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# Policing Persons with Mental Illness in Georgia: Elucidating Perceptions of the Mental Health System

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POLICING PERSONS WITH MENTAL ILLNESS IN GEORGIA: ELUCIDATING  
PERCEPTIONS OF THE MENTAL HEALTH SYSTEM

BY

MEREDITH L. KNOWLES

A Thesis Submitted in Partial Fulfillment  
Of the Requirements for the Degree  
of  
Master of Science  
in the  
Andrew Young School of Policy Studies  
of  
Georgia State University

GEORGIA STATE UNIVERSITY  
2012

## ACCEPTANCE

This thesis was prepared under the direction of the candidate's Thesis Committee. It has been approved and accepted by all members of that committee, and it has been accepted in partial fulfillment of the requirements for the degree of Master of Science in Criminal Justice in the Andrew Young School of Policy Studies of Georgia State University.

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## DEDICATION

This Master's thesis is dedicated to my loving husband, Christopher, for his unwavering faith, support and love. I would also like to thank my family for their continuous encouragement. I love you all and I am blessed to share this achievement with everyone in my life.

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Working title:

Policing Persons with Mental Illness in Georgia: Elucidating Police Perceptions of the Mental Health System

(Under the direction of DR. WENDY P. GUASTAFERRO)

### ABSTRACT

The criminal justice and mental health systems increasingly overlap as persons with mental illness (PMI) are disproportionately present throughout components of the criminal justice system, a concern to mental health and criminal justice professionals alike. In response, various initiatives (aimed across components of the criminal justice system) have been developed and implemented as a means of combating this overrepresentation. The following research will focus on one specialized police-based initiative, the Crisis Intervention Team (CIT), which aims to train police how to recognize mental illness, de-escalate persons in crisis, and to seek treatment-based alternatives to arrest, when appropriate (Schwarzfeld, Reuland, & Plotkin, 2008). Alternatives to arrest consist of various community-based mental health services such as public hospitals (some of which are designated as emergency receiving facilities, or ERFs) or private clinics. While the components of CIT training likely influence officers in unique ways, research has yet to empirically examine how CIT influences police perception, behavior or the incidence of referrals to mental health treatment. As an initial step, this research assessed the attitudes police have regarding the hospital and mental health system within their district. Specifically, this research provides a basic understanding of how police regard their local hospitals and mental health facilities that are posited as available alternatives to arrest, and help identify the role CIT plays in shaping these attitudes. This study found almost no significant difference in the attitudes CIT-trained officers had towards district ERF and the local mental health system as compared to non-CIT officers. Only in one of the six departments studied was there a significant difference between the attitudes of CIT-officers and non-CIT officers; with the non-CIT officers actually having more positive attitudes about their local mental health system than CIT-officers. The six departments studied had nearly similar attitudes of their mental health resources, which would barely be considered passing on a standard grading scale. While officers in this study do not have very positive attitudes towards the ERF they use to transport PMI or their districts' mental health system, these attitudes may in fact be more positive than many police departments without any specialized approach or initiative. The significance and policy implications of these attitudes are discussed at length, as these findings speak to the need for increased attention by both the mental health and criminal justice systems. Recommendations for future research, including expanding this study to rural departments or agencies with no connection to CIT, are also outlined.

INDEX WORDS: police perceptions, crisis intervention team, mental health system

## **CHAPTER I**

### **INTRODUCTION**

At first glance, the criminal justice and mental health systems may appear to be independent of one another, meeting distinct societal needs. In reality, the two systems are not so dissimilar, especially because they share the responsibility of promoting and protecting public safety. Moreover, they are increasingly overlapping, as persons with mental illness (PMI) are disproportionately present throughout components of the criminal justice system. The increased rates of arrest, adjudication and incarceration of PMI are concerning to both mental health and criminal justice professionals. In response, various initiatives (aimed across components of the criminal justice system) are being developed and implemented as a means of combating this overrepresentation.

Amidst the many ongoing collaborative efforts between the mental health and criminal justice systems, the following research will primarily focus on one specialized police-based initiative, the Crisis Intervention Team (CIT). The basic goal of CIT is to train police to recognize mental illness, de-escalate persons in crisis, and to seek treatment-based alternatives to arrest, when an officer (using their discretion) deems it appropriate. Alternatives to arrest consist of various community-based mental health services such as public hospitals (some of which are designated as emergency receiving facilities, or ERFs) or private clinics. The components of CIT training likely influence officers in unique ways and research has only recently begun to empirically examine how CIT impacts officer's behavior and the incidence of referrals to mental health treatment. An important facet to examine in this line of research is the officer-level decisions on what course of action to take with a particular PMI and whether CIT influences those decisions. Existing research has shown CIT improves knowledge, attitudes and reduces

stigma regarding PMI (Bahora, Hanafi, Chien & Compton, 2008; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Wells & Schafer, 2006) but has largely failed to link program implementation with actual police behaviors.

Training, especially CIT, is being implemented throughout the country, yet little is known about officer attitudes and behaviors. As an initial step, this research will assess the attitudes police have regarding a primary alternative to arrest: the hospital and mental health system within their district. A defining moment of CIT success or failure is when an officer seeks a resolution to an interaction with a PMI. While many factors likely influence the disposition an officer pursues, research has yet to explore the intricacies and significance of these influences. Furthermore, mental health treatment resources, such as ERFs and non-emergency treatment centers, vary significantly in terms of services, emergency intake protocols, and responsiveness to law enforcement. Presumably, officers could have a variety of attitudes regarding the different mental health facilities (namely ERFs) that are available in their respective district. Therefore, this research will take a first step in understanding such officer-level outcomes by exploring the individual attitudes toward the mental health system. Specifically, this research will establish a basic understanding of how positively or negatively police regard the hospitals and facilities to which they are told to bring PMI and help identify the role CIT plays in shaping these attitudes.

In order to effectively answer this research question, this work will first outline a review of existing literature as it relates to the mental health and criminal justices systems, specifically addressing the confluence of the two. Mental illness will be delineated as a global, national and local problem, presenting personal and economic challenges within society. A result of these problems is the high rate at which PMI are represented throughout the criminal justice system.

Therefore, current responses to the overrepresentation, particularly law enforcement-based efforts to divert PMI, will be discussed in detail. In order to properly examine law enforcement programs, this work will also address past and present practices of policing PMI and how specialized training initiatives, such as CIT, influence the attitudes and behaviors of police officers.

### **Mental Illness**

The vast body of knowledge on mental health and mental illness serves as a foundation for the proposed study. Mental illness and its treatment have a distinct history as both a science and social subject (President's New Freedom Commission on Mental Health, 2003). While science has acknowledged the public health challenges of mental illness, the general public has largely underestimated the burden that now weighs on many systems of society (President's Commission, 2003). As disabilities of all kinds are recognized and addressed, mental illness is taking priority as a public health issue; driving research, public debate and policy initiatives. In order to provide a foundation with which to interpret current data and support future research, it is important to understand the basics of mental illness and the difficulties persons with mental illness (PMI) live with on a daily basis.

