prosecution/pre-incarceration; diversion to treatment by a court, such as a mental health court; treatment three months before and three months after release from a correctional facilities while transitioning back into communities; and diversion to treatment by probation and/or parole officers (pp. 545 – 547). However, according to Munetz and Griffin (2006), the sequential intercept model can only be effective if there is a "close collaboration between the mental health and criminal justice systems" (p. 547).

New River Valley, VA. The New River Valley consists of the city of Radford and the four counties of Floyd, Giles, Montgomery, and Pulaski (New River Valley VA, n.d., p. 1). It rests between the Appalachian and Blue Ridge Mountains. It also includes the New River which is actually the oldest river in the United States (Explore New River Valley, n.d.). In fact, it is the second oldest river in the world after the Nile (p. 1).

In the year 2000, Victoria Huber Cochran, J.D. was introduced to the CIT program at a conference in Washington D.C. (DMC Administration, 2010). She worked with the Mental Health Association to obtain a federal grant for the purpose of starting Virginia's first CIT program in the New River Valley (p. 2). According to the CIT Program Development Guidance (2014), the New River Valley CIT (NRVCIT) program became "the nation's first multijurisdictional, rural adaptation of the Memphis CIT model" (p. 2).

Since the New River Valley region already had a collaboration of community mental health agencies which served this specific region, the existing infrastructure supported the idea that a CIT for this region was possible. In 2001, several different law

enforcement agencies partnered with the mental health community to form the NRVCIT (CIT Program Development Guidance, 2014, p. 2).

In 2005, Victoria Cochran attended the first national CIT conference in Ohio (DMC Administration, 2010 & Woody, 2017). The next year, Cochran and two other leaders from NRVCIT joined representatives from Ohio, Georgia, Florida, and Tennessee to form the CIT National Advisory Board, now known as CIT International, Inc. (Woody, 2017). Those additional NRVCIT leaders were Amy Forsyth-Stephens of the Mental Health Association and Radford University's Chair of the Department of Criminal Justice Professor Isaac T. van Patten, Ph.D. (Forsyth-Stephens, n.d., Van Patten, 2018 & Woody, 2017). All three NRVCIT leaders contributed toward Dupont, Cochran, and Pillsbury's (2007) *Crisis Intervention Team Core Elements.*

In addition to working with the local and national CIT communities, Victoria Cochran lobbied the CIT model to Virginia's General Assembly and Governor Tim Kaine to help spread the CIT program statewide (DMC Administration, 2010, p. 3). Unfortunately, the tragic mass shooting at Virginia Tech on April 16, 2007 may have contributed to the increased interest in CIT by Virginia's governor and General Assembly (Virginia Tech Review Panel, 2007). That year, the NRVCIT received state funding to help CIT expansion, and Governor Kaine began to investigate policy changes to improve Virginia's mental health system (CIT Program Development Guidance, 2014 & Sluss, 2007).

With the funding, NRVCIT helped the Thomas Jefferson Area, Mount Rogers, and Hampton-Newport News to develop their own CIT programs (CIT Program

Development Guidance, 2014). These CITs joined together to form the Virginia CIT Coalition (VACIT) which promoted CIT programs statewide (p. 3).

In 2009, Virginia's General Assembly passed Senate Bill 1294 which amended the *Code of Virginia* to support the statewide spread of CIT (DCJS & DBHDS, 2009a). The DCJS and the DBHDS were put in charge of this effort (p. 2). Since the NRVCIT was the first established in Virginia, it has been instrumental in providing training and mentorship to other regions in Virginia attempting to start their own CIT programs.

In 2013, the innovative New River Valley CIT Assessment Center (CITAC) was opened (Halpern, n.d.). It is located near the emergency department of a local hospital (p. 2). Its purpose was to offer a centralized location to assess people with mental illness and to hold them during civil commitment procedures (p. 2). It allows law enforcement officers to transfer custody of these people to the Center daily and has significantly reduced their time involved (p. 2).

Exosystem: Social Environments That Indirectly Influence an Individual

An exosystem indirectly links individuals to environments, organizations, and people that directly influence the individual's daily contacts (Psychology Notes HQ, 2013 & Baxter, n.d.). It involves the influential network within local communities of which many people may not be aware (Modesto Junior College, n.d., p. 1). For the purpose of this Literature Review, this broader community will encompass the people and environments of Virginia who indirectly influence people with mental illness through the people and organizations with whom they regularly interact.

Department of Criminal Justice Services

In 2009, the DCJS was directed by the amendment in the *Code of Virginia* by the passage of SB 1294 to support the spread of CIT statewide (DCJS & DBHDS, 2009b, p. 3). To achieve that directive, the DCJS reviewed local programs and awarded grant money to local law enforcement (p. 15). They also established hiring and training standards for security and law enforcement (p. 13).

Department of Behavioral Health and Developmental Services

The DBHDS was directed by the passage of SB 1294 to assist the DCJS in the spread of CIT programs throughout Virginia (DCJS & DBHDS, 2009b, p. 3). It directly oversees Community Service Boards (CSBs) in the Commonwealth of Virginia and provides them with problem solving, training, guidelines, and program evaluation (Virginia DMHMRSAS & DSS, 1988).

Microsystem: Social Environments That Directly Influence an Individual

A microsystem is made up of people, organizations, and environments that are in direct contact with an individual (Modesto Junior College, n.d., p. 1). In this Literature Review, the microsystems consist of those people who directly interact with people with mental illness who live in Virginia.

Community Services Boards

CSBs either provide or refer mentally ill persons to mental health care, substance abuse recovery services, case management, housing assistance, etc. (Virginia DMHMRSAS & DSS, 1988). They are mainly funded through the state, but the local

governments are required to provide 10% of their funding (p. 15). There are 40 CSBs within Virginia (p. 14).

Emergency Rooms/Departments

In most communities, the emergency department is the most direct access point to mental health care for people with mental illness during a mental health crisis. Partnerships between CIT officers and emergency department staff helps improve the outcomes for the people with mental illness who are brought into the emergency department (Ralph, 2010, p. 60).

Family Members

Family members of people with mental illness tend to care for their loved ones as much as possible. Yet, they are often uneducated regarding the mental health system and are left to fend for themselves. They can become enmeshed in the judicial system and are often unprepared about what might happen to their loved ones in the process (Lee-Griffin, 2001, p. 19). It would be beneficial to educate families and to work with them as much as possible.

Homeless Shelters

Although homelessness should not require police intervention, the restriction of the length of mental health hospitalization has caused law enforcement to become involved in many cases with people with mental illness who are homeless (Miller, n.d. & Lee-Griffin, 2001). Because of the high percentage of homeless people with mental illness, homeless shelters have significant contact with this population.

Homes for Adults

Homes for Adults (HFAs) were originally intended for elderly citizens in Virginia who needed assistance but who did not need the specialized medical care which is provided in nursing homes (Virginia DMHMRSAS & DSS, 1998). After the nationwide, mass release of patients from mental hospitals in the 1980s, HFAs housed many of the people with mental illness who were unable to live alone unassisted (p. 3).

Law Enforcement Agencies

Law enforcement agencies include local and state police departments, sheriff offices, and university police departments. They are often the first responders to mental health crises and generally are responsible for transporting people with mental illness to hospitals when they have civil commitment orders.

Mental Health Association

The Mental Health Association (MHA) promotes the education and advocacy of mental health (Mental Health Association of the New River Valley, n.d., p. 1). The MHA offers counseling services to low-income people with mental illness (Riding-Malon, Cordial, & Stroup, 2011).

National Alliance on Mental Illness

NAMI is an organization that educates and supports the family members of people with mental illness (NAMI Dane County, n.d.). They were instrumental in the development of the Memphis CIT program and have worked closely with law enforcement and the mental health system to help spread CIT (Dupont & Cochran, 2000).

Religious Organizations

Religious organizations include churches, mosques, synagogues, and temples which may offer emotional and physical support to people with mental illness in times of crises. Historically, they have often advanced civil rights and humanitarian practices.

Mesosystem: The Interaction Among Microsystems

A mesosystem happens when two or more microsystems interact regarding an individual who is not directly involved in the interaction (Modesto Junior College, n.d., p. 1). For people with mental illness, these mesosystems may include CITs, Community Emergency Response Teams (CERTs), and Threat Assessment Teams (TATs).

Crisis Intervention Team

According to Dupont and Cochran (2000), the CIT program is a community partnership which exhibits a "dynamic relationship between community policing, mental health service delivery, and advocacy that focus[es] on issues of police use of force and jail diversion" (p. 339) during mental health crises. CIT partners collaborate to offer people with mental illness emergency services, mental health counseling, substance abuse rehabilitation services, medical services, legal services, emergency shelters, housing resources, and information (Charlottesville-Albemarle Prevention Coalition, 2014). They also educate CIT officers and other first responders about de-escalation techniques and how to access community resources for people with mental illness.

Community Emergency Response Team

A CERT consists of volunteers at the state and local level who train to respond to disaster situations (Ready.gov, n.d., p. 1). That training consists of search and rescue, first aid, and other basic skills which may be needed during a disaster (p. 1). CERTs are nationally registered on the FEMA Citizen Responder website at https://community.fema.gov/Register (p. 2).

Threat Assessment Team

TATs study risk assessment within schools and workplaces (Sokolow & Lewis, n.d., p. 2). TAT members include representation from local law enforcement and facility administration (pp. 1-2). Instead of just reacting to a threat, TATs may assess background information about at-risk students or employees to put preventative measures in place to stop potential threats (p. 2).

Chronosystem: Periods of Time That are Influential to Behavior

A chronosystem refers to influential periods of time which can greatly affect an individual's behavior (Bronfenbrenner, 1986, p. 724). For many people with mental illness, this may include the cumulative effects of stigma and the often-frightening moments during a mental health crisis.

Mental Health Crises

Mental health crises occur when an individual is unable to cope with a situation or circumstance that the individual perceives to be threatening (Dattilio & Freeman, 1994, p. 1). This usually occurs when a person's equilibrium becomes unbalanced (p. 2). During a crisis, the individual may exhibit confusion and erratic behaviors (p. 2).

Law enforcement officers respond to mental health crises more often than mental health professionals (Miller, n.d., p. 4). This is often due to the danger involved during a crisis situation. According to Lowry (2016), "about nine in 10 of the mentally troubled people killed by police were armed, usually with guns, but also with knives or other sharp objects" (p. 4).

Stigma

Gluck (2016) defined the word stigma as any distinction which may cause an individual to be degraded by others. Historically, society has treated mental illness as demonic possession or a willful manifestation of immoral character (Joint Commission on Mental Illness and Health, 1961). Because of this way of thinking, mental illness has been mainly treated with punishments and scourges (p. 27).

In a study, Marcussen, Ritter, and Munetz (2010) "found that perceived stigma had a negative impact over time on self-esteem and sense of control" (p. 493). When the words to describe psychiatric conditions are used as insults, feelings of shame can often make symptoms worse (Francolini, 2016).

According to Major Sam Cochran, the word "stigma" should be substituted for the word "prejudice" when it relates to describing mental illness (Moore, 2008, p. 62). In fact, not all signs of mental illness are visible. People with major depression can often hide their symptoms from others (Troung, 2017, p. 1).

Francolini's (2016) following statement about stigma was very insightful:

> Mental health disorders affect us all. But we walk past people in crisis, we ignore those in our immediate communities, including friends and family. We let the

stigma overshadow our compassion, and this is the most insidious manifestation of discrimination (p. 3).

Chapter 3: Research Method

Research Design

For this study, I used a mixed-methodology research design that was exploratory. The focus of the research revolved around CIT stakeholder cooperation within central Virginia and how the passage of SB 1294 of 2009 may or may not have affected that cooperation.

For the qualitative portion, the research was phenomenological in that I concentrated on how the passage of SB 1294 may or may not have affected CIT stakeholder cooperation. For that purpose, I interviewed CIT leaders who had either law enforcement or mental health provider roles within the CIT program. I designed the interview questions to learn about cooperation techniques, common disputes within the CIT program, and the impact that SB 1294 had on the CIT program.

For the quantitative portion, I used correlational methods to explore the topic. To find out if there was a correlational relationship, I developed a questionnaire that was modeled after questionnaires found in business management journal articles by Lee (2001) and Squire, Cousins, and Brown (2009). The terminology that was used to measure cooperation was found within the studies of Allwood (2007) and Deutsch (1948). The descriptions of CIT practices that were influenced by SB 1294 used in the questionnaire were adapted from those developed by DCJS and DBHDS (2009a). Descriptions of general CIT practices used in the questionnaire were adapted from *CIT Core Elements* written by Dupont, Cochran, and Pillsbury (2007) and by the DCJS and DBHDS (2009a). In all, I designed nine questions which described cooperative CIT

practices affected by SB 1294 and 11 questions which described general cooperative CIT practices which were in effect before SB 1294 was passed.

Role of the Researcher

For this study, the role of the researcher was to define a social problem and ask certain questions which could help find a solution to that problem. For this role, I was responsible for constructing a data collection plan that showed how I was going to treat study participants ethically correct. Then I presented that plan to Walden's Institutional Review Board (IRB) for approval and revisions.