The term mental illness, as used here, has a deep-rooted history and collectively refers to all diagnosable mental disorders. Mental illnesses are legitimate medical conditions that disrupt one's ability to think, process emotion, or function on a daily basis. Oftentimes, mental illness is also associated with substance abuse issues because a significant proportion of PMI have a high prevalence of substance disorders (Kessler, Chiu, Demler, & Walters, 2005). PMI often use drugs or alcohol to manage their illness and therefore develop addiction problems in addition to their mental disorder. These dual disorders are referred to as co-occurring disorders, or COD

(Ding, Yang, Cheng, Schiltz, Summers & Skinstad, 2011). COD are usually categorized as subsets of mental illness and for the most part, this work will refer to them as such (unless exceptions are noteworthy to the proposed research). A number of serious mental illnesses such as schizophrenia, depression, bipolar disorder and post-traumatic stress disorder (to name just a few) manifest in distinct ways from one another. Rather than highlight these differences, this work will focus on common characteristics of various mental disorders, such as the cognitive and behavioral deficiencies that can impact how PMI act and react to others. Furthermore, this work will outline how these functional impairments can lead to familial and social difficulties that may increase the likelihood of PMI involvement in the criminal justice system.

### ***Personal Challenges***

PMI face challenges unique to their respective conditions and environments. Kane and Ennis (1996) outline these challenges to include difficulty in caring for oneself, obtaining medical care, housing, or employment. Interaction with others can also be complicated for some PMI as several disorders are characterized by social withdrawal or a difficulty in managing environmental stimuli (Kane & Ennis, 1996). These challenges are all related to cognitive deficiencies experienced by PMI, making the implications of mental illness identifiable on an individual and a community scale. This work will provide a basic understanding of mental illness as a medical condition, as well as the related implications and costs for society.

### ***Economic Challenges***

While it is difficult to measure or describe the total cost of mental illness, certain medical, social and fiscal factors can be quantified in order to provide the proper context. To begin, mental illness is a pervasive issue that recognizes no ethnic, social or economic boundaries. In fact, mental disorders are a leading cause of disability on a global, national and

familial level, with an estimated one in four adults struggling with a disorder in any given year (National Institute of Mental Health, 2010). From an economic standpoint, mental illness accounts for nearly eighty billion dollars in expenditures in the U.S. alone (Rice & Miller, 1996). These expenditures include costs incurred by the government through avenues like the criminal justice system and Medicaid as well as costs incurred by PMI and their families, including treatment for the disorder. Furthermore, the mental health system is largely funded by taxpayer dollars, underlining the need for an effective response to this societal problem.

Mental illness requires treatment in several forms, including medications and therapies that can be taxing on the medical and insurance industries. The challenges facing PMI may also result in loss of work productivity and higher rates of substance abuse (which financially impact communities). Additionally, unmanaged illnesses can result in increased hospitalizations, interaction with the criminal justice system, and even suicide (President's Commission, 2003). Suicide is perhaps the ultimate cost of mental illness, as the majority of people who attempt or commit suicide have suffered from mental illness, whether they have been diagnosed or not (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

In addition to these quantifiable costs of mental illness, PMI also face social rejection and prejudice related to their disorder, which is referred to as stigma. Stigma is a term that encompasses the stereotypical, prejudicial and discriminatory behavior of others that may result in loss of opportunity and demoralization for PMI (Corrigan & Wassel, 2008). Withdrawal, secrecy and isolation due to stigma may worsen symptoms, interfere with gainful employment or hinder access to treatment. As such, stigma is a factor that weighs heavily in modern day mental health care efforts and underscores the need for effective treatment options to ensure a proper recovery.

## **Responding to PMI**

The notion of recovery is not a vague or metaphorical ideal, but rather a reality. In fact, the overarching takeaway from existing mental health research is that mental illness is treatable and PMI can live normal, healthy lives with the right combination of treatment. Treatment may take the form of psychosocial therapies, pharmaceutical remedies, or a combination of the two. Any number of factors influence the manner in which treatment options affect PMI, with different medications or therapies having different effects on different people. In addition to the lessening of symptoms and the enhancement of functioning, the pursuit of recovery has also improved the study of the human brain and the collective understanding of mental disorders. “Scientists have learned much more about the workings of the brain as a result of their investigations into how psychotherapeutic medications relieve the symptoms of disorders such as psychosis, depression, anxiety, obsessive-compulsive disorder, and panic disorder” (NIMH, 2008, p. 2). The current treatments of mental illnesses (especially the pharmacological treatments) are based on the effectiveness in reducing symptoms and suffering rather than an established understanding of how they act on the human brain (Noroian, 2007). However, it is in the pursuit of improving such treatments that the brain is studied and the causes of mental disorders are elucidated.

The field of effectively treating mental disorders is complex and ever-changing. However, it is the process of accessing these legitimate means of treatment that is the root problem of the mental health care system. Treatment is not readily available to a significant portion of those in need, so an increasing percentage of untreated PMI (including those in a crisis state) are amidst their local community on any given day.



The reality of such a broken mental health system is largely attributed to the ineffective shift from institutionalization to community-based treatment and the imposing economic changes of the last several decades. Primarily, a shift away from institution-based care and towards community-based services markedly altered the course of mental health care in the U.S. From the 1950s to the 1970s, the decrease in institutionalized care led to an unprecedented number of PMI living in the general population. However, this transition was not effectively funded or implemented within local communities. State governments and municipalities have been unable to finance adequate treatment and face growing budget deficits. Since mental health treatment is primarily funded by Medicaid and the state, federal and state budget cuts have direct impacts on the availability of treatment resources (Appelbaum, 2003).

Mental health treatment is increasingly expensive for the medical community to provide, and government funding has been unable to supplement the growing costs incurred by treatment providers. Disparities that were once covered by state funds are even further exacerbated by recent economic downturns (Appelbaum, 2003). The reality of fiscal shortfall and economic recession is that local communities are responsible for providing mental health treatment to a larger number of PMI with fewer resources than ever before. The public health and criminal justice systems bear direct operational and financial burdens as a result.

With fewer accessible treatment options, PMI suffer consequences such as frequent visits to emergency rooms and hospitalizations, homelessness, premature deaths and suicides and involvement with the criminal justice system (Honberg, Diehl, Kimball, Gruttadara, & Fitzpatrick, 2011). Hospitals are increasingly becoming the first access point for mental health treatment, as PMI are more likely to require emergency mental health services when disorders go untreated. Therefore, emergency rooms are accommodating a growing number of PMI in need of

psychiatric evaluation and services. However, not all hospitals are staffed or equipped to handle PMI in a crisis state, so certain facilities have special designations as an Emergency Receiving Facility<sup>1</sup> (ERF). Public safety personnel are instructed to take PMI in crisis to an ERF, but PMI and their loved ones most often access the closest hospital when in crisis. As a result, hospital resources and staff become overwhelmed with mental health cases and struggle to find local placement for PMI. Police are aware of the burden on these facilities, as they often rely on hospitals when trying to get a PMI treatment in lieu of arrest (yet research has yet to elucidate the basic attitudes police have towards such facilities). However, the intersection of the mental health and criminal justice systems does not just end in the hospital lobby. The two systems are increasingly related to one another as they work to leverage existing resources to achieve their respective missions and improve interactions with PMI.

Families, communities and other public systems are significantly impacted by insufficient mental health care resources. Therefore, community police are interacting with PMI regularly (Hails & Borum, 2003). They have effectively become responsible for facilitating access to what limited treatment options are available. This responsibility has been placed on police without understanding or even assessing the basic attitudes police officers have towards the mental health system they are now encouraged (even required in some cases) to leverage. Without effective coordination and continuity of mental health care in the community, jails and prisons develop significant disparities within offender populations. As a result, the criminal justice system assumes the burden and cost of mental health care for a significant subset of PMI who are increasingly coming into contact with police (Steadman, Morris & Dennis, 1995).

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<sup>1</sup> The official code of Georgia, title 37, chapter 3, which outlines the Georgia Civil Commitment Statute regarding mental health examination and treatment, defines an Emergency Receiving Facility (ERF) as a facility designated to receive patients under emergency conditions. (O.C.G.A. § 37-3-1 et seq, 2010).

Research estimates that of all those arrested, jailed, in-prison or under-correctional supervision in the United States, anywhere from 7% to 18% qualify as PMI (Lamb & Weinberger, 1998). While medication and programming is provided to some incarcerated PMI, these mental health services are limited at best, and certainly insufficient for the overall population of PMI in jails and prisons (Beck & Maruschak, 2001). The prevalence of PMI throughout the justice system speaks to the need for reform and effective alternatives to incarceration. Many also contend that the rise of incarcerated PMI rates is caused by a justice system that lacks the proper response to a population in need (Wells & Schafer, 2006). A narrative regarding how these offender disparities are a result of the justice system's response to legislative change has since developed.

Deinstitutionalization made the provision of mental health care a responsibility of local communities and facilities were subsequently overwhelmed with PMI in need of treatment. This resulted in a higher percentage of PMI (representing various degrees of treatment compliance) living amongst the general population. Law enforcement was unprepared and inadequately trained to handle the community influx of PMI following deinstitutionalization (Anderson & Lynch, 1984). Higher numbers of PMI amongst general populations and an increased frequency of PMI involvement in criminal offender populations resulted in a higher rate of PMI and law enforcement interaction (Teplin, 1984). Consequently, the courts and corrections systems saw a rising number of PMI adjudicated and incarcerated. In recognition of historic and existing PMI disparities, diversion efforts have become a priority goal of the criminal justice system.

### ***Diversion Initiatives***

Collaborative efforts aimed at addressing PMI overrepresentation throughout the criminal justice system are known as diversion programs. These initiatives may be aimed at those already

in the formal criminal justice system (post-booking diversion programs) or work to divert PMI from being arrested to begin with (pre-booking diversion programs). Diversion programs include specialized first responder initiatives, mental health courts and jail-based diversion programs, which work to ensure that PMI have access to appropriate treatment within the community upon release from incarceration. Of these initiatives, law enforcement-based intervention programs are particularly popular because police are seen as the gatekeepers of the criminal justice system, exercising a significant amount of discretion during the course of their duties (Menzies, 1987). If the overall goal is to ebb the flow of PMI into the criminal justice system, stakeholders are inclined to recognize police as serving a critical role in diverting PMI. Therefore, police behavior is a common focus of study, seeking to identify, predict and influence the decisions officers make.

Subsequent chapters of this work provide more information on diversion programming, given that research has begun to study the effectiveness of individual initiatives. By demonstrating which programs are effective, agencies, municipalities and governments can make more educated policy decisions and resource allocations. However, in addition to gauging the success of programs, it would be helpful to better understand how a program works or how the attitudes and decisions of those involved impact the overall initiatives. Therefore, subsequent to identifying a specific initiative as “effective,” researchers should examine what fundamental components contribute to the efficacy. While this work will explore police-based intervention programming in-depth, the basic differences between other intervention strategies and their respective research gaps are also addressed in subsequent portions of the literature review. Specifically, this work will look at how one pre-booking diversion effort, the Crisis Intervention

Team (CIT), has been widely implemented without examining the attitudes police officers (the primary facilitators of CIT) have regarding the hospitals and resources CIT stresses.

Police are increasingly expected to play a central role in diverting PMI from the justice system; yet police-initiated intervention programs are being implemented without knowing enough about the dynamic context of these interactions, including how police officers view the intervention and perceive the resources that are available to them. Current efforts rely heavily on police to facilitate access to mental health treatment but research has yet to assess how officers perceive their mental health resources. It is important to understand more about what police want to do regarding PMI and how their attitudes towards local mental health resources (i.e. hospitals) impact their decisions. Therefore, this research takes a critical first step by elucidating the basic attitudes police have regarding their local emergency rooms and mental health treatment facilities. To better understand police attitudes and behavior, this work also provides a general framework of organizations, practices, and interactions with PMI.

### **Policing PMI**

Law enforcement agencies serve several primary functions within local communities: the maintenance of public safety, the provision of service to citizens and the responsibility to be a response force to accidents and injuries (Cumming, Cumming, & Edell, 1965). An increasingly significant portion of law enforcement's time and resources are spent on issues involving PMI. Cordner (2006) estimates that as much as 10% of sworn personnel's time is spent concerning matters involving PMI, suggesting these interactions are a significant factor in terms of law enforcement resource allocation. Furthermore, the social tendency to identify police as the gatekeepers of the criminal justice system brought about new studies on the discretion officers and law enforcement agencies have (Menzies, 1987).

Several high profile events called attention to the manner in which law enforcement was responding to PMI and brought criticism on police agencies. Most notably, the 1988 Memphis, Tennessee case in which an individual with a history of mental illness and substance abuse who was wielding a knife was fatally shot by officers (Dupont & Cochran, 2000). Many communities experienced similar incidents in which police had to use force (sometimes deadly force) on a PMI actively exhibiting symptoms of a mental disorder (Hails & Borum, 2003). Given these and other similar events, the public recognized the significant amount of discretion police have when interacting with citizens and communities began to see law enforcement's traditional response as failing to address a special-needs population (Wells & Schafer, 2006).

While most police interactions with PMI are non-violent, research has found that officers are less confident and develop anxiety with regard to their personal safety when responding to such calls for service (Arcaya, 1989; Wells & Schafer, 2006). Additionally, police are frustrated with more time consuming calls and responding to chronic requests from the same PMI (Hails & Borum, 2003). Police departments traditionally have lacked special instructions for officers dealing with PMI and hospitals presented significant barriers to care access (Dupont & Cochran, 2000). As a result of police anxiety, frustrations and the system's obstacles, police relied on their discretion and informal practices when interacting with PMI. Police chose from a variety of options ranging from ignoring the PMI or eliciting the help of family members to transporting a PMI to a hospital. In lieu of any practical non-custodial options, police often viewed arrest as the only option (Dupont & Cochran, 2000).