Recruitment of Participants

The partnering organization assisted with the recruitment of participants within central Virginia. It provided me with the personal email addresses of potential participants so that I could contact them about the study.

The study invitation that I emailed to CIT members in central Virginia stated a short description of the study and that I would be at a facility owned by the partnering organization at certain dates and times. During those dates and times, I was going to be collecting data in the form of questionnaires and interviews. The people who were interested in participating in the study emailed a reply to me stating their interest. I emailed a response back to the participant stating a date and time to come to the facility and participate.

Explanation of Study to Participants

I explained to the study participants that the purpose of the study was to learn more about cooperation among CIT stakeholders and about how SB 1294 may have

affected that cooperation. I also requested that participants of the questionnaire leave a space between themselves and other participants so that their answers would remain private and a blank cover sheet was provided to them to cover their answers when they had finished. I told the questionnaire participants not to write their name or any other identification on the questionnaire. I estimated that the time to complete the questionnaire would be around 15 to 20 minutes.

I explained to interview participants that I would be audio recording the interview. I informed them that their identities would be masked on the interview transcripts and in the study itself. I estimated that the interview would take between .5 and 1 hour to complete.

Explanation of Informed Consent to Participants

During the explanation of informed consent, I told participants that participation was completely voluntary and that participants could withdraw from the study at any time. I stated that participants' identities would be masked or kept anonymous when possible. I also mentioned that the audio recordings and paper questionnaires would be stored in a locked safe at my home and that they would be destroyed after 5 years.

Researcher Bias

I had experience in law enforcement, nursing, and lobbying the U.S. Congress for legislation meant to create positive social change. The majority of that experience has been in law enforcement. This experience has made the me aware of the difficulty that law enforcement may have when they are faced with calls for service involving mental

health crises and transportation of people with serious mental illness to mental health facilities.

At the time of the study, I was working with my state and local communities in the form of a CIT Coordinator. As a CIT Coordinator, I learned that although I had personal biases based on my experiences, it was imperative to the CIT program that I put aside my differences to try to cooperate for the good of my community.

Therefore, it was my goal to learn from the Commonwealth of Virginia about the passing of SB 1294 in 2009 and the subsequent involvement of Virginia's DCJS and DBHDS in the statewide spread of CIT. In addition to this primary goal, I planned on learning from Virginian CIT leaders about strategies for initiating and maintaining cooperative efforts within the CIT program.

Research Questions

I designed the following research questions to help triangulate data regarding how state-involvement may affect the success of local and regional CIT programs and how cooperation, which is a known element of success within a CIT program (Cochran, Deane & Borum, 2000), may be better achieved by community stakeholders.

Research Question 1 (RQ1): How has the passage of Virginia's 2009 SB 1294 affected the level of stakeholder cooperation within Virginia's statewide CIT program?

Research Question 2 (RQ2): What was the relationship between what questionnaire participants perceived regarding questions about CIT stakeholder cooperation when stakeholders are performing CIT practices which were affected by the

passage of Virginia's 2009 SB 1294 and those questions about CIT practice which were in effect before the passage of SB 1294?

Null Hypothesis: ($H_0$2): There would be no relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Alternative Hypothesis (H_a2): There would be a relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Context

I conducted this study in a region of central Virginia in 2019, 10 years after the passage of SB 1294. This region included several counties which had rural, mountainous terrain. The total population of the region was 178,237 with the largest city in the region containing almost a quarter of that population (Suburban Stats, Inc., 2019). The male population was slightly larger than the female population at 50.48%. The ethnic demographics were 90.08% Caucasian, 4.09% African American, 3.11% Asian, 2.23% Hispanic, and 0.11% Native American. The percent of the population that was multiracial was 1.80%.

SB 1294 was a landmark piece of CIT state legislation in that it mandated that two state departments, the DCJS and the DBHDS, provide leadership in the statewide expansion of CIT (Virginia General Assembly, n.d., § 9.1–187). The departments did so by distributing grants to help start and expand CIT programs statewide, by establishing universal CIT training criteria, and by assessing CIT program effectiveness (§ 9.1–187).

Another unusual mandate of the legislation was that instead of just training law enforcement officers about CIT de-escalation techniques and theories, all first responders and mental health professionals involved in de-escalating mental health crises had to receive CIT training (§ 9.1–188).

Participants

The participants of the study were a nonrandom, non-probabilistic, homogenous sampling from a regional CIT program in central Virginia. The CIT members of that region seem to be more representative than those of CIT programs in other states. They included advocates for mental health consumers such as family members and friends, Emergency Medical Technicians (EMTs), fire department personnel, hospital employees, law enforcement officers, mental health providers, religious leaders, social workers, university administration, and others. The qualitative participants all held administrative positions in their fields and were highly involved in the CIT program.

Inclusive/Exclusive Criteria

The inclusive criteria for questionnaire participants were that the participant had to be involved in the regional CIT program in central Virginia before and after the passage of SB 1294 and that the participant had to have a role in the CIT program whether it was being an advocate for a mental health consumer or being in a profession in which they may come in contact with a person during a mental health crisis.

The main exclusive criterium was that the participant was not a CIT member of the region of study in central Virginia before 2009. During the data collection phase of the study, I may not have made that distinction clear when recruiting participants. After

reviewing the first set of questionnaires which were completed, it was determined that I would have to collect another set of questionnaires from participants who met the requirements of the study.

Participation in either part of the study did not affect the inclusive or exclusive criteria for one or the other. The inclusive and exclusive criteria for interview participants were the same as those for questionnaire participants except that the interview participants had to have leadership roles in the CIT program.

Recommended Number of Participants for Qualitative Part of Study

For the qualitative part of this study, I was interested in learning about the perspective that participants had about the effect that the passage of SB 1294 had on CIT stakeholder cooperation. Because this type of inquiry was phenomenological, the recommended number of participants was 10 (Noko, 2017).

Recommended Number of Participants for Quantitative Part of Study

For the quantitative part of this study, I used a power calculation to find the minimum number of participants that were needed to make the data results be statistically significant. The power calculation used was for categorical data that was to be used in chi-squares. Using the data and calculation from *Figure 1*, I found that the recommended number of participants for the quantitative part of the study was 75.

Figure 1. Power Calculation

Power Calculation for Categorical Data

$$n = [P_1(1-P_1) + P_2(1-P_2)] / (P_1-P_2)^2 * f(\alpha,\beta)$$

Equation and $f(\alpha,\beta)$ chart source was from Cornish (2006)

α=.05, β=.20, $f(\alpha,\beta)$=7.9, P_1=.12, P_2=.01, n=75.4 or 75 participants

P_1= 12% difference between cooperative and competitive groups regarding task inter-dependence (Johnson et al., 1981, p. 55)

P_2= 1% difference between cooperative and competitive participants was statistically significant (Deutsch, 1948, p. 91)

Data Collection

For this study, I collected the qualitative and quantitative data in tandem to make the best use of my time and access to participants. I collected data at a facility owned by the partnering organization who was a community stakeholder in the regional CIT program in central Virginia. I scheduled the interviews with participants before I arrived on site to allow for sufficient time to interview participants. Likewise, I scheduled blocks of time on certain dates for questionnaire participants to participate at the time that was most convenient for them.

Qualitative Data Collection

I collected the qualitative data in a private room at the partnering organization's facility. It had a boardroom setting with chairs placed around a central table so people could all face each other. I chose to sit across from each interview participant during their scheduled interview times.

Before the interview started, I shut and locked the door so that someone had to knock before he or she could interrupt the interview. Then, I summarized the purpose and details of the study and explained about informed consent which allowed participants to voluntarily participant in the study and that they could end participation at any time. I then informed the participant that the interview would be digitally audio recorded on a small device which I then placed on the table between myself and the participant.

I asked the questions from the list of interview questions and followed up some of those questions with questions and/or comments about what the participant had just said. There were 11 interviews conducted in total. The interview times ranged from 15 minutes to 2 hours. The average time needed for the interview was about 30 minutes.

Qualitative Instrument

The 11 interview questions are included in the following list:

- How did CITs differ in the Commonwealth of Virginia after SB 1294 passed in 2009 from what they were like before it passed?
- How have the DCJS and the DBHDS helped to increase cooperation among local CIT stakeholders?

- In what ways does having state department involvement help to develop CITs statewide?
- What are the best strategies for maintaining cooperation between CIT stakeholders?
- What are the basic elements needed for maintaining a mental health assessment center?
- What are the most common disputes between CIT partnering agencies?
- How are disputes usually resolved within the CIT community?
- How does a rural setting affect cooperation?
- What strategies have been used for collecting evaluation and assessment data on mental health calls for service statewide?
- Which agencies, organizations, and/or individuals are involved in CIT besides mental health and law enforcement, and how important is their involvement in the CIT partnership?
- Please comment on any other aspect of cooperation between CIT partners locally and/or statewide which you have not already discussed.

Quantitative Data Collection

I collected the quantitative data in a room designed for educational purposes located at the partnering organization's facility. It had five rows of tables and chairs which faced a large whiteboard at the front of the room. There was a column of space between tables which was designed for the purpose of having easier access to seats. The normal capacity for the room was 40 students, but it could fit up to 50 students if needed.

Each group consisted of 20 to 30 participants. Altogether there were seven groups that each came on a different day to complete a questionnaire, including when I had to return to the region to pass out and collect more questionnaires. The total number of participants was 179. Sixty-four participants were not CIT members before 2009, so they did not meet the criteria of the study and were not used in the data analysis. All the interview participants also chose to participate in a questionnaire session.

I noted the number of participants who came to the room for each scheduled assembly. If any of the participants were missing by the scheduled time, then I waited an extra five minutes before I began to address the group.

Before I passed out the questionnaires, I summarized the purpose and details of the study. I explained that informed consent allowed participants to voluntarily participate in the study and that they could end participation at any time. I also explained that the questionnaires were not to signed or labeled in any way that could identify the participant. I asked participants to sit with an empty chair spaced between each participant and to place a blank coversheet on each questionnaire after it was completed. I asked the participants to bring the covered questionnaire up to the front of the room when they had finished filling it out and to place it on a table near the exit. Then I told participants that when they were finished, they would be free to leave. The questionnaire took about ten to 15 minutes to complete.

Quantitative Instrument

The questionnaire contained 20 statements regarding cooperative CIT practices. Participants could choose the degree that they agreed or disagreed with the statement

using a 5-point Likert scale (from 1 = “Strongly disagree” to 5 = “Strongly agree”), or they had two additional responses to choose from (DK = “I do not know” and NA = “I prefer not to answer”). Those statements are presented on the following list:

- The DBHDS helps to resolve conflicts between local and state CIT stakeholders.
- The *Essential Elements for the Commonwealth of Virginia’s CIT Programs* helps to keep CIT standards uniform statewide.
- The local CSB usually assesses mental health referrals in a timely manner.
- Mental health workers are committed to a positive relationship with CIT officers.
- Mental health workers keep CIT officers informed of patients with violent tendencies before the CIT officers transfer the patients.
- The local CIT Coordinator has a direct line of communication with a representative of the DCJS.
- The local mental health assessment center has an average time of 30 minutes or less for transfer-of-custody procedures.
- The VACIT keeps local CITs informed of relevant information and events.
- The DCJS helps to maintain local CITs when its help is needed.
- CIT officers can rely on the mental health community to provide timely access to mental health services to those in their custody who may need it.
- Cooperation between CIT agencies has increased since 2009.

- CIT-trained police officers provide assistance for mental health workers when it is requested.
- The criminal courts routinely divert people with mental illness to treatment programs when appropriate.
- Judicial officials, law enforcement, and mental health professionals hold routine meetings about difficult cases involving people with mental illness in the community.
- Providing access to appropriate care to underserved populations is the responsibility of every CIT-partnering agency.
- The DBHDS provides educational information to the public about CIT programs.
- Law enforcement routinely reports data to the DCJS regarding service calls involving mental health issues.
- Community stakeholders have sufficient protocols for diverting people with mental illness away from the criminal justice system and into appropriate treatment programs.
- Public awareness of the CIT program has increased since 2009.
- The local community CIT taskforce encourages the local CIT partnership to keep a joint purpose of diversion of people with mental illness from the criminal justice system.

There were also four demographic questions in the questionnaire. I included the first question to rule out if the participants met the inclusive/exclusive criterium of being

a CIT member before the year 2009. The other three questions pertained to participants' CIT role, sex, and ethnicity.

The last item on the questionnaire was open-ended. It was a request for participants to please comment on any insight that they had gained regarding cooperation within CITs.

Data Analysis

Qualitative Data Analysis

My digital audio recorder held 32 gigabytes of data storage, so all the interview recordings fit on the device. The recordings were also backed up on two different USB memory devices. I listened to the recordings and decided to just transcribe the material relevant to the interview questions and topic. For that material, I transcribed what the participant said verbatim minus expressions such as "uhm". I also made notes for any other important content such as the participant's demeanor or if there was an interruption.

After I transcribed an interview, I reviewed the transcript and notes for any kind of words or phrases that might help answer the qualitative research question. I collected these words and phrases on a single document. After I completed the transcripts, I scanned the words and phrases looking for themes and important phrases to include in the results.

Quantitative Data Analysis

The questionnaire contained 20 questions which used a 5-point Likert scale to describe the participant's perception about cooperation in the CIT program. Four questions were demographic, and the last question was open-ended. The researcher

assigned a number to each of the Likert scale responses in the following way: (from 1 = "Strongly disagree" to 5 = "Strongly agree". The responses labeled "I don't know" and "I prefer not to answer" were assigned a missing value. I determined that nine of the questions described CIT cooperative techniques which were affected by the passage of SB 1294 and that 11 questions described general CIT cooperative techniques which would have been in practice before 2009.

I entered the raw data of the questionnaire results into a SPSS database. This database was used to find the results for descriptive frequencies, cross-tabulation, and factor analysis. A second database was developed using the total mean Likert score of the nine questions influenced by the bill and the total mean Likert score of the 11 questions describing general CIT practices as values for each of the 115 participants who met the recommended criteria of the study. The missing values of the first database were counted in the total mean Likert score as zeros in the second database. The second database was used to find the results for a paired sample T test.

Since this study was exploratory, I chose to use an alpha of .05 or 5% that was a standard level of statistical significance (Frankfort-Nachmias & Leon-Guerrero, 2015). Furthermore, I chose to use a beta value of .20 that gave an 80% assurance that there was a change of cooperation for this study.

Frequencies. I used the SPSS program to calculate the frequencies of responses and the mean Likert scale score for each question. This method showed the basic patterns of the results.

Cross-tabulation. I then used the SPSS program to calculate cross-tabulations, Pearson chi-squares, and Cramer's V. In the cross-tabulations, I compared each of the three participant demographics of CIT role, sex, and ethnicity individually to the participants' responses to the 20 Likert scale questions to discover if there was a correlational pattern. There are three possible patterns that could occur: positive, negative, and zero (McCombes, 2019). Because I conducted a non-experimental study, I was able to use the patterns to help support my alternative hypothesis even though I could not prove causation (pp. 1–2).

I used the Pearson chi-square to test for the statistical significance of the relationship between variables (Frankfort-Nachmias & Leon-Guerrero, 2015). Because this study was exploratory, I decided to use the standard *p*-value of .05 to determine statistical significance.

I measured the strength of a correlational relationship between the cross-tabulation variables with Cramer's V. Cramer's V has a range between 0 and 1. According to Frankfort-Nachmias and Leon-Guerrero (2015), a Cramer's V of 0 indicated that there was no relationship between variables; whereas, a Cramer's V of 1 indicated that there was a perfect relationship between variables (p. 369). For the purpose of this study, I assigned any Cramer's V that was less than or equal to .39 the designation has having a weak association. Cramer's V's that were .40 to .60 were designated as having a moderate association, and those that were .61 and above were designated as having a strong association.

Paired samples T test. I used the paired sample T test to compare the mean Likert scale score for the nine questionnaire questions about CIT stakeholder cooperation techniques which were affected by the passage of SB 1294 and the mean Likert scale score for the 11 questions about general CIT stakeholder cooperation techniques which were in effect before the passage of the bill. I calculated the mean Likert scale scores for each of the 115 questionnaire participants who met the inclusive requirements of the study.

"The purpose of the test is to determine whether there is statistical evidence that the mean difference between paired observations on a particular outcome is significantly different from zero" (Kent State University Libraries, 2019, p. 1). It can find the strength, direction, and significance of the mean difference between two variables (p. 8).

Factor analysis. I used factor analysis to discover a pattern of which questionnaire questions best described the latent variable of CIT stakeholder cooperation (Rahn, n.d.) for two different sets of questions: (a) those which described CIT stakeholder cooperation techniques affected by SB 1294 and (b) those which described CIT stakeholder cooperation techniques not affected by the bill. The method of factor analysis used was principle components, and the extraction was based on a fixed number of factors which equaled the number of questions being analyzed.

After the test was run, I studied the first column of the component matrix for which items (i.e., questionnaire questions) correlated the most to each other (UCLA Statistical Consulting Group, 2016, p. 9). The larger the correlation number that each item had, the more the item described the variable in common to all the items.

Reliability

According to Surbhi (2017), "reliability… mean[t] the extent to which the measurement tool provides consistent outcomes if the measurement is repeatedly performed" (p. 3). It can be enhanced by increasing the number of participants, increasing internal consistency, and by standardizing the directions used to take the questionnaires and interviews.

The internal consistency of the questions in both the interviews and the questionnaire were measured by using different sets of questions that included diverse cooperation characteristics used in Virginia's statewide CIT partnerships and observing if participants perceived the cooperative characteristics in a similar way. The more often that participants answered in a similar way, the more reliable the interviews and questionnaire were at measuring cooperation (Difference Between, 2011).

Validity

Validity meant that the research instrument was effectively measuring the concept that it was meant to measure (Surbhi, 2017). For this study, that concept was cooperation within the context of CIT partnerships in Virginia after the passage of SB 1294 in 2009.

I adapted my questions used to measure cooperation from the studies of Lee (2001) and Squire, Cousins, and Brown (2009) that I found in business management journal articles. These studies incorporated the Likert scale and Deutsch's (1948) list of cooperative, competitive, and neutral actions. In addition, I also considered Allwood's (2007) four actions of cooperation in the development of the questionnaire and interview

questions. Doctoral professors and CIT members reviewed my preliminary questions to obtain their opinion about their validity to the research question.

Data Storage

I stored the data on hardcopies, USB hard drives, and on digital recording devices. These items were locked up in a safe at my home to be available for review by authorized people from Walden University if needed. These items will be destroyed five years after the completion of the study.

Limitations and Delimitations

Because of the specificity of this study, I limited the sample population to being non-random and non-probabilistic. The questionnaire participant sample consisted of CIT law enforcement officers who were members of three different regional CIT programs in the Commonwealth of Virginia. Likewise, the interview participant sample consisted of CIT leaders in Virginia who were active in Virginian CIT programs before and after the passage of SB 1294 in the year 2009.

Another limitation of this study was that it was cross-sectional. Unfortunately, known data were not collected before 2009 that could have been used to measure the cooperation levels of study participants.

Geographical area was another limitation of this study. This study was limited to participants who were involved in Virginian CIT programs.

Lastly, the study was limited by my bias, economical resources, and restrictions to available Virginian populations. Because I did not live in Virginia, I had to rely on the participating organization to the provide directory information of potential participants such as personal email addresses.

Delimitations to the study included participants' honesty, memory, and willingness to respond.

Chapter 4: Results

I used mixed methodology to help triangulate data regarding CIT stakeholder cooperation and how Virginia SB 1294 may or may not had affected that cooperation. I obtained the qualitative data through interviews with 11 CIT leaders within a region in central Virginia. Likewise, I obtained the quantitative data from 115 questionnaires that were filled out by CIT members from a region in central Virginia who were CIT members before and after the year 2009. I did not use an additional 64 questionnaires in the study results because they were filled out by CIT members who were not members before the year 2009.

Research Questions

Research Question 1 (RQ1): How has the passage of Virginia's 2009 SB 1294 affected the level of stakeholder cooperation within Virginia's statewide CIT program?

Research Question 2 (RQ2): What was the relationship between what questionnaire participants perceived regarding questions about CIT stakeholder cooperation when stakeholders are performing CIT practices which were affected by the passage of Virginia's 2009 SB 1294 and those questions about CIT practice which were in effect before the passage of SB 1294?

Null Hypothesis: ($H_0$2): There would be no relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Alternative Hypothesis (H_a2): There would be a relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not.

Qualitative Results

The purpose of the qualitative portion of this study was to discover how SB 1294 affected CIT stakeholder cooperation and to find strategies on how to increase cooperation levels among stakeholders. To accomplish this, I interviewed CIT leaders within a region in central Virginia.

The interview participants were all administrative level persons in their professional fields. Eight were male, and three were female. Five participants were in law enforcement. Four were mental health providers, and two were administrative personnel at a major university in the student admissions department. I labeled the participants by the order that the interviews were conducted (from P1 = "Participant 1" to P11 = "Participant 11"). I decided not to include a detailed description of the participants so that I could better protect their identities.

I designed the interview questions to stimulate conversation about CIT stakeholder cooperation and how the passage of Virginia SB 1294 in 2009 may or may not have affected that cooperation. Many participants' answers overlapped for sequential questions. For that reason, I decided to present the data in themes.

Theme 1: De-escalation Training for First Responders is Essential

Many of the interview participants were insistent that de-escalation training for first responders was essential. Because law enforcement are the first responders to most

mental health crises, they need to be trained on how people with mental illness may react to basic police procedures and how those procedures may be modified to prevent bad outcomes including injuries and death.

According to P10, "Encounters between police and people in mental crisis are dangerous to the police, the person with the mental illness, and others. And to me it is unconscionable for communities to ignore that."

P3 added that, "Mental health is asked to train law enforcement officers on how to deal with mental health issues. From a mental health perspective, it is really something that is necessary because law enforcement are the first responders."

Theme 2: Unifying Mental Health Crisis Events

Virginia Tech mass shooting. The Virginia Tech Review Panel (2007) reported that "on April 16, 2007…, a disturbed young man at Virginia Tech took the lives of 32 students and faculty, wounded many others, and killed himself" (p. vii). This mass shooting event had far reaching impact across Virginia and the United States in part because of its devastating effect to the community, but also because of the lessons that were learned about the lack of support and continuity in mental health care when people advance past the adolescent phase of their lives.

Immediately after the event, Virginia Governor Timothy Kaine formed a panel to investigate how and why this tragedy occurred (Virginia Tech Review Panel, 2007, p. vii). The panel included eight experts in a variety of fields who each had both relevant but different perspectives. This strategy was similar to how the CIT program works

because it included representatives from different agencies working toward a common goal.

The investigative report that was produced by the Virginia Tech Review Panel recommended strategies on target-hardening, campus-wide emergency communication systems, and active shooter emergency response policy (Virginia Tech Review Panel, 2007). It also showed that there was a breakdown in the mental health system which may have prevented the event.

Some of the interview participants were affected personally by this event. The accounts were told solemnly and with an immediacy that made it feel like the event only happened a week ago. It was argued by at least one participant that SB 1294 may not have been passed if this event had not occurred or if it occurred in another state. As P2 said, "it made the General Assembly take notice of the need for mental health reform."

Senator Deeds personal tragedy. In 2013, another mental health crisis took the notice of the Virginian General Assembly. This time it involved the son of Virginia Senator R. Creigh Deeds. This tragedy helped the General Assembly personalize the consequences of what might happen when a person with mental illness does not get enough treatment.

Vozzella (2014) described the events in the following statement:

> [The senator's son], Austin Deeds had undergone a psychiatric evaluation in November [of 2013], and a magistrate judge issued an emergency custody order. But he was sent home after being told no psychiatric bed was available. The next day at the family home, he stabbed his father repeatedly in the face and chest,

> then fatally shot himself. Officials at the local community service board initially said all area hospitals had been contacted but none had space for the younger Deeds. But three nearby hospitals later confirmed that they had beds but had not been called. (p. 1)

To prevent a similar incident, SB 260 of 2014 was introduced and signed into a law that was more popularly known as The Bed of Last Resort (Vozzella, 2014). This law required Virginian state mental hospitals to provide a hospital bed for patients with emergency custody orders if there were no beds available in a private mental hospital (p. 2).

Several of the interview participants referred to this law as having both positive and negative consequences. One argued that it was better to get a patient mental health treatment that was on the other side of the state rather than just release the patient with nothing but a safety plan. Another one argued that it took too much time for law enforcement to transfer patients to the different state hospitals and made the law enforcement agencies understaffed. Yet another one argued that it did not solve the original problem of not having enough mental health treatment options at a community level.

The Associated Press (2019) mentioned a possible solution to police officers transporting patients over long distances in the following statement:

> [Because there were so many problems about taking law enforcement officers away from their regular duties to transport patients], the state Department of Behavioral Health and Developmental Services [planned] to award a private

> security firm a $7 million, two-year contract to provide transportation for patients who are involuntarily hospitalized. The firm G4S will provide drivers to take patients to the nearest hospital with an available mental health bed…. The private firm will begin transporting patients… [the] summer [of 2019], using specially trained, unarmed drivers in unmarked vehicles. (Associated Press, 2019, p. 1).

Theme 3: The Impact of Virginia SB 1294

` According to P1,

> Virginia SB 1294 had no discernable impact on [CIT-trained police officers]. Most officers that were trained in my community before 2009 would have no idea this piece of legislation exists. Essentially what this bill did was to codify the goals of CIT in state code and required the two state agencies responsible for oversight to collaborate on a report for three successive years. For a variety of reasons, those three years likely represent the peak in those agencies' partnership around CIT. The legislative initiative did, however, mandate and create a state level partnership and, ultimately, laid the foundation which produced the political acceptance and support for CIT that enabled and sustained growth. Without the legislative buy-in, statewide efforts would have stalled. Now, CIT… is the rule rather than the exception in Virginia.

The other participants' responses to this topic were not as in depth as P1's response. Generally, participants mentioned that increased access to grant money for CIT programs was the biggest impact that SB 1294 had on the CIT programs in Virginia.