Law enforcement agencies and the criminal justice system as a whole recognized the need for a new approach that would equip police with the tools for responding to PMI with improved skills, attitudes and effective alternatives to arrest. In 1988, the Memphis Police

Department joined with local mental health and university partners to develop the original model of the Crisis Intervention Team (CIT), a collaborative effort to enhance police response to PMI. Recently, different models of CIT programming have been implemented across the U.S. and vary based upon local jurisdictions and resources. The state of Georgia features a statewide initiative that offers training (based on the original, Memphis-model of CIT) to any law enforcement or public safety agency. The Georgia program has grown significantly, working towards a goal of training 20% of the law enforcement in the state, which the Georgia Peace Officer Standards and Training Council (POST) estimates at more than 53,000 sworn officers (Oliva & Compton, 2008). While the program is growing, research on CIT initiatives is comparatively limited.

Current research on the success of CIT is limited to larger, more urban law enforcement agencies and communities and fails to address rural agencies (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Steadman, et al., 2000). It is erroneous to presume that CIT success within urban departments would translate to other policing environments. This presumption is particularly flawed because CIT programs (including Georgia's) rely heavily on the cooperation of community-based mental health service providers which some rural areas may not have. Hospitals and mental health treatment resources are different in each jurisdiction and many rural communities may not have the resources that larger, urban departments have available.

Existing research aimed at evaluating the rate at which CIT influences the rates of PMI arrest is limited, yet CIT has spread quickly in the last few decades (Ritter, Teller, Marcussen, Munetz, & Teasdale, 2011; Teller, Munetz, Gil, & Ritter, 2006; Watson, Morabito, Draine & Ottati, 2008). The spread of CIT is (at least in part) attributed to the model's mass appeal to law enforcement organizations, yet there is virtually no solid evidence base CIT influence on police interventions (Watson, Morabito, Draine & Ottati, 2008). Additionally, only a small handful of

studies address specific programmatic elements that contribute to the understanding of how police behavior is influenced and the role mental health facilities assume in CIT implementation. (See Borum, et al., 1998; Compton et al., 2006, and Sellers et al., 2005 for examples).

Police confidence in responding to calls with PMI (self-efficacy) and their comfort level being around PMI (desired social distance) have been measured in officers before and after CIT training, finding that CIT improves police knowledge and self-efficacy while reducing their desire for social distance from PMI (Bahora et al., 2008; Compton et al., 2006). Measured changes in police attitudes are used to support the argument that CIT training would improve police interactions with PMI, and enhance the safety of subjects and officers yet further research is needed to test these presumptions (Bahora, et al., 2008). Research has also found CIT models yield more positive police perceptions of mental health resources than other specialized police-based diversion models (Sellers et al., 2005). However, studies have highlighted police departments assuming a traditional or non-specialized approach to policing PMI that have comparable, or more positive relationships between police and hospitals (Sellers et al, 2005).

This work will highlight how CIT-related outcomes have been evaluated before clarifying how components of CIT influence one another. Specifically, research has yet to comprehensively elucidate the basic attitudes police have with regard to mental health facilities in their jurisdictions. Since behavior is influenced by attitude, it is important to first assess the attitudes police have about the emergency rooms and mental health facilities available to them. While some studies have examined CIT from an officer-level perspective, they fall short of fully assessing the attitudes and outlook police have about their jurisdictions mental health system. Although more than 3100 Georgia law enforcement officials in Georgia alone have been trained



in CIT, only two studies have examined basic police officer perceptions and attitudes (P. Strode, personal communication, September 9, 2010; Borum, et al., 1998; Sellers et al., 2005).

Developing upon those studies, this work seeks to examine police officer attitudes and perceptions regarding a variety of mental health treatment resources. These resources, including hospitals and mental health facilities, are central to the success of CIT initiatives because they are posited as better alternatives to arrest. The experiences police have with such facilities likely influences their perception of the hospital and the mental health system as a whole. Since mental health facilities and hospitals presumably vary by setting in terms of their services, emergency intake protocols and responsiveness to law-enforcement mental health referrals, this work will determine whether police perception of such services varies accordingly. It is important to better understand these attitudes in order to clarify how police perception influences behavior and discretion in an officer's work.

### **The Current Study**

This work examined the attitudes of police officers from six Georgia police departments toward their local hospitals and mental health systems. Officers from these six departments were asked a series of questions regarding their opinion of their local hospital and mental health systems': responsiveness, efficiency, resistance to PMI intake, timeliness, and effectiveness. Additionally, officers were asked to rate their levels of comfort and attitudes related to using non-law enforcement mental health resources. Only a portion of responding officers have been trained in CIT, therefore this research also elucidates whether CIT training is associated with a marked difference in police attitudes of such facilities. This research will improve the collective understanding of police decisions and interactions with PMI.

This work addresses the following research questions:

**Research Question One: *How do officer attitudes regarding their jurisdiction's mental health facilities vary by department?***

Based upon a review of existing literature and the diversity represented by the six hospitals and mental health systems from different areas of Georgia, officers' perceptions of the ERF in their jurisdiction are expected to vary between departments. This expectation is based on the notion that facilities (especially hospitals) create significant barriers to care by leaving police responsible for the custody and behavior of PMI, establishing unrealistic admission criteria and failing to successfully organize the delivery of care (Dupont & Cochran, 2000). Therefore, facilities that offer expedient PMI processing will likely be viewed more favorably by police than those that require extensive officer involvement and time commitment in referring PMI to treatment. The six departments included in this research represent different areas of Georgia, and therefore have different mental health resources and intake protocols. If these hypothesized differences are supported, significant differences between hospitals could be identified in an effort to address less favorable police perceptions. Should no such inter-agency disparities exist, this would suggest that officer attitudes across these six jurisdictions do not vary significantly.

**Research Question Two: *Does specialized training, specifically CIT training, influence the attitudes officers have regarding the hospitals and mental health system in their jurisdiction?***

Research has found CIT models yield more positive police perceptions of mental health resources as compared to other specialized police-based diversion models (Sellers et al., 2005). A part of CIT training involves site-visits to local emergency receiving facilities in an effort to enhance police familiarity and attitudes regarding the facilities. Therefore, CIT-trained officers may have a more positive attitude about their local mental health system. However, studies have also shown that police departments without a specialized approach to policing PMI can have

comparable or even more positive relationships between police and hospitals than departments with specialized approaches to PMI (Sellers et al, 2005). Therefore, training may not be the most effective means of changing officer perceptions and attitudes. Research is needed to clarify the role training, especially CIT, has with regard to shaping police attitudes about mental health facilities. Therefore, this work will determine if there is a significant difference between officers who are trained in CIT and those who are not trained in CIT; both within their respective departments and across all six departments. Furthermore, if this research finds that no significant difference between those trained in CIT and not trained in CIT, it will suggest that officer attitudes regarding hospitals and mental health systems are influenced by factors other than training. The implications for policy and practice are also addressed.

**Research Question Three: *Within each agency, does CIT training influence the attitudes officers have regarding the hospitals and mental health systems in their jurisdiction?***

Since this study examines how attitudes vary between departments and based upon specialized training, the third research question examines how attitudes vary based upon CIT training within each of the six agencies. This analysis investigates how police attitudes vary within their respective group environments, based upon having specialized training like CIT. This question is important, because it serves to compare police attitudes towards the same hospital or mental health system. This analysis also helps to examine other intra-agency factors that may influence officer attitudes.