Such as when P5 replied that the "bill… provided the ability to provide more services and resources to make crisis intervention happen as it should."

Theme 4: All Perspectives are Valuable

According to many participants, the perspectives of all community stakeholders were important in planning a community response to preventing mental health crises. They were also important when resolving issues that came up in stakeholder meetings. P8 mentioned that sharing different perspectives helped to "develop shared purpose and goals."

Along with shared perspectives in stakeholder meetings, different perspectives were important to learn during CIT training. Training included learning about (a) basic types of mental illnesses; (b) some of the common medications used to treat mental illnesses; (c) de-escalation techniques; (d) mental health treatment options in the community; and (e) first-hand accounts of what mental illness was like to the mental health consumers themselves. In Virginia, CIT training was not reserved to just police officers or mental health workers. All types of CIT stakeholders were encouraged to participate in CIT training including firefighters and EMTs.

Theme 5: Mental Health Assessment Centers

Mental health assessment centers were either free-standing or connected with a hospital emergency room. They were meant to be safe places where police officers could transfer the custody of persons undergoing mental health crises. Once there, the person would be examined for underlying physical conditions that may be contributing to the mental illness or for any serious medical condition which may be life-threatening if left

untreated. After the person was medically cleared, the person could start to receive psychiatric treatment.

P10 was concerned about the image of mental health assessment centers to the persons who were brought there. He said that if police were the only ones bringing people to a mental health assessment center, then it "may make them look like a mental health jail." It might be better if people with mental illness themselves or their family members could also be able to access an assessment center.

P3 was more concerned about the funding needed to maintain a mental health assessment center. She said that one of the most important things that SB 1294 did was help get funding to create the centers.

P3 elaborated on the importance of the centers in the following statement:

> The hospital is thrilled to have officers there to provide a safe environment for people who are in their ER. The police are thrilled to be able to bring someone in and transfer custody and get back on the road. There is no negative aspect to this process.

P1 listed the following components as the ideal elements that were "necessary to achieve the most successful type of triage/assessment site":

- 24/7 availability of the assessment site for law enforcement to use as an access point for services which is an alternative to incarceration.
- 24/7 availability at that site of emergency services/clinical personnel who can determine clinical status and assess treatment needs for the individual.

- 24/7 availability of security to support the site/program in accepting transfer of the individual and to provide for the safety of all persons involved.
- 24/7 ready availability of medical screening.
- 24/7 ready access to dispositional options including [temporary detention order or] TDO beds, crisis stabilization, detox, and other community-based service.
- 24/7 availability of peer support for individuals awaiting evaluation or transportation to dispositional options.

However, it was important to realized that most mental health assessment centers did not have all or even any of the ideal elements for the most successful assessment centers. Many of them were only open during peak hours of the day. Some of them had to partner with hospitals to medically clear people before they were sent to the assessment center.

It was also important to realize that most communities did not have an assessment center when their CIT programs were started. However, as P10 mentioned, “if you wait until you have everything in place to start this,” then the CIT program may never be implemented. Therefore, the best thing for community stakeholders to do when they began a CIT program was to find and partner with community resources that were already in place that could help prevent or resolve mental health crises.

Theme 6: Conflict Among CIT Stakeholders is Normal

Several participants said that conflict among CIT stakeholders was normal, especially in the start-up phase. When a CIT program was started, there were several independent agencies with different perspectives and priorities wanting to make their jobs easier or more effective. There might have been some who were not as cooperative and/or compassionate as others who might have tried to put more work on the other agencies. The important aspect to remember in this situation was to find a similar agency or partner to fill in the gap of the uncooperative agency or partner.

However, once a CIT program was started, it was important to have regular meetings and communication among partner stakeholders. A set structure of administrators and representatives who can contact each other most of the time was important for maintenance of the CIT program. If an issue came up, the issue should have been dealt with as soon as possible to retain the cooperative involvement of the everyday participants of the CIT program.

Theme 7: Mental Health Crises Require a Community Response

A few participants talked about how mental health crises did not usually happen in isolation. They were usually a systemic problem which required a systemic approach. That was why it was important to include many types of community stakeholders including advocates for mental health consumers, EMTs, emergency dispatchers, lawyers, firefighters, hospitals and emergency departments, school administrators, mental health providers, social workers, law enforcement officers, local government officials, religious leaders, judges, correctional officers, probation officers, and parole officers.

Theme 8: CITs are in Constant Evolution

Several of the participants noted that the CIT program seemed to be in constant evolution. For instance, a law might be enacted which might solve one problem and cause other ones. Also, there might be an emphasis for community stakeholders to concentrate on a major problem area within the community. As that problem was dealt with, another one may have occurred in response or because of possible neglect. That was why it was important to keep communication lines open for all CIT stakeholders.

Theme 9: Each Community Needs CITs to be Custom Fitted

Each community has its own laws, topography, industries, and populations. For instance, a small rural community would not have the same resources as a major metropolis, and a major metropolis might not have the community comradery that a small town might have. For that reason, it was important for community stakeholders to look at all the community resources in place and the common problems regarding serious mental illnesses within the community when they were putting a CIT program in place. As P11 said, “our argument is you grow the program with what resources you got.”

Theme 10: Rural CITs

P7 mentioned that “cooperation within rural CITs is critical.” Rural communities usually did not have the resources that cities have. Transportation sources and times were a crucial problem for the prevention and treatment of mental health crises. Because of the large areas of coverage that police agencies had, several counties made a contract to share resources such as police officers and mental health treatment centers. Neighboring

counties also collaborated to form mental health assessment centers which they all could share.

Theme 11: CIT Champions

P9 advised that an important part of starting, spreading, and maintaining CITs was finding a champion who could "spearhead changes across barriers" and bring diverse stakeholders together to discuss common resources, problems, and successes. For Virginia, one of those champions was Victoria Huber Cochran.

The Department of Public Safety and Homeland Security (n.d.) described Cochran's contribution to CIT in the following statement:

> Since 2001, Ms. Cochran has worked as a criminal justice and mental health "boundary spanner," leading key stakeholder groups throughout the Commonwealth to develop programmatic policy and process initiatives that enhance systems interoperability and improve outcomes for justice involving individuals with behavioral health issues. Her leadership was instrumental in establishing Virginia's first Crisis Intervention Team and the program's ensuing statewide expansion. (p. 1).

Theme 12: Communication is key

Probably the number one point that most of the participants made was that in order to have a successful CIT program, there must be regular communication and meetings among community stakeholders. Because, as P3 mentioned, "bringing everyone together is how we deal with conflicts."

Theme 13: Best Strategies for Maintaining Cooperation Between CIT Stakeholders

P1 made a long list of the following strategies for maintaining cooperation between CIT stakeholders that may be helpful for others beginning a CIT program to learn:

- Have regular meetings.
- Educate and inform CIT stakeholders about the program and community resources.
- Develop shared purpose and goals among CIT stakeholders.
- Have an agenda when a meeting takes place so that it will be meaningful.
- Assign tasks to multiple people so there are no dependencies on a single person.
- Promote CIT as a community program.
- Nurture, develop, and engage new champions and partners.
- Remember that promotions, retirements, and reassignments impact the CIT team.
- Always be developing new champions.
- Talk when things go well; talk when things go poorly.
- Share all the data you collect as well as your positive outcomes.
- Look at your data to see if they indicate that something should be done differently.
- Always do in-service training to keep your law enforcement engaged and up to date with new developments, services, code, etc.

- Educate and engage the community at large.
- Make newsletters and events to keep stakeholders engaged and informed.
- Work with your prevention programs.
- Acknowledge work that is well done with positive comments, awards, and letters of recommendation.

Quantitative Results

Demographic Questions

Were you a CIT member before the year 2009? This question was the key question for establishing whether a questionnaire participant's answers could be used in the study. A total of 179 persons filled out a questionnaire. Sixty-four participants answered that they were not a CIT member before the year 2009. Their data were not entered into the SPSS database. The remaining 115 participants did indicate that they were CIT members before 2009. The following results were based on their data.

Which role do you provide for your CIT? The roles that participants provided to their CIT were a mixture of supportive and professional roles. There were 12 advocates for mental health consumers, nine EMTs, six firefighters, ten hospital/ER employees, 44 law enforcement officers, 21 mental health providers, five religious leaders, seven social workers, and one not specified.

What is your sex? For this study, there were 73 participants who were male and 42 participants who were female.

What is your ethnicity? The ethnic demographic for this study was 22 African Americans, nine Asians, 59 Caucasians, 17 Hispanics, six Native Americans, and one who was not specified.

Open-ended Question

Please comment on any insight which you have gained regarding cooperation within CITs. None of the participants chose to write a comment.

Frequencies and Cross-tabulations of the 5-Point Likert Questionnaire Statements

The 20, questionnaire statements included in this section used a 5-point Likert scale to gauge the participants' perceptions (from 1 = "Strongly disagree" to 5 = "Strongly agree"). Each of the participants responses that used the Likert scale was represented by its corresponding number when they were recorded in the SPSS database. The two other options (DK = "I do not know" and NA = "I prefer not to answer") were assigned missing values, so they were included in the frequency counts but not in the cross-tabulations.

I used SPSS to develop three cross-tabulations for each of the previously mentioned statements to compare the demographic categories of CIT role, sex, and ethnicity with the participants' perceptions about the cooperative act mentioned in the statement. The independent value categories were CIT role, sex, and ethnicity. While, the dependent value category was the participants' perceptions on stakeholder cooperation using examples of CIT techniques. The CIT techniques were described using terminology that were found in the Allwood (2007) and Deutsch (1948) cooperative studies.

Because there was a total of 60 cross-tabulations generated for this study, there were massive amounts of data. I decided that the most meaningful pieces of data included (a) whether the number of participants who answered the statement using the Likert scale was equaled to or was greater than 75; (b) the mean Likert score of the participants' perceptions about the cooperative statement; (c) the mean Likert score interpretation; and (d) the *p*-value and Cramer's V for each of the three participant demographics of CIT role, sex, and ethnicity.

In addition to limiting the data presented, I decided to divide the statements into two groups. The first group consisted of nine statements that contained cooperative CIT techniques that were influenced by the passage of SB 1294. The second group consisted of 11 statements that contained general cooperative CIT techniques that were being used before the passage of SB 1294.

I listed the nine statements that involved the influence of SB 1294 in *Table 1.* The statements were labeled (from L1 = "Law 1" to L9 = "Law 9") so that they could be condensed and identified in *Table 2.*

In *Table 2,* I included the statements in *Table 1* as the dependent variables at the beginning of each row, labeled as they were in *Table 1.* I also added column headings for (a) if the number of participants was greater than or equal to 75; (b) the mean Likert score; (c) the Likert score interpretation; and (d) the *p*-values and Cramer's V of the independent variables: CIT role, sex, and ethnicity.

Table 1

Questionnaire Statements Including Cooperative CIT Techniques Influenced by SB 1294

Label	Questionnaire statement
L1	The DBHDS helps to resolve conflicts between local and state CIT stakeholders.
L2	The *Essential Elements for the Commonwealth of Virginia's CIT Programs* helps to keep CIT standards uniform statewide.
L3	The local CIT Coordinator has a direct line of communication with a representative of the DCJS.
L4	The Virginia CIT Coalition keeps local CITs informed of relevant information and events.
L5	The DCJS helps to maintain local CITs when its help is needed.
L6	Cooperation between CIT agencies has increased since 2009.
L7	The DBHDS provides educational information to the public about CIT programs.
L8	Law enforcement routinely reports data to the DCJS regarding service calls involving mental health issues.
L9	Public awareness of the CIT program has increased since 2009.

Table 2

Results for Questionnaire Statements Including Cooperative CIT Techniques Influenced by SB 1294

Label	*n*≥75	Mean Likert Score	Score Interpretation	Role *p* value	Role Cramer's V	Sex *p* value	Sex Cramer's V	Ethnicity *p* value	Ethnicity Cramer's V
L1	No	3.76	Strongly agree	NSS	NSS	NSS	NSS	NSS	NSS
L2	Yes	3.93	Strongly agree	.001	.489	NSS	NSS	NSS	NSS
L3	Yes	3.51	Strongly agree	.001	.631	NSS	NSS	.002	.340
L4	Yes	3.62	Strongly agree	.001	.457	NSS	NSS	.009	.323
L5	No	3.79	Strongly agree	NSS	NSS	NSS	NSS	NSS	NSS
L6	Yes	4.09	Strongly agree	.001	.360	NSS	NSS	.001	.396
L7	Yes	3.72	Strongly agree	.001	.400	NSS	NSS	.001	.418
L8	No	3.35	Agree	NSS	NSS	NSS	NSS	NSS	NSS
L9	Yes	4.26	Strongly agree	.001	.361	NSS	NSS	.006	.298

Note. NSS = "Not statistically significant." The dependent variables are labeled (from L1 = "Law 1" to L9 = "Law 9") and are listed on *Table 1*.

When I designed the questionnaire statements, I gave participants two alternative choices to the 5-point Likert scale. They were "I don't know" and "I prefer not to answer." Because the minimum number of participants needed to be statistically significant was 75, I considered the three statements of L1, L5, and L8 not statistically significant. For those questions, many participants claimed that they did not know enough about the statements to agree or disagree with them.

The mean Likert score was the average perception of participants regarding the statements. Most of the mean scores were 3.5 or higher. Since 3.5 rounds up to 4.0, I interpreted the score as meaning that the average participant strongly agreed with the statement. L8 was the only statement that had a mean Likert score less than 3.5, and I interpreted it as meaning that the average participant agreed with the statement.

In this study, I decided that a *p*-value of .05 or less would be statistically significant because it is a standard level of statistical significance for most studies, especially if they are exploratory. In *Table 2,* most of the *p*-values for the CIT roles were statistically significant. None of the sex *p*-values were significant. About half of the ethnicity *p*-values were statistically significant.

For the purpose of this study, I assigned any Cramer's V that was less than or equal to .39 the designation of having a weak association between variables. Cramer's Vs that were .40 to .60 were designated as having a moderate association, and those that were .61 and above were designated as having a strong association. In *Table 2,* six sets of variables had a weak association, whereas; four sets of variables had a moderate association. L3 and CIT role had a strong association between each other.

In *Table* 3, I listed the questionnaire statements that included general cooperative CIT techniques. They were labeled (from G1 = "General 1" to G11 = "General 11").

I listed all the same column headings in *Table 4* as I did for *Table 2*. The only difference between the tables was that I listed the questionnaire statements that described general cooperative CIT practices instead of those influenced by SB 1294.

In *Table 4,* enough of the participants answered using the 5-point Likert scale so that all the statements had the potential of being statistically significant. Generally, the participants' mean Likert score was greater than those in *Table 2.* All the questionnaire statements had a significant relationship with the independent variable of CIT role. The other independent variables of sex and ethnicity had more significant relationships with the dependent variables of the questionnaire statements than there were in *Table 2.* The Cramer's V values indicated that the strength of the relationships between variables was weak to moderate.

Besides the data listed in the tables, there were some other significant data. As I looked at the cross-tabulations, I noticed a general trend of a few, widespread disagreements with a statement while most of the participants agreed with it. However, for five of the statements, there were small clusters of specific demographic groups that did not follow the general trend.

Table 3

Questionnaire Statements Including General Cooperative CIT Techniques

Label	Questionnaire Statement
G1	The local CSB usually assesses mental health referrals in a timely manner.
G2	Mental health workers are committed to a positive relationship with CIT officers.
G3	Mental health workers keep CIT officers informed of patients with violent tendencies before the CIT officers transfer the patients.
G4	The local mental health assessment center has an average time of 30 minutes or less for transfer-of-custody procedures.
G5	CIT officers can rely on the mental health community to provide timely access to mental health services to those in their custody who may need it.
G6	CIT-trained police officers provide assistance for mental health workers when it is requested.
G7	The criminal courts routinely divert people with mental illness to treatment programs when appropriate.
G8	Judicial officials, law enforcement, and mental health professionals hold routine meetings about difficult cases involving people with mental illness in the community.
G9	Providing access to appropriate care to underserved populations is the responsibility of every CIT-partnering agency.
G10	Community stakeholders have sufficient protocols for diverting people with mental illness away from the criminal justice system and into appropriate treatment programs.
G11	The local community CIT taskforce encourages the local CIT partnership to keep a joint purpose of diversion of people with mental illness from the criminal justice system.

Table 4

Results for Questionnaire Statements Including General Cooperative CIT Techniques

Label	$n \geq 75$	Mean Likert Score	Score Interpretation	Role *p* value	Role Cramer's V	Sex *p* value	Sex Cramer's V	Ethnicity *p* value	Ethnicity Cramer's V
G1	Yes	3.96	Strongly agree	.001	.451	.049	.297	NSS	NSS
G2	Yes	4.09	Strongly agree	.001	.390	.037	.302	.001	.317
G3	Yes	3.75	Strongly agree	.001	.406	.001	.441	NSS	NSS
G4	Yes	3.97	Strongly agree	.001	.460	.021	.338	.001	.358
G5	Yes	4.00	Strongly agree	.001	.390	.033	.310	NSS	NSS
G6	Yes	4.07	Strongly agree	.001	.386	NSS	NSS	.001	.379
G7	Yes	3.78	Strongly agree	.001	.385	NSS	NSS	NSS	NSS
G8	Yes	3.94	Strongly agree	.001	.411	.037	.325	.038	.289
G9	Yes	4.23	Strongly agree	.001	.445	.035	.308	.003	.310
G10	Yes	3.84	Strongly agree	.001	.413	.004	.375	.021	.281
G11	Yes	4.02	Strongly agree	.001	.379	NSS	NSS	.001	.315

Note. NSS = "Not statistically significant." The dependent variables are labeled (from G1 = "General 1" to G11 = "General 11") and are listed on *Table 3*.

The largest cluster was seven law enforcement officers who disagreed with the L8 statement that was listed in *Table 1*. Four law enforcement officers disagreed with G3. Four African Americans and three advocates for people with mental illness disagreed with G10 and G11. Three African Americans and three advocates for people with mental illness disagreed with G9. The other four statements were listed in *Table 3*.

Paired Samples T Test

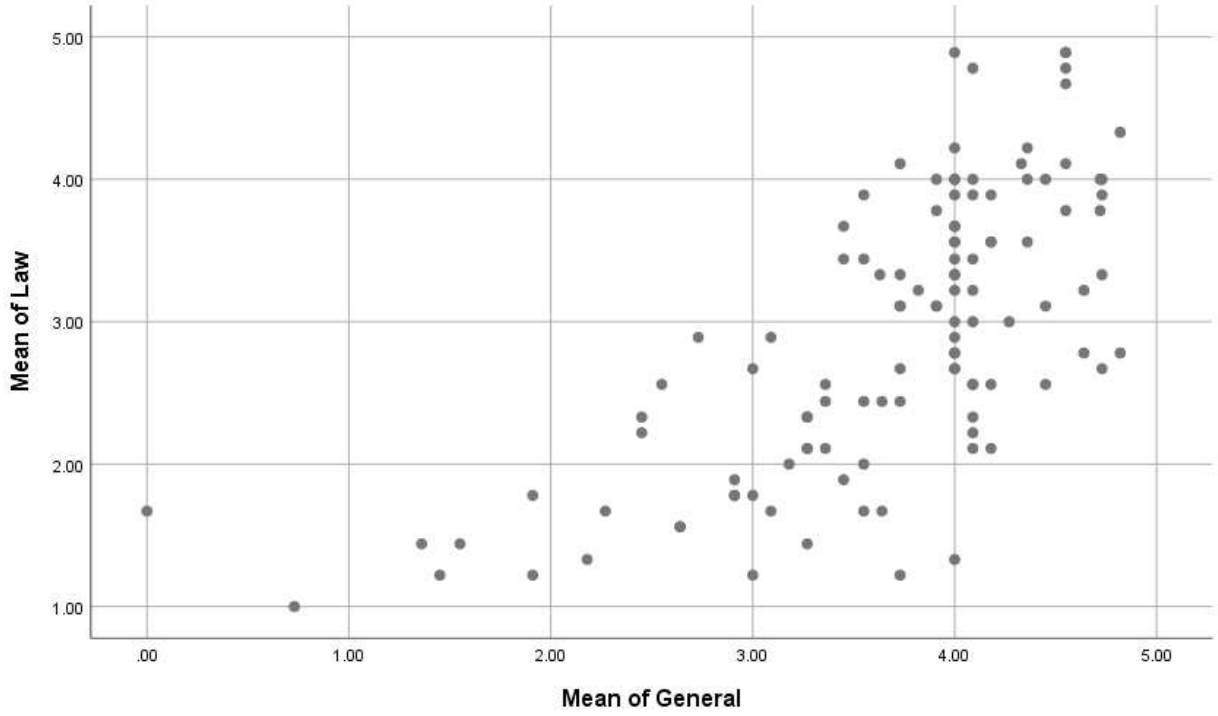
I used the paired samples T test to determine if there was a mean difference between how the same group of participants perceived general cooperative CIT techniques as compared to how they perceived cooperative CIT techniques influenced by SB 1294. The test could also be used to find the strength, direction, and significance of the mean difference between the two sets of variables (Kent State University Libraries, 2019).

For this study, I compared the mean Likert score for the nine questionnaire statements about CIT stakeholder cooperation techniques that were affected by the passage of Virginia SB 1294 with the mean Likert score for the 11 statements about general CIT stakeholder cooperation techniques that were in effect before the passage of the bill. I calculated each of the 115 questionnaire participants' scores who met the inclusive requirements of the study. I added a zero for those responses that were either "I do not know" or "I prefer not to answer" so they could be reflected in the mean scores.

There was a positive slope in the graph depicted on *Figure 2.* This meant that the participants who agreed with one set of statements tended to agree with the other set of

statements. This trend was the same for those who disagreed because participants generally each statement in a similar way.

Figure 2. Scatterplot of mean of law vs. mean of general.



The participants had a mean Likert score of 3.67 when answering the questionnaire statements including general CIT cooperative techniques. It had a standard deviation was .866. For those statements including CIT cooperative techniques influenced by SB 1294, the mean Likert score was 2.92 with a standard deviation of .977. There was a positive correlation of .679 between the general techniques and the techniques influenced by SB 1294 with a statistically significant *p*-value of .001. There was a difference of .758 between the two sets of data. These results meant that participants perceived that there were higher cooperation levels among stakeholders

regarding factors involving general CIT practices rather than those factors involving CIT practices that were affected by Virginia SB 1294 of 2009. T(114) = .75809 *p*-value= .001

The null hypothesis stated that there would be no relationship between what questionnaire participants perceived about cooperative CIT practices that were affected by SB 1294 and those which were not. I found that there was a relationship between the two sets of cooperative CIT practices using the paired samples T test. Therefore, the null hypothesis was rejected.

Factor Analysis

I used factor analysis to discover a pattern of which questionnaire statements best described the latent variable of CIT stakeholder cooperation (Rahn, n.d.) for two different sets of questions: (a) those that described CIT stakeholder cooperation techniques affected by SB 1294 and (b) those that described general CIT stakeholder cooperation techniques. I used the principle components method of factor analysis. The extraction was based on a fixed number of factors which equaled the number of statements being analyzed.

After the test was run, I studied the first column of the component matrix for which items (i.e., questionnaire statements) correlated the most to each other (UCLA Statistical Consulting Group, 2016, p. 9). The larger the correlation number that each item had, the more the item described the variable in common to all the items.

I created *Table 5* to show the first component for each of the questionnaire statements regarding cooperative CIT techniques that were influenced by the passage of SB 1294. Those statements were also known as factors when I used them in this factor

analysis. Likewise, *Table 6* contained the questionnaire statements that were describing general cooperative CIT practices and the first component in the factor analysis.

In *Table 5,* the first component that was the least like the other first components was the one for factor L8. L8's component was .523 while the others ranged from .858 to .885. *Table 6* had a similar trend. Factor G3 had a first component of .495. The other first components in *Table 6* ranged from .738 to .872. This meant that the questionnaire statements of L8 and G3 did not describe the obscure meaning of cooperation as well as the other statements and should be discarded in the future.

Summary

Because of the exploratory nature of this study, I conducted mixed-method research to help triangulate data. The qualitative data was derived from 11 interviews with CIT leaders within a region in central Virginia. The quantitative data was derived from 115 questionnaires which were filled out by CIT members within a region in central Virginia who were members before the year 2009.

The qualitative interviews had two main issues which the researcher wanted the participants to elaborate on: (a) how did SB 1294 affect CIT stakeholder cooperation levels and (b) what was the best way to increase CIT stakeholder cooperation levels in general. The most common reply that participants gave for how SB 1294 affected cooperation levels was that it gave CIT programs in Virginia more funding for things like mental health assessment centers and CIT officer training. The most common answer that participants gave for how to increase CIT stakeholder cooperation levels in general

Table 5

Factor Analysis of *SB 1294*-Inspired Statements

Factor	Component 1
L1	.859
L2	.884
L3	.883
L4	.885
L5	.858
L6	.873
L7	.859
L8	.523
L9	.865

Note. Factors are labeled (from L1 = "Law 1" to L9 = "Law 9") and are found in *Table 1*.

Table 6

Factor Analysis of General Statements

Factor	Component 1
G1	.819
G2	.761
G3	.495
G4	.872
G5	.838
G6	.738
G7	.842
G8	.782
G9	.768
G10	.776
G11	.765

Note. Factors are labeled (from G1 = "General 1" to G11 = "General 11") and are found in *Table 3*.

was to have regular communication and meetings with other CIT community stakeholders.

For the quantitative part of the study, the researcher conducted four basic tests: (a) descriptive frequencies; (b) cross-tabulations; (c) paired sample t test, and (d) factor analysis. The descriptive frequencies included the Likert scale results and the demographic distributions of participants' CIT role, sex, and ethnicity. The cross-tabulations showed that most participants either agreed with the statements regarding CIT techniques that demonstrated cooperation among stakeholders or did not know enough about the CIT techniques to answer. The paired sample t test showed that participants perceived that there were higher cooperation levels among stakeholders regarding factors involving general CIT practices rather than those factors involving CIT practices which were affected by Virginia SB 1294 of 2009. Finally, the factor analysis listed correlation numbers for statements used in the questionnaire to describe CIT stakeholder cooperation levels. According to the correlation numbers, two of the statements should be discarded from future questionnaires.