To answer these questions, this research proceeds in the following manner: a review of literature that centers on persons with mental illness (PMI), their involvement in the criminal justice system, and policing strategies regarding PMI will be presented. The literature review is followed by an overview of the proposed research methods including descriptions of the sample

and setting. Subsequently, the results of the analysis are presented and accompanied by graphical representations of the findings. Lastly, this research discusses the findings in light of previous research and study limitations. The significance and policy implications of this study's findings are discussed at length, and recommendations for future research, are outlined.

## **CHAPTER II**

### **REVIEW OF LITERATURE**

To understand the dynamic interplay and interdependency of the mental health and criminal justice systems, one must first understand some fundamental aspects of each. It is indeed a challenge to concisely incorporate the sum of established knowledge on mental health into various frameworks. Previous studies have largely limited the scope of their research to single issues, perspective or frameworks because of the many changes in mental health policy, practice and resource availability (President's New Freedom Commission on Mental Health, 2003). Similarly, Mowbray and Holter (2002) acknowledge that producing a comprehensive and accurate summary of mental health research is nearly impossible due to the extensive changes that have occurred in the mental health community over the past 25 years alone. Scientific developments regarding mental illness are broadening what we know about the brain, the body and individual behavior. Kane and Ennis (1996) acknowledge the current state of knowledge on mental illness as eclipsing the limited perspectives of previous decades and recognize the progression of mental illnesses from specific disorders to clinical syndromes. Advances in epidemiological research establish the distribution and detriments of mental disorders throughout populations groups (including racial, ethnic and minority groups) and are to be presented here.

Given that this work examines an exchange between the mental health and criminal justice systems, this chapter will begin with a concise review of mental illness as a problem which impacts multiple societal systems. By first outlining the basic realities of mental health care, the narrative will then establish the context in which today's criminal justice system has developed stark disparities within offender populations. The chapter will then address research relevant to combating the disparities, including diversion programs that feature police officers as

the primary facilitators of intervention. This work also speaks to policing organizations and practices, particularly law enforcement's approach to PMI. Therefore, this chapter will highlight existing knowledge gaps regarding what is known about police attitudes and behavior and establish how specialized training initiatives, such as CIT, may influence officers.

### **An Introduction to Mental Illness**

The term mental illness is used throughout this work and collectively refers to all diagnosable mental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV). Generally speaking, mental illnesses are medical conditions that disrupt a person's cognitive ability, feeling, mood, relationships and daily functioning (<http://www.nami.org>). Serious mental illnesses include, but are not limited to: schizophrenia, depression, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder (President's Commission, 2003). All humans experience a wide range of moods, emotions and thoughts throughout life that may be characteristics of mental disorders, however; this review of literature and subsequent research will focus on persons with serious or chronic mental illness.

For the purpose of this work, persons with mental illness (PMI) are defined as, "individuals who have (or have had) a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria of the DSM that has resulted in functional impairment which substantially interferes with or limits one or more major life activities," (President's Commission, 2003, p. 2). A significant proportion of PMI also suffer from substance abuse disorders that may exaggerate or mask the symptoms of mental illness. PMI are inherently sensitive to the effects of alcohol and other drugs and may abuse these substances as a way to self-medicate or manage certain symptoms, so there is a heightened risk of developing substance

abuse or addiction issues (NAMI, 2011). Individuals with one or more substance-related disorders in addition to having one or more diagnosable mental illnesses are said to have a co-occurring disorder (Ding, Yang, Cheng, Schiltz, Summers, & Skinstad, 2011). Therefore, co-occurring disorders (COD) are often referred to as a subset category of mental illness because while not all PMI have a COD; all persons with a COD must have a diagnosable mental illness. Persons with co-occurring disorders (PCOD) have unique implications in terms of diagnosis and treatment which will be discussed throughout this work when appropriate, but for the most part the term PMI will collectively refer to mental disorders or COD.<sup>2</sup>

Regardless of the cause, mental illness leads to a broad spectrum of deficits in an individual's ability to function day to day (Kane and Ennis, 1996). These functions include caring for themselves (financially and physically), accessing and maintaining housing and medical care, and interacting socially with others. Many of the various mental illnesses are characterized by social withdrawal and may severely inhibit an individual's ability to understand or manage environmental stimuli (Kane and Ennis, 1996). Such impairments have a significant impact on the behavior of PMI and their reaction to other persons. These functional and cognitive deficiencies are often exacerbated in PCOD, as substance abuse and addiction coupled with mental illness is associated with a higher risk of relapse, non-compliance with treatment, and a worsening of the mental disorder (Bradizza, Stasiewicz, & Paas, 2006). PCOD often experience more severe and chronic medical, social and emotional problems including more negative health outcomes, longer hospital stays, and an increased need for emergency hospitalizations (Ding et al., 2011). The daily struggles of PMI and their families are also tied to the community, as mental illness has impacted society on a larger, even global level.

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<sup>2</sup> For the purpose of this work, the term PMI will encompass PCOD unless otherwise noted. Unique aspects of co-occurring disorders (COD) will be discussed when applicable, but still is considered a subset of the overall discussion of mental illness.

### ***Mental Illness: A Global, National and Local Dilemma***

The World Health Organization (WHO) has identified mental illness as the leading cause of disability worldwide (World Health Organization, 2003). A 2000 study by the WHO found mental illnesses such as depression, schizophrenia, and bipolar disorder to account for nearly 25% of the total disability across major industrialized countries (the United States, Canada and Western Europe), (World Health Organization, 2002). Furthermore, alcohol and drug use disorders, which are closely linked to mental illness, comprised an additional 12% of the total causes of disability. These findings reflect the serious health challenges posed by mental illness and substance abuse disorders on a worldwide scale.

On a smaller scale, almost every single American family is impacted by mental illness, either directly or indirectly (President's Commission, 2003). The National Institute of Mental Health reports that one in four adults (approximately 57.7 million Americans) experience a mental health disorder in a given year (2010). A significant portion of those 57.7 million Americans is increasingly diagnosed as struggling with substance abuse disorders as well. Throughout the last two decades, COD diagnoses have risen steadily, partially as a result of improvements in diagnostics and clinical attention (Ding et al., 2011). Recent estimates by the Office of Applied Studies (2008) reported that 5.4 million adults had a COD (as cited in Ding et al., 2011). In addition to the staggering number of adults grappling with mental illness, anywhere from 5% to 9% of children suffer a serious emotional disturbance<sup>3</sup> (Farmer, Mustillo, Burns, & Costello, 2003). Mental illness directly impacts a significant portion of the population and

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<sup>3</sup> DSM-IV defines a *serious emotional disturbance* as a mental, behavioral, or emotional disorder of a specified duration that results in the functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Children under the age of 18 are not diagnosed with a mental illness but rather a serious emotional disturbance which may be characteristic of a mental illness.



indirectly affects countless families and friends of PMI, making it difficult to quantify the number of lives impacted each year in America by mental illness.