Chapter 5: Discussion, Recommendations, and Conclusion

Summary of the Study

The purpose of this study was to take a systemic look at the Commonwealth of Virginia's statewide CIT program within the context of a region in central Virginia to help other states learn about cooperation levels among CIT stakeholders and how the passage of Virginia SB 1294 may or may not have affected those cooperation levels. The bill did two main things which was unique for state legislation at the time: (a) it mandated that two state departments, the DCJS and the DBHDS cooperate to help spread the CIT program successfully across the state and (b) it mandated that "all team members… [had to] receive… [CIT] training" (Virginia General Assembly, n.d., § 9.1-187) and not just CIT law enforcement officers.

This study was exploratory, and I used mixed methodology. The qualitative portion had a phenomenological research design in which I interviewed 11 CIT leaders from a region in central Virginia about how the passage of SB 1294 may or may not have affected CIT stakeholder cooperation levels. The quantitative portion had a correlational research design in which I had 115 participants who were CIT members in a region in central Virginia before and after the year 2009 fill out a questionnaire. The questionnaire included a combination of demographic and Likert scale questions which were meant to measure the participants' perceptions about cooperative CIT procedures.

Interpretation of Findings

Qualitative Findings

I presented the qualitative results of this study as 13 themes. The two themes which best answered the research questions of this study were Theme 3: The impact of Virginia SB 1294 and Theme 12: Communication is key. According to the interview participants, the greatest impact that the bill had on CIT stakeholder cooperation was that it made extra funding available for CIT programs to implement things like mental health assessment centers and to increase the rate of CIT training for CIT members. Furthermore, the most common answer that participants gave as a solution for increasing cooperation levels among CIT stakeholders was communication. They said that frequent and routine communication and meetings between CIT stakeholders helped the most to prevent and resolve conflict because, as P3 said, "bringing everyone together is how we deal with conflicts."

Demographic Findings

The population demographics for the population of the region in central Virginia where the study took place were 50.48% male and 49.52% female, 90.08% Caucasian, 4.09% African American, 3.11% Asian, 2.23% Hispanic, and 0.11% Native American (Suburban Stats, Inc., 2019). The population sample for this study was a little more diverse, probably because the study took place in an urban center of this predominantly rural region. It was 63.48% male and 36.52% female, 50.30% Caucasian, 19.13% African American, 14.78% Hispanic, 7.83% Asian, 5.22% Native American, and 0.87% unidentified. The sample population's CIT role demographics were as follows: 83.26%

law enforcement, 18.26% mental health providers, 10.43% advocates for mental health consumers, 8.70% hospital/ER workers, 7.83% EMTs, 6.09% social workers, 5.22% firefighters, 4.35% religious leaders, and 0.87% unidentified.

Cross-tabulation Findings

In general, the cross-tabulation findings indicated that participants tended to agree that CIT stakeholders were participating in cooperative procedures. This was an overall positive finding which indicated that there was an abundance of cooperation among the CIT stakeholders in a region of central Virginia. However, there did seem to be areas in which there was a need for improvement.

More participants reported not knowing enough about the statements involving CIT procedures that were affected by the passage of SB 1294 than about statements involving general CIT procedures. For three of the statements, so many participants did not know enough about the cooperative CIT techniques involved that the number of participants who answered with the Likert scale was below the minimum sample size to make the study statistically significant. Two other statements had 20 or more participants who did not know.

The three statements that had 40 or more participants who did not know were the following: L1: The DBHDS helps to resolve conflicts between local and state CIT stakeholders; L5: The DCJS helps to maintain local CITs when its help is needed; and L8: Law enforcement routinely reports data to the DCJS regarding service calls involving mental health issues. These results may indicate that the reason why so many participants may not know if these statements were true was because the two state

departments may not be as involved in CIT programs as they were from 2009 to 2011 when they were required to report to the Joint Commission on Health Care (DCJS & DBHDS, 2009a).

The two statements that had 20 to 39 participants who did not know were the following: L2: *The Essential Elements for the Commonwealth of Virginia's CIT Programs* helps to keep CIT standards uniform statewide and L4: The VACIT keeps local CITs informed of relevant information and events. The participants who seemed to know the most about VACIT were law enforcement and mental health providers. This may indicate that VACIT may need to communicate more information to people other than those in law enforcement and mental health agencies.

Most of the statements had a few, evenly dispersed disagreements among participant demographics. However, there were four statements that had small clusters of specific demographics that may be significant. Three statements had more law enforcement disagreeing with them than the others, and three statements had more African Americans and advocates for mental health consumers disagreeing with them than the others. In general, men disagreed with more statements than women did.

The three statements that had more law officers disagreeing with them than the other statements were the following: L8: Law enforcement routinely reports data to the DCJS regarding service calls involving mental health issues; G3: Mental health workers keep CIT officers informed of patients with violent tendencies before the CIT officers transfer the patients; and G5: CIT officers can rely on the mental health community to provide timely access to mental health services to those in their custody who may need it.

These results may indicate two issues. One may be that there might be a lack of data sharing statewide which was also indicated in the qualitative portion of the study. The other issue may be that there may be a need for more communication between law enforcement and mental health providers especially during transfer of custody procedures.

The two statements that had more African Americans and advocates for people with mental illness disagreeing with them than the other statements were the following: G9: Providing access to appropriate care to underserved populations is the responsibility of every CIT-partnering agency; G10: Community stakeholders have sufficient protocols for diverting mentally ill persons away from the criminal justice system and into appropriate treatment programs; and G11: The local community CIT taskforce encourages the local CIT partnership to keep a joint purpose of diversion of mentally ill people from the criminal justices system. These results may indicate that advocates for mental health consumers and minorities may perceive that persons with serious mental illness may not be properly diverted from the criminal justice system. There may be a cultural factor for this perception.

Paired Samples T Test Findings

I used the paired samples T test to compare the mean Likert score for those statements regarding CIT procedures that may be affected by the passage of SB 1294 with the mean Likert score for those statements regarding general CIT procedures. The Likert scale had a value range of 1–5 for each answer. Those answers that indicated that the participant did not know or did not want to answer were assigned a value of zero.

The scatterplot showed a positive relationship between the means. This finding indicated that participants who disagreed in one section tended to disagree in the other section. Likewise, those who agreed in one section also agreed in the other section.

The total mean Likert score of the participants perceptions on those statements regarding CIT cooperative procedures which were affected by the passage of SB 1294 was 2.92. The total mean Likert score for the general CIT cooperative procedures was 3.67. There was a correlation of .679 that was significant with a p-value of .001. The mean difference between the mean Likert scores was .758. These findings indicated that participants perceived that there were higher cooperation levels among CIT stakeholders regarding factors involving general CIT practices rather than factors involving CIT practices which were affected by SB 1294. Because there was a correlation found between the two sets of CIT cooperative procedures, I was able to reject the null hypothesis.

Factor Analysis Findings

For this study, I had participants respond to two groups of statements regarding cooperative CIT procedures using a 5-point Likert scale. A group of nine statements described cooperative CIT procedures which were affected by the passage of SB 1294. Another group of 11 statements described general cooperative CIT procedures which were in effect before 2009.

For the group of statements of CIT procedures influenced by the passage of the bill, the responses to the questionnaire statement of L8 listed on *Table 1* differed the most from the other statements. There were more participants who disagreed with this

statement than with other statements. It also has a higher of concentration of law enforcement who disagreed with the statement than for other statements. In addition, there were 45 participants who did not know enough about the statement to answer and five participants who did not want to answer.

For the general group, the responses for the questionnaire statement G3, listed on *Table 3,* varied the most from the other statements in the group. There were 17 participants who did not know about this statement that were the most for the general group. There were also more participants who were neutral or disagreed about this statement than for the other statements in this group.

Because the two questionnaire statements L8 and G3 had response patterns that differed so much from the rest of the statements, they should be discarded from future studies regarding CIT cooperative procedures. However, it may be beneficial to look further into why the response patterns were so different from the other statements' response patterns.

Implications

For this section of the study, I presented my thoughts about the participants' perceptions about the cooperation levels between CIT stakeholder that occurred during the time of the study and about what future actions might change those levels of cooperation.

The first implication that I discovered about this study was that cooperation levels seemed to be strong between the CIT stakeholders in the region of central Virginia where this study took place. This cooperation was in place before the passage of SB 1294 and

did not seem to be greatly affected by its passage. However, its passage may have helped to spread cooperation techniques to CIT stakeholders in other regions of Virginia.

The second implication was that cooperation levels may not be as strong for certain CIT procedures as it is for others. In some cases, transfer of care and/or diversion from the criminal justice system procedures may not be as effective as they should be. There may need to be more communication between the parties involved.

The third implication was that there may be cross-cultural misunderstandings between the criminal justice system and minorities who have mental illness. Furthermore, there may be racial tensions in the community that may be exacerbating the issue. Therefore, it might be beneficial for the criminal justice system to be more culturally sensitive.

The last implication was that misunderstandings and conflict can be common when diverse stakeholders come together to work in a new way. Community stakeholders need to realize that the CIT program involves partnership and respect, not a dictatorship. All perspectives are important, even the perspectives of people with mental illness themselves. It is vitally important that people with mental illness and their families feel safe and that they are treated with civility. Without the acceptance of the advocates for people with mental illness, the CIT program will never be used to its fullest potential.

Social Change Implications

According to Form and Wilterdink (2019), "social change… is the alteration of mechanisms within the social structure [that are] characterized by changes in cultural symbols, rules of behavior, social organizations, or value systems" (p. 1). However,

social change can be complicated because actual social change can differ greatly from what was predicted. According to Reeler (2007), social "change cannot be engineered, [so] practitioners are challenged to keep reading the situation, to recognize how change processes already shape the situation, and to adjust practice accordingly" (p. 1).

The social change implications for this study were that communities who are interested in having a successful CIT program have to be willing to communicate, compromise, share resources, start small, map their mental health crisis system, respect all stakeholder perspectives, and develop a plan that could be put into practice right away but can be allowed to evolve as circumstances change. The main point was that mental health crises are a systemic problem and so require a systemic solution. No one person or agency can solve it by themselves. The solution requires the whole community working together as a whole to help keep society in equilibrium.

Limitations and Delimitations of the Study

Because of the specificity of this study, the sample population was limited to being non-random and non-probabilistic. The questionnaire participant sample consisted of CIT members from a region in central Virginia. Likewise, the interview participant sample consisted of CIT leaders who were active in Virginian CIT programs before and after the passage of SB 1294 in the year 2009.

Another limitation of this study was that it was cross-sectional. Unfortunately, known data were not collected before 2009 that could have been used to measure the cooperation levels of study participants.

Geographical area was another limitation of this study. This study was limited to participants who were involved in Virginian CIT programs.

Lastly, the study was limited by the researcher's bias, economical resources, and restrictions to available Virginian populations. Because the researcher lived in a different state than Virginia, he had to rely on the participating organization to the provide directory information of potential participants such as personal email addresses. Delimitations to the study included participants' honesty, memory, and willingness to respond.

Recommendations

Recommendations for the CIT Program in Central Virginia

I recommended two types of investigation for the CIT program in a region of central Virginia who participated in this study. (a) More work may be needed on three areas of concern: data-sharing regarding service calls involving persons with mental illness; information-sharing regarding persons with violent tendencies; and timely access to mental health treatments. (b) Cultural sensitivity training may be needed in the criminal justice system because some advocates for mental health consumers and African Americans perceived that some persons with mental illness were not being properly diverted away from the criminal justice system.

Recommendations for Communities Beginning a CIT Program

For those communities who were beginning a CIT program, I recommended that communities start with identifying community stakeholders, mental health resources and where people with mental illness may be interacting with the criminal justice system.

There were also some excellent guides available on the CIT International, Inc. website www.citinternational.org that explained about the CIT process, particularly *Crisis intervention team (CIT) programs: A best practice guide for transforming community responses to mental health crises* (CIT International, 2019) and *Crisis intervention team core elements* (Dupont, Cochran, & Pillsbury, 2007).

Recommendations for Future Study

Many of the previous CIT program scholars focused on CIT officer training. Some exceptions were (a) some local studies on the effectiveness of the CIT program and (b) a recently published guide that helped to explain the systemic nature of cooperation within the CIT program more clearly titled *Crisis intervention team (CIT) programs: A best practice guide for transforming community responses to mental health crises* (CIT International, 2019). However, it may be beneficial to have future studies regarding how people with mental illness may be benefitting from participating in the CIT program. It might be appropriate to consult with advocates for mental health consumers such as NAMI on this issue because many people with mental illness may be within a protected population that might require extra restrictions regarding data collection because of ethical concerns.