Another unfortunate (and all too common) societal consequence of mental illness is suicide. The World Health Organization's (2002) *World Report on Violence and Health* found suicide to be responsible for more deaths each year than homicide or war and was found to be the leading cause of violent deaths worldwide. The lack of media attention surrounding suicide is significantly disproportionate with the rates of death each year (President's Commission, 2003). The Institute of Medicine (2002) reported that suicide was the 11<sup>th</sup> leading cause of adult death in 2000, claiming approximately 30,000 lives each year in addition to some 650,000 people who are hospitalized after a suicide attempt. Even more concerning is the fact that suicide is even more common among youth; it is the third leading cause of death in American youth (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). The same report found the vast majority of people who die by suicide (or attempt it) to have suffered from a mental illness, "often times having gone undiagnosed or untreated," (Goldsmith et al., 2002 p. 2). These statistics help to illustrate how pervasive the impact of mental illness is in communities across America and throughout the world.

In addition to the mortality rate findings, mental illnesses have also been examined from a fiscal perspective in order to calculate the associated costs. Rice and Miller (1996) examined the various impacts and deficiencies associated with mental illness and found that in the United States, mental illness could account for \$79 billion in expenditures. These figures include the loss of productivity associated with individuals not working, mortality costs, treatment for incarcerated PMI and more (Rice & Miller, 1996). Moreover, mental health treatment is largely

funded by taxpayer dollars, “in 1997, the United States spent almost 71 billion dollars treating mental illnesses” (President’s Commission, 2003, p. 3).

In 2002, President George W. Bush announced the creation of the New Freedom Commission on Mental Health as a part of an initiative to address and overcome the inequalities facing Americans with various disabilities. In his public address, President Bush proclaimed, “Our country must make a commitment. . .Americans with mental illness deserve our understanding and they deserve excellent care,” (President’s Commission, 2003, p.1). A commission was established with the goal to thoroughly review and analyze the status of mental health in America and identify points throughout the mental health system in need of reform. President Bush’s formation of this initiative identified mental health as a recent priority of the country and spoke to a larger movement towards a society that sees mental illness as a treatable medical condition that deserves further research and understanding.

From 2002 to 2003, the President’s New Freedom Commission on Mental Health met monthly to examine the public and private mental health systems, visit innovative model programs throughout the country and interact with the many stakeholders with a vested interest and role in the system. Stakeholders in the mental health community include consumers of mental health care, families, advocates, researchers and the public and private providers of mental health services. After a year of study, review and reflection, the Commission acknowledged that mental health is treatable, yet the existing mental health system is, “fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.” “Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities,” (President’s Commission, 2003, p. 1).

The National Alliance on Mental Illness (NAMI) is a grassroots advocacy organization for individuals and families affected by mental illness that offers a wide range of statistics and information on various mental disorders (NAMI, 2011). NAMI also represents a body of stakeholders (invested or affected parties of an issue) in the mental health community and is a primary partner in many initiatives aimed at helping PMI access treatment in lieu of arrest and incarceration. Although mental illness is widespread in the American population, the main burden of illness is concentrated in a much smaller proportion; impacting about six percent, or one in 17 Americans who live with a serious mental illness (<http://nami.org>).

***Stigma: Society's Response to PMI***

In addition to the physical, emotional and financial costs related to mental disorders, PMI often must endure elements of social rejection and prejudice referred to as stigma. Stigma may take the form of social or professional rejection, family conflict or even an inability to develop positive feelings of self-worth. Corrigan and Wassel (2008) acknowledge that the term “stigma” is complex, representing the overall stereotypical and prejudicial process of human behavior related to PMI. Stigma is often used to describe the personal demoralization and lost opportunity PMI face when society learns about their respective disorder. Common societal responses to a person's mental illness may be job discrimination, social rejection, and family discord (Feldman & Crandall, 2007). These responses are based on common misconceptions people have about PMI including (but not limited to): the idea that PMI are dangerous, incompetent, and to blame for their own illness (Watson, Corrigan, Larson & Sells, 2007).

When a person is diagnosed with a mental disorder, they may reflect on the social stereotypes regarding mental illness and begin to take them personally. This can result in another form of stigma, called self-stigma. In this process, PMI can internalize the negative attitudes held

by others and in the process, further diminish one's self-worth and self-efficacy (Watson et al., 2007). The convergence of negative or markedly changed social, familial, and self-attitudes can be hard to handle effectively by a PMI. To the extent that PMI anticipate negative stigma and in response, they also limit their social networks and opportunities (Watson et al., 2007).

Withdrawing from others in this way can potentially aggravate existing symptoms of a disorder. Furthermore, isolation can result in unemployment and lowered income, which also augments the problems associated with accessing treatment services (Watson et al., 2007). Feldman and Crandall (2007) argue that the harm caused by stigma of mental illness is equal to the physical symptoms. The negative impact of stigma is perhaps most damaging when it keeps PMI from accessing vital treatment services to address their disorders.

It is important to note that not all PMI self-stigmatize upon diagnosis. Watson, Corrigan, Larson and Sells are careful to mention that some individuals become "energized and empowered or others remain relatively indifferent and unaffected" by a diagnosis (2007, p. 1312). No matter how a PMI responds to their diagnosis, it seems that society's response is the most influential factor in determining whether PMI will hinder their own treatment plans, personal aspirations and goals. Strategies aimed at reducing this negative stigma will be discussed below.

### ***Mental Health Treatment Options and their Benefits***

Perhaps the most important piece of information elucidated from existing mental health research is that mental illnesses, like other health disorders, are treatable. The National Alliance on Mental Illness (NAMI) works to combat the stigma surrounding mental illnesses and educate the public to the reality that most PMI can experience relief from associated symptoms through active participation in treatment programs that feature a combination of pharmacological and

psychosocial treatment and support resources (NAMI, 2011). Treatment may consist of compliance with psychiatric medications, psychosocial therapy, peer support groups, or a unique combination of these options. NAMI reports that “the best treatments for serious mental illnesses today are highly effective; between 70 and 90 percent of individuals have significant reduction in symptoms and improved quality of life” when the proper combination of medicine and therapy is obtained (2011). This proper combination of treatment options is based on the individual’s needs, medical situations and under the care of a doctor.

### **Psychosocial Treatments**

A fundamental element of mental illness treatment is the provision of support, education, and guidance to PMI and their families, collectively referred to as psychosocial therapies (NAMI, 2001). This term generally refers to the variety of non-pharmacological methods of addressing the symptoms of mental illnesses and helping PMIs understand and cope with a disorder. One specific method, psychotherapy (or talk-therapy), is used to treat emotional, behavioral, and social problems associated with mental illness through counseling on an individual or group basis. The overarching goal of such therapies is to help PMI understand “why they are acting and thinking in ways that are troubling or dangerous to themselves or others so they have more control over their behaviors and can correct them” (NAMI, 2001).

Talk-therapy sessions may focus on a consumer's current or past problems, experiences, thoughts, feelings, or relationships. By sharing experiences with a trained, knowledgeable, and understanding person--by talking about the consumer's world with someone outside it--people with mental illnesses may gradually understand more about themselves and their problems. (NAMI, 2001).

In addition to methods such as cognitive behavioral therapy or interpersonal therapy sessions;<sup>4</sup> peer support groups (involving other PMI) and other community services (like volunteer or vocational programs) are common components of a comprehensive recovery plan. These various psychosocial treatments offer education related to mental illness and help PMI interact with society: lessening the isolation associated with mental illness stigma.

### **Psychiatric Medications**

Medications for mental illnesses were first introduced in the early 1950s with the antipsychotic chlorpromazine and since then, psychiatric medications have become an increasingly critical part of treating PMI (Croft, 2009). Medicinal treatments evolve as practitioners understand more about the symptoms of mental illness. The National Institute of Mental Health (NIMH) website defines psychiatric medications (sometimes referred to as psychotropic or psychotherapeutic medications) as pharmaceuticals that are used to treat the symptoms of mental disorders such as (but not limited to): schizophrenia, depression, bipolar disorder, and anxiety disorders (NIMH, 2008). Psychiatric medications are forms of treatment and not outright cures for mental illness, “just as aspirin can reduce a fever without curing the infection that causes it, psychotherapeutic medications act by controlling symptoms” (Croft, 2009, p. 2). Effective pharmacological treatments also serve to enhance other treatment options such as psychosocial therapies by lessening the physical symptoms of certain mental disorders that may inhibit a PMI from effectively engaging in counseling sessions (Croft, 2009). However, there are a number of biological and lifestyle factors that influence the chemical effectiveness and side-effects of medications (NIMH, 2008). Therefore, even PMI who are compliant with prescribed psychiatric medications may still exhibit symptoms of mental illness, require routine medical attention and come into contact with law enforcement as a result.

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<sup>4</sup> For a full listing of psychosocial therapy methods, see NAMI’s website: [NAMI | Psychosocial Treatments](#)

Advances in pharmacology and technology aid the development and implementation of effective treatment plans for PMI and reiterate the notion that mental illness is treatable. PMI can live normal, productive lives within the community when they have access to legitimate means of treatment. However, treatment is not readily available to many PMI, a reality that is the result of systemic political, social and economic change. For a smaller subset of PMI (the homeless and those with co-occurring disorders) treatment options are even scarcer. Breaks in the system are largely attributed to the ineffective shift from institutionalization to community-based treatment that resulted in a higher proportion of un-treated PMI in the general population. As a result, police are increasingly relied upon to bridge the gaps that exist in accessing treatment despite the fact that research has failed to assess the basic attitudes police have towards the mental health resources they are being encouraged to use. Issues with the policy, funding and implementation of community-based treatment are discussed below and serve to explain how the criminal justice system is increasingly bearing the burden of shrinking mental health resources.

### ***Treating PMI in the Community: Funding Crises and Shifting Burdens***

This increased presence of PMI in the community is attributed to the major changes in mental health policies that have occurred within recent decades. Teplin (1984) cites deinstitutionalization, legal restrictions regarding civil commitment and reduction in funding for community-based health programs as the basis for the increasing number of PMI in the community. The deinstitutionalization movement was the result of federal legislation encouraging the use of community-based treatment over custodial hospitalization care; dramatically altering the burden of mental health care (Anderson & Lynch, 1984). From 1955 to 1974, the number of mental institution residents dropped from 559,000 to 216,000 while mental health service at local hospitals doubled during the same time period (Anderson & Lynch, 1984).

Policies and services were forced to respond to large numbers of people being in the community who were once confined to the custodial care of hospitals (Draine, Wilson, & Pogorzelski, 2007). Knee and Lamson (1977) noted the steady increase in outpatient treatment participation over three decades, finding outpatient care to account for 22% of mental health care in 1955, 60% in 1969 and 68% in 1973 (Anderson & Lynch, 1984; p. 41).

The decrease in institutionalized care resulted in the increased presence of PMI in the general population and fostered a new set of ideas about how mental health services should be organized (Draine, Wilson, & Pogorzelski, 2007). While this new ideal of mental health service organization appeased legal restrictions and political agendas, it was not effectively funded or implemented within the community. Instead, communities were suddenly faced with significant budgetary and resource-based disparities between what was needed to treat the number of PMI and what was feasible to fund and provide. States were not equipped to fund the resources that were implemented. Access to adequate treatment is even further threatened by decreased funding, largely due to the recent economic recession.

To understand how the economic downturn has exacerbated the mental health crisis one must understand the basics of how community-based mental health treatment is funded. Mental health treatment is funded by three primary sources: insurance coverage managed by behavioral health care organizations (MBHOs), Medicaid, and state-general funds (Appelbaum, 2003). MBHOs and Medicaid work on a compensation basis in which mental health providers are reimbursed for services rendered to PMI. However, this reimbursement is often inadequate; resulting in budgetary shortfalls in which facilities are losing money for their day-to-day services (Appelbaum, 2003). While the cost to provide mental health treatment has steadily risen since the early 1990s, the reimbursement rate provided by Medicaid and MBHOs has only slightly



increased, resulting in a substantial disparity between operating costs and funding (Appelbaum, 2003). In other words, mental health providers in general hospitals and community clinics cannot cover the costs of the services they are providing and lose money on the majority of the PMIs they serve. These losses were once covered by some state's funding, but this has largely disappeared with recent economic downturns (Appelbaum, 2003).

In a recent audit of national mental health service providers, Lutterman (2010) found Medicaid (a joint federal-state program) and state general funds were the two largest sources of state support for mental health services. Perhaps most importantly, these two funding sources are largely contingent upon changes in the federal and state budgets. Therefore, the state of the economy is a significant factor in the funding of mental health resources. Within the last several years, the U.S. has experienced the worst economic recession since the Great Depression of the 1930s, resulting in declines in consumer spending and governmental budget deficits (Willis, 2009). With this recession, considerable cuts have been made to an already inadequate system of mental health resources.

### **Federal Funding Challenges**

Federal funding has been unable to supplement the cuts being made to state budgets on an annual basis. In response to the latest economic recession, the American Recovery and Reinvestment Act of 2009 (ARRA) provided temporary federal fiscal relief to states by increasing the federal Medicaid matching rate (the rate of reimbursement discussed above) for a specified amount of time (Kaiser Commission on Medicaid and the Uninsured, 2010). However, this temporary resolution was already extended once previously and recently expired on June 30<sup>th</sup>, 2011 (Honberg, Diehl, Kimball, Gruttadara, & Fitzpatrick, 2011). State officials who are already facing significant budget shortfalls are now struggling to decide how to respond

accordingly as demand for Medicaid increases (a result of rising unemployment) and federal funding decreases. Possible responses could range from additional cuts to “optional” services currently available in state Medicaid programs to a renewed interest in the adoption of managed care systems,<sup>5</sup> which consist of a standardized approach to financing and delivering health care that attempts to control costs and ensure care (Honberg et al., 2011).