Conclusion

During this study, I focused on the systemic nature of the CIT program; how cooperation could be improved between CIT stakeholders; and how the passage of Virginia SB 1294 may or may not have affected that cooperation within a region of central Virginia. I found that the cooperation levels were strong between the CIT

stakeholders who participated in this study. Much of that cooperation was maintained with communication and mutual respect between CIT partners and was in existence before the passage of the bill. However, the bill did increase access to funds for creating mental health assessment centers and other programs that helped the CIT process greatly.

References

Abedon, S. T. (2016). Dynamic equilibrium. http://www.biologyaspoetry.com/terms/dynamic_equilibrium.html

ACLU. (n.d.). ACLU history: Mental institutions. https://www.aclu.org/other/aclu-history-mental-institutions

ADA. (n.d.). Introduction to the ADA. https://www.ada.gov/ada_intro.htm

Allwood, J. (2007). Cooperation, competition, conflict, and communication. *Gothenburg papers in theoretical linguistics.* https://hal-hprints.archives-ouvertes.fr/hprints-00460498

Alvelo, P. J. (2009). *The politics of madness: The mental patients' liberation movement in the 1970s* (Publication No. 1466470) [Master's thesis, Sarah Lawrence College]. ProQuest Dissertations Publishing.

Amadeo, K. (2018). Deinstitutionalization, its causes, effects, pros, and cons: How deinstitutionalization in the 1970s affects you today. https://www.thebalance.com/deinstitutionalization-3306067

Associated Press. (2019, May). Private security firm to transport mental health patients. *U.S. News*. https://www.usnews.com/news/best-states/virginia/articles/2019-05-09/private-security-firm-to-transport-mental-health-patients

Bakalar, N. (2015, August). 1940: Electroshock therapy. *The New York Times,* D5. https://www.nytimes.com/2015/08/18/science/1940-electroshock-therapy.html

Barton, K. P. (1996). *Democracy and confinement: Pennsylvania asylums in the Post-Revolutionary Republic (1792-1800)*. (Publication No. 9731572) [Doctoral dissertation, New School for Social Research]. ProQuest Dissertations Publishing.

Baxter, J. (n.d.). Exosystem. https://joannabax.wordpress.com/context/exosystem

Bayne, W. C. (1987, September). Furor sparks call for crisis team. *Memphis Metro,* B1, B2. http://www.gocit.org/uploads/3/0/5/5/30557023/gocit_student_cit_overview_12_27_17.pdf

Bertalanffy, L. V. (1972). The history and status of general systems theory. *The Academy of Management Journal, 15*(4), 407-426. http://www.jstor.org/stable/255139

Bienaimé, P. (2014, December). The cure for syphilis was developed as part of the US effort to win World War II. *Business Insider.* https://www.businessinsider.com/the-cure-to-syphilis-was-discovered-as-part-of-the-us-effort-to-win-world-war-ii-2014-12

Bibeau, T. (1994). The dark side of psychiatric drugs. *USA Today Magazine, 122*(2588), 44-52. http://www.stopshrinks.org/reading_room/drugs/dark_side_1.htm

Bly, N. (1887). *Ten days in a mad house.* New York, NY: Ian L. Munro, Publisher. http://digital.library.upenn.edu/women/bly/madhouse/madhouse.html

Borelli, F. (2018, January). President Trump signs LEO mental health act into law. https://www.officer.com/command-hq/supplies-services/news/20988292/president-trump-signs-leo-mental-health-act-into-law

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723-742. https://pdfs.semanticscholar.org/1737/8413f37060b3b705b7158af59d61d3cb3385.pdf

Bush, G. H. W. (1990). Presidential proclamation 6158. http://loc.gov/loc/brain/proclaim.html

Bushatz, A., & Sisk, R. (2018, January). Trump orders expanded mental health services to curb veteran suicides. https://www.military.com/daily-news/2018/01/09/trump-orders-expanded-mental-health-services-curb-veteran-suicides.html

Callahan, D., Wilson, E., Birdsall, I., Estabrook-Fishinghawk, B., Carson, G., Ford, S., & Yob, I. (2012). *Expanding our understanding of social change: A report from the Definition Task Force of the HLC Special Emphasis Project (2012).* Walden University Press.

California Legislature. (2018). Assembly Bill No. 1971. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB1971

Carter, J. (1977). Executive order 11973—President's commission on mental health. http://www.presidency.uscb.edu/ws/?pid=6643

Chamberlin, J., Rogers, E. S., & Ellison, M. L. (1996). Self-help programs: A description of their characteristics and their members. *Psychiatric Rehabilitation Journal, 19*(3), 33-42. https://doi.org/10.1037/h0101293

Charlottesville-Albemarle Prevention Coalition. (2014). *First response community connection resource guide.* https://oarjacc.files.wordpress.com/2016/07/firstresponsecommunityconnectionguidefy2014.pdf

Chem Europe. (n.d.). Insulin shock therapy. http://www.chemeurope.com/en/encyclopedia/insulin_shock_therapy.html

CIT International. (n.d.-a). Major Sam Cochran (ret.). https://davidshopeaz.wildapricot.org/resources/Documents/Major%20Sam%20Cochran%20bio%20and%20pic%20pdf.pdf

CIT International. (n.d.-b). Mike Woody bio. http://citinternational.org/page-18249

CIT International. (2019). *Crisis intervention team (CIT) programs: A best practice guide for transforming community responses to mental health crises*. CIT International Press. http://www.citinternational.org/resources/Documents/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf

CIT Program Development Guidance. (2014). *Essential elements for the Commonwealth of Virginia's Crisis Intervention Team programs (CIT).* http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20vacitessentialelements.pdf

Cochran, S., Deane, M. W., & Borum, R. (2000). Improving police response to mentally ill people. *Psychiatric Services, 51*(10), 1315-1316. https://doi.org/10.1176/appi.ps.51.10.1315

Cohen, W. J., & Ball, R. M. (1965). Social Security amendments of 1965: Summary and legislative history. https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf

Cornish, R. (2006). Statistics: An introduction to sample size calculations. www.statstutor.ac.uk/resources/uploaded/sample-size.pdf

Dattilio, F. M., & Freeman, A. (Eds). (1994). *Cognitive-behavioral strategies in crisis intervention.* New York, NY: The Guilford Press.

Davis, C. M. (2012). Laura's Law and Kendra's Law bandages and bondage: These laws are touted saviors. Are they? https://www.psychologytoday.com/us/blog/the-bipolar-coaster/201201/lauras-law-and-kendras-law-bandages-and-bondage

DeBello, V. L. (n.d.). History: Willowbrook State School. http://willowbrookstateschool.blogspot.com/history.html

DCJS, & DBHDS. (2009a). *Report to the Joint Commission on Health Care regarding crisis intervention team program assessment.* https://rga.lis.virginia.gov/Published/2009/RD420

DCJS, & DBHDS. (2009b). *Report to the Joint Commission on Health Care regarding the status of crisis intervention team programs in the commonwealth.* https://rga.lis.virginia.gov/Published/2009/RD366

DCJS, & DBHDS. (2011). *Assessing the impact and effectiveness of Virginia's crisis intervention team program FY2011.* https://rga.lis.virginia.gov/Published/2011/RD306

DCJS, & DBHDS. (2014). *Essential elements for the Commonwealth of Virginia's crisis intervention team programs (CIT).*

http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20vacitessentialelements.pdf

Department of Public Safety and Homeland Security. (n.d.). Victoria Cochran, Deputy Secretary of Public Safety and Homeland Security. https://www.pshs.virginia.gov/about/staff/victoria-h-cochran/

Deutsch, M. (1948). *The effects of cooperation and competition upon group process.* [Doctoral Thesis, Massachusetts Institute of Technology]. MIT Libraries. https://dspace.mit.edu/handle/1721.1/34691

Difference Between. (2011). Difference between reliability and validity. http://www.differencebetween.net/miscellaneous/difference-between-reliability-and-validity/

Disability Justice. (2018). The right to education. https://disabilityjustice.org/right-to-education

DMC Administration. (2010). Victoria Huber Cochran. https://valawyersweekly.com/2010/05/06/victoria-huber-cochran

Duke Trinity College of Arts & Sciences. (n.d.). Ecology. https://biology.duke.edu/undergraduate/major/concentrations/ecology

Dupont, R., & Cochran, S. (2000). Police response to mental health emergencies—Barriers to change. *The Journal of the American Academy of Psychiatry and the Law, 28*(3), 338-344.

Dupont, R., Cochran, S., & Pillsbury, S. (2007). *Crisis Intervention Team core elements.* The University of Memphis Press. http://www.citinternational.org/resources/Pictures/CoreElements.pdf

Eighty-eighth Congress. (1963). Transcript of offprint of public law 88-156, maternal and child health and mental retardation planning amendments of 1963. https://www.archives.gov/research/americans-with-disabilities/transcriptions/naid-6050326-offprint-of-public-law-88-156.html

Engber, D. (2013). FYI: Do lobotomies work? https://www.popsci.com/science/article/2013-03/fyi-do-lobotomies-work

Explore New River Valley. (n.d.). Welcome to Virginia's New River Valley! http://explorenewrivervalley.com

Finn, P., & De Cuir, W. J. (1988). Law enforcement and the social service system: Handling the mentally ill. *FBI Law Enforcement Bulletin, 57*(7), 1-7. https://leb.fbi.gov/file-repository/archives/july-1988.pdf/view

Form, W., & Wilterdink, N. (2019). Social change. https://www.britannica.com/topic/social-change

Forsyth-Stephens, A. (n.d.). Forsyth Stephens consulting. https://www.nchn.org/partner/forsyth-stephens-consulting.html

Francolini, J. (2016, January). 5 reasons mental health is a hidden civil rights issue. [web log comment]. https://www.huffingtonpost.com/janine-francolini/5-reasons-why-mental-heal_b_8992028.html

Frankfort-Nachmias, C., & Leon-Guerrero, A. (2015). *Social statistics for a diverse society* (7th edition). SAGE Publications, Inc.

Friedman, L. (2018, February). We can't stand idly by when there are people who cannot help themselves. *Los Angeles Times.* http://www.latimes.com/socal/glendale-news-press/opinion/tn-gnp-me-commentary-friedman-20180215-story.html

Gargan, E.A. (1981, February). As 'psychiatric ghettos,' Boarding homes get more dangerous. *New York Times,* A6. https://www.nytimes.com/1981/02/08/weekinreview/as-psychiatric-ghettos-boarding-homes-get-more-dangerous.html

Gilliland, B. E., & James, R.K. (1997). *Crisis intervention strategies* (3rd Edition). Brooks/Cole Publishing Company.

Gluck, S. (2016). What is stigma? https://www.healthyplace.com/stigma/stand-up-for-mental-health/what-is-stigma

Goldberg, J. (2017). Electroconvulsive therapy and other depression treatments. https://www.webmd.com/depression/guide/electroconvulsive-therapy#1

Gorman, M. (2017, February). Trump overturns a mental health regulation on gun purchases. *Newsweek.* https://www.newsweek.com/trump-set-overturn-guns-mental-health-regulation-557237

Halpern, P. (n.d.). New River Valley Crisis Intervention Team (CIT). http://www.nrvcs.org/cit

Hart, J. W. (2016). How presidents have shaped mental health care. [web log comment]. https://www.nami.org/Blogs/NAMI-Blog/February-2016/How-Presidents-Have-Shaped-Mental-Health-Care

Harvey, C. (ed.). (2012). A history of mental institutions in the United States. http://www.tiki-toki.com/timeline/entry/37146/A-History-of-Mental-Institutions-in-the-United-States/

Herman, E. (1995). *The romance of American psychology: Political culture in the age of experts.* University of California Press.

Hilchey, T. (1994, November). Dr. James Watts, 90, pioneer in use of frontal lobotomy. *The New York Times*, B00007. https://www.nytimes.com/1994/11/11/obituaries/dr-james-watts-90-pioneer-in-use-of-frontal-lobotomy.html

History.com. (2017). Eugenics. http://www.history.com/topics/eugenics

History Net. (n.d.). Antebellum period. http://www.historynet.com/antebellum-period

Hollister, J. C. (1959). *Rehabilitation practices for tuberculosis patients at the Oregon State Hospital.* [Master's thesis, Oregon State College]. https://ir.library.**oregonstate**.edu/downloads/rx913t67j

James, R. K. (2008). *Crisis intervention strategies* (6th edition). Thomson Brooks/Cole.

Joint Commission on Mental Illness and Health. (1961). *Action for mental health*. Basic Books, Inc. http://www.archive.org.details.actionformentalh00join

Joint Legislative Audit and Review Commission. (1996). *Funding incentives for reducing jail populations.* https://rga.lis.virginia.gov/Published/1996/HD9/PDF

Johnson, D. W., Maruyama, G., Johnson, R., Nelson, D., & Skon, L. (1981). Effects of cooperative, competitive, and individualistic goal structures on achievement: A meta-analysis. *Psychological Bulletin, 89*(1), 47-62.

Kent State University Libraries. (2019). Paired samples t test. https://libguides.library.kent.edu/SPSS

Kirsch, T. (n.d.). Worcester state hospital. https://opacity.us/site56_worcester_state_hospital.htm

Kodjak, A. (2017). Texas shooter's history raises questions about mental health and mass murder. https://www.npr.org/sections/health-shots/2017/11/07/562546682/texas-shooters-history-raises-questions-about-mental-health-and-mass-murder

Kuroski, J. (2017). The twisted history of the widely misunderstood lobotomy. http://allthatsinteresting.com/lobotomy-walter-freeman

LBJ Presidential Library. (2012). The 1965 Medicare amendment to the Social Security Act. http://www.lbjlibrary.org/press/the-1965-medicare-amendment-to-the-social-security-act

Lee, J.N. (2001). The impact of knowledge sharing, organizational capability, and partnership quality on IS outsourcing success. *Information & Management, 38*, 323-335. www.elsevier.com/locate/dsw

Lee-Griffin, P. (2001). *The criminalization of individuals suffering from symptoms of mental illness: An exploratory study* (Publication No. 3002466). [Doctoral dissertation, The Fielding Institute]. ProQuest Dissertations Publishing.

Legal Action Center. (2014). The Medicaid IMD exclusion: An overview and opportunities for reform. https://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf

Lenz, L. (2017). The secret lobotomy of Rosemary Kennedy. https://www.marieclaire.com/celebrity/a26261/secret-lobotomy-rosemary-kennedy

Lowry, R. (2016). Outsourcing the mentally ill to police. *National Review.* https://www.nationalreview.com/2016/01/police-shootings-mental-illness-problem

Lumen Candela. (n.d.). The Federalist era. https://courses.lumenlearning.com/boundless-ushistory/chapter/the-federalist-era

Mandell, B.R. (2010, Winter). Still fighting: Interview with Judi Chamberlin. *New Politics, XII* (4), 49-54. https://newpol.org/issue_post/still-fighting-interview-judi-chamberlin/

Marcussen, K., Ritter, C., & Munetz, M.R. (2010). The effect of services and stigma on quality of life for persons with serious mental illnesses. *Psychiatric Services, 61*(5), 494. https://doi.org/10.1176/ps.2010.61.5.489

McCombes, S. (2019). Correlational research. https://www.scribbr.com/methodology/correlational-research

McGarvey, E. L. (2007). *Civil commitment practices in Virginia: Perceptions, attitudes, and recommendations.*

http://courts.state.va.us/programs/concluded/cmh/reports/civil_commitment_practices_focus_groups.pdf

Mental Health Association of the New River Valley. (n.d.). Mental health association of the New River Valley. https://www.facebook.com/pg/Mental-Health-Association-of-the-New-River-Valley-617376848306871/about/?ref=page_internal

Mental Illness Policy Org. (2017). Competency of mentally ill—Rogers v. Okin. https://mentalillnesspolicy.org/legal/competency-rogers-okin.html

Mental Illness Policy Org. (n.d.). O'Connor v. Donaldson, 422 U.S. 563 (1975). https://mentalillnesspolicy.org/legal/survive-safely-oconnor-donaldson.html

Miller, J. (n.d.). *Crisis intervention team*. Easton Police Department Press. https://bha.health.maryland.gov/Documents/CIT%20Perspectives%20from%20Family%20to%20LE%20-%20Jim%20Miller.pdf

Mind Freedom International. (n.d.). About David W. Oaks, former Mind Freedom International executive director. http://www.mindfreedom.org/who-we-are/david-w-oaks/brief-bio-oaks

MIWatch.org. (2011). Ronald Reagan, mental health, and spin. http://www.miwatch.org/2011/02/ronald_reagan_and_mental.html

Modesto Junior College. (n.d.). Understanding children in context: The ecological model of human development. http://fcs.sites.mjc.edu/109EcologicalModelofHumanDevHandout.pdf

Moore, C. (2008). Diffusing crisis. *Law Enforcement Technology,* 56-62. https://www.officer.com/home/article/10248858/diffusing-crisis

Morning Earth. (n.d.). Balance in natural communities. http://www.morning-earth.org/Graphic-E/Bal-Commun.html

Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544-549. https://ps.psychiatryonline.org/doi/full/10.1176/ps.2006.57.4.544

Munetz, M.R., Morrison, A., Krake, J., Young, B., & Woody, M. (2006). Statewide implementation of the crisis intervention team program: The Ohio model. *Psychiatric Services, 57*(11), 1569-1571. https://ps.psychiatryonline.org/doi/full/10.1176/ps.2006.57.11.1569

NAMI. (2013). Saving lives, changing communities. [web log comment]. https://www.nami.org/Blogs/NAMI-Blog/October-2013/Saving-Lives,-Changing-Communities

NAMI Dane County. (n.d.). NAMI Dane County-Madison, WI: Who we are. http://www.volunteeryourtime.org/agency/detail/?agency_id=43771

NAMI Wisconsin. (n.d.). Mission & history. https://www.namiwisconsin.org/mission-history/

National Council on Disability. (2005). *The civil rights of institutionalized persons act: Has it fulfilled its promise?* https://www.ncd.gov/publications/2005/08082005

National Institutes of Health. (2017). National Institute of Mental Health (NIMH). https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh

National Public Radio. (2005, November 16). A lobotomy timeline. https://www.npr.org/templates/story/story.php?storyId=5014576

National Public Radio. (2016, March 7). The Supreme Court ruling that led to 70,000 force sterilizations [Transcript]. https://www.npr.org/templates/transcript/transcript.php?storyId=469478098

New River Valley VA. (n.d.). Virginia's New River Valley: Our region. https://www.newrivervalleyva.org/our-region

Noko, E.J. (2017). Sample size determination in qualitative and quantitative research. https://educacinfo.com/sample-size-determination-qualitative-quantitative-research

Norbury, F. B. (1999). Dorothea Dix and the founding of Illinois' first mental hospital. *Journal of the Illinois State Historical Society, 92*(1), 13-29. https://www.jstor.org/stable/40193299

Oliva, J. R., & Compton, M. T. (2008). A statewide crisis intervention team (CIT) Initiative: Evolution of the Georgia CIT program. *The Journal of the American Academy of Psychiatry and the Law, 36*(1), 38-46.

Paquette, D., & Ryan, J. (2001). Bronfenbrenner's ecological systems theory. https://www.professorcarlson.net/c4dcourse/module_2/m2_unit3/m2_u3_oldreadings/ecological_systems_theory2.pdf

Parry, M. (2010). From a patient's perspective: Clifford Whittingham Beers' work to reform mental health services. *American Journal of Public Health, 100*(12), 2356-2357. doi.10.2105/AJPH.2010.191411

Psychology Notes HQ. (2013). What is Bronfenbrenner's ecological systems theory? https://www.psychologynoteshq.com/bronfenbrenner-ecological-theory

Rahn, M. (n.d.). Factor analysis: A short introduction, Part 1. https://www.theanalysisfactor.com/factor-analysis-1-introduction

Ralph, M. (2010). The impact of crisis intervention team programs: Fostering collaborative relationships. *Journal of Emergency Nursing, 36*(1), 60-62. doi.10.1016/j.jen.2009.10.018

Ready.gov. (n.d.). Community emergency response team. https://www.ready.gov/community-emergency-response-team

Reeler, D. (2007). A theory of social change and implications for practice, planning, monitoring and evaluation. http://www.mspguide.org/resource/theory-social-change-and-implications-practice-planning-monitoring-and-evaluation-0

Riding-Malon, R. J., Cordial, P. M., & Stroup, J. E. (2011). Planning for socially just mental health treatment in an underserved Appalachian region: The New River Valley needs-assessment study. https://www.apa.org/pi/ses/resources/indicator/2011/08/convention-activities.aspx

Sabbatini, R. M. E. (n.d.). The history of shock therapy in psychiatry. http://www.cerebromente.org.br/n04/historia/shock_i.htm

Scott, K.G. (2011). A short history of Thorazine. https://katherinegscott.wordpress.com/2011/02/03/a-short-history-of-thorazine/

Shapiro, J. (2009). WWII pacifists exposed mental ward horrors. https://www.npr.org/templates/story/story.php?storyId=122017757

Shields, J. (2013). Another voice – Mental health myths. http://www.ukiahdailyjournal.com/article/zz/20130609/news/130607065

Sincero, S. M. (n.d.). Ecological systems theory. https://explorable.com/ecological-systems-theory

Singer, M. (n.d.). Coercive mind control tactics. http://www.psychologicalharassment.com/coercive-mind-control-tactics.htm

Sluss, M. (2007, December). Mental health changes unveiled in Tech shootings aftermath: The governor's proposal addresses many of the issues revealed by the Virginia Tech shootings. *McClatchy-Tribune Business News.*

Smark, C. (2008). Remembering Dorothea "Dragon" Dix: Nineteenth century mental health reformer. *The Business Renaissance Quarterly: Enhancing the Quality of Life at Work, 3*(4), 151-170.

Sokolow, B. A., & Lewis, W. S. (n.d.). Behavioral intervention v. threat assessment: Best practices for violence prevention. https://nabita.org/documents/BehavioralInterventionThreatAssessmentArticle.pdf

Squire, B., Cousins, P.D., & Brown, S. (2009). Cooperation and knowledge transfer within buyer—supplier relationships: The moderating properties of trust, relationship duration and supplier performance. *British Journal of Management, 20*, 461-477. doi.10.1111/j.1467-8551.2008.00595.x

Stephens, J.D. (n.d.). Brief history of community mental health centers in Indiana. http://iccmhc.org/sites/default/files/History%20of%20Community%20Mental%20Health%20in%20Indiana.pdf

Suburban Stats, Inc. (2019). Current population demographics and statistics for Virginia by age, gender, and race. https://suburbanstats.org/population/how-many-people-live-in-virginia

Supreme Court of United States. (1927). Buck v. Bell, superintendent. https://scholar.google.com/scholar_case?about=17003047728057029 14&q=Buck+v.+bell&hl=en&as_sdt=806

Surbhi, S. (2017). Difference between validity and reliability. https://keydifferences.com/difference-between-validity-and-reliability.html

Tartakovsky, M. (2011). The surprising history of the lobotomy. *Psych Central.* https://psychcentral.com/blog/the-surprising-history-of-the-lobotomy/

Torrey, E. F. (1997). *Out of the shadows: Confronting America's mental illness crisis*. John Wiley & Sons, Inc.

Torrey, E. F. (2013). Ronald Reagan's shameful legacy: Violence, the homeless, mental illness. https://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness

Troung, K. (2017). Reminder: Depression isn't always visible. https://www.refinery29.com/2017/09/173826/depression-invisible-illness

UCLA Statistical Consulting Group. (2016). Introduction to SAS. https://stats.idre.ucla.edu/spss/seminars/introduction-to-factor-analysis/a-practical-introduction-to-factor-analysis/

University of Memphis. (n.d.). CIT center: A resource for CIT programs across the nation. http://www.cit.memphis.edu/curriculuma.php?id=0

U.S. Congress. (2016). Summary: H.R.2646. https://www.congress.gov/bill/114th-congress/house-bill/2646

Van Patten, I.T. (2018). Isaac Van Patten: Professor of criminal justice. https://www.radford.edu/content/chbs/home/criminal-justice/staff/vanpatten.html

Van Putten, T., May, P. R., & Marder, S. R. (1984). Akathisia with haloperidol and thiothixene. *Archives of General Psychiatry, 41*(11), 1036-1039. https://www.ncbi.nlm.nih.gov/pubmed/6497564

Vickers, B. (2000). *Practitioner Perspectives: Memphis, Tennessee, police department's crisis intervention team*. https://www.ncjrs.gov/pdffiles1/bja/182501.pdf

Virginia DMHMRSAS & DSS. (1988). *Aftercare needs of mentally disabled clients in adult homes*. https://rga.lis.virginia.gov/Published/1988/HD17

Virginia General Assembly. (n.d.). *Code of Virginia*. https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-187/

Virginia Tech Review Panel. (2007). *Mass shootings at Virginia Tech.* https://scholar.lib.vt.edu/prevail/docs/April16ReportRev20091204.pdf

Vitali, A. (2017). Trump signs bill revoking Obama-era gun checks for people with mental illness. https://www.nbcnews.com/news/us-news/trump-signs-bill-revoking-obama-era-gun-checks-people-mental-n727221

Vozzella, L. (2014, April 28). McAuliffe signs 'first step' to reforming Virginia's mental health system. *The Washington Post.*

https://www.washingtonpost.com/local/virginia-politics/mcauliffe-signs-first-step-to-reforming-virginias-mental-health-system/2014/04/28/6acc5d9e-ccbb-11e3-95f7-7ecdde72d2ea_story.html

Wood, D. (n.d.). Ecosystem homeostasis: Definition & examples. https://study.com/academy/lesson/ecosystem-homeostasis-definition-examples.html

Woody, M. (n.d.). Michael Woody. https://www.linkedin.com/in/michael-woody-3535b557

Woody, M. (2005). The art of de-escalation. *The Journal of Olympic Tactical & Investigations.* http://www.olytac.com/wp-content/uploads/2013/12/Woody.-2005.-The-Art-of-De-Escalation-.pdf

Woody, M. (2017). Fall 2017 president's message. http://www.citinternational.org/Message-from-our-President

Word Press. (2013). Real life examples: Bronfenbrenner's bioecological system. https://bronfenbrennerproject.wordpress.com/category/real-life-examples