It is important to note that while Medicaid supplements to the states are useful in tough economic times, the program is markedly flawed. Many PMI don't even qualify for Medicaid to begin with. Honberg et al., (2011) note the Medicaid qualification threshold as well below the poverty level in many states. Many PMI make too much money to qualify for Medicaid, yet not enough to obtain private health care. Of those who do qualify for Medicaid, many are incapable of applying for the program, whether they are too ill or heavily abusing alcohol or drugs. Herein poses a significant problem for PCOD, as many programs limit participation based upon substance abuse. Therefore, PCOD may be denied enrollment in certain programs and require more involved and expensive treatment. “The diagnosis and therapeutic process for CODs tend to be more complicated and often involve different criteria, processes and treatment procedures than that for sole diagnosis” (Ding et al., 2011, p. 367). These specialized programs are more expensive and difficult to have covered by health care plans. Even for the smaller proportion of those who do qualify and are able to apply for treatment, Medicaid still does not pay for some of the most vital services such as inpatient psychiatric treatment (Honberg et al., 2011, p. 3). In summation, federal funding sources (namely the Medicaid program) have been inadequate prior to the 2009 economic downturn, and continue to be unable to mitigate the significant state budget deficits.

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<sup>5</sup>The State of Utah is an example of a statewide managed care system for the provision of mental health services. For additional information on how managed care systems are organized, see the Utah Medicaid Program's website at [http://health.utah.gov/medicaid/provhtml/managed\\_care.htm](http://health.utah.gov/medicaid/provhtml/managed_care.htm).

### **State Funding Challenges**

There is no one source that provides a collective assessment of state budgets, but Honberg et al. (2011) examined each state individually. Between 2009 and 2011, states cumulatively cut more than \$1.8 billion from their budgets for services for children and adults living with mental illness (Honberg et al., 2011, p. 3). Additionally, current statistics are derived from information obtained before the worst of the state budget deficits were calculated, meaning cuts through the year 2012 are projected to be even more substantial as than recent estimates (Honberg et al., 2011 p.8). For example, Levenson (2011) reported that in February 2011, the Governor of Massachusetts proposed a \$21.4 million cut in mental health service funding for the fiscal year 2012 that translates to the proposed elimination of 25% of the state's psychiatric hospital beds (Honberg et al., 2011). Simply put, states have to serve more PMI with significantly less money and the services are crippled as a result. As a response, states are cutting services and limiting access to (or altogether closing) community-based and hospital-based psychiatric care.

The reality of these fiscal shortfalls is that communities bear the overwhelming burden of providing vital mental health treatment to a larger number of PMI with fewer facilities, minimal personnel, and inadequate funding. The damage resulting from these cuts is two-fold. First, fiscal cuts to services may appear to save states and communities money, but cost more in the long-term because they simply shift financial burdens to other areas. Secondly, while the majority of PMI have no increased level of violence potential, a small subset of PMI may become a danger to themselves or others when mental illness goes untreated or is self-medicated through the use of drugs or alcohol (Honberg et al., 2011, p. 2).

With fewer accessible treatment options, PMI suffer consequences such as frequent visits to emergency rooms and hospitalizations, homelessness, premature deaths and suicides and involvement with the criminal justice system (Honberg et al., 2011). As a result, the public health (including hospital emergency rooms) and criminal justice systems are bearing excess financial and operational burdens. “Rather than saving states and communities money, these cuts to services simply shift financial responsibility to emergency rooms, community hospitals, law enforcement agencies, correctional facilities and homeless shelters” (Honberg et al., 2011, p. 1).

In lieu of other readily available treatment options, hospitals are increasingly being used to access mental health resources. Without day to day treatment programs, PMI are more likely to have psychiatric emergencies that require crisis and emergency department services. Appelbaum (2003) contends that a portion of PMI who are unable to obtain the timely outpatient care options are more likely to deteriorate to the point where urgent intervention is needed. Therefore, emergency rooms, specially designated Emergency Receiving Facilities<sup>6</sup> (ERF), are increasingly accommodating persons in need of psychiatric evaluations and services. Moreover, PCOD traditionally have more complicated and negative health problems that require more frequent (and longer) hospitalizations of an urgent nature, than compared to PMI with a single diagnosis (Ding et al., 2011). As a result, PMI (whether suffering from a COD or not) are increasingly in need of emergency services and medical attention.

Not all hospitals are staffed or equipped to handle PMI in a crisis state, so certain facilities are specially designated as ERF. While law enforcement agencies establish protocol to take PMI in crisis to an ERF, PMI and their families often try to use the closest emergency

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<sup>6</sup> The official code of Georgia, title 37, chapter 3, which outlines the Georgia Civil Commitment Statute regarding mental health examination and treatment, defines an Emergency Receiving Facility (ERF) as a facility designated to receive patients under emergency conditions. (O.C.G.A. § 37-3-1 et seq, 2010).

facility (regardless of its designation) when in need of services. As a result of the significant cuts to non-emergency mental health services, emergency rooms become backlogged with PMI who resort to accessing services through an ERF (or brought there by law enforcement) while staff struggle to find facilities able and willing to accept them (Appelbaum, 2003). In addition to the backlogs, hospitals bear the burden of emergency treatment for those without insurance. Judd (2010) found that in 2009, Georgia hospitals reportedly spent \$68.8 million treating uninsured psychiatric patients in emergency rooms, nearly doubling the amount spent on the same subset in 2006.

PMI admittance to hospitals (regardless of an ERF distinction) is significantly increasing and results in a backlog of PMI in need of critical services. From 2001 to 2002 in a Massachusetts hospital, the number of children needing emergency psychiatric services rose thirty (30) percent (Appelbaum, 2003, p. 113). More recently reports cite the number of juvenile PMI entering into public hospital emergency rooms (in lieu of other treatment options) in Rhode Island rose sixty-five (65) percent from 2008 to 2011 (Honberg, et al., 2011, p. 6). Judd (2010) reported that from January to April of 2010, approximately one in every five PMI committed to Georgia psychiatric facilities, waited more than 24 hours to be admitted. During that same time frame, “at least three PMI waited in an emergency room for six days and two more PMI waited in the ER for seven days” (Judd, 2010, ¶ 7). These statistics are staggering, especially when it is understood that those waiting in the emergency room for hours or even days are people suffering from mental disorders that are indeed treatable.

### **PMI and the Criminal Justice System**

The increasing prevalence of PMI in the general population, coupled with shrinking mental health resources has a direct impact on families, communities and societal structures:

namely the criminal justice system. The lack of coordination and continuity of mental health care related to today's criminal justice system has resulted in significant disparities within offender populations, legal action, and a crushing burden placed upon jails, prisons, and the mental health community as a whole, (Steadman, Morris & Dennis, 1995). Police, courts and prisons are shouldering an unequal burden of the costs associated with mental illness as PMI are increasingly coming into contact with the justice system. The significant presence of PMI throughout the criminal justice system is viewed as a daunting problem by mental health and criminal justice professionals alike and statistics emphasize the need for reform.

### ***Prevalence and Consequence of PMI in Offender Populations***

Correctional institutions across the nation were never designated as facilities for the treatment of PMI, yet the provision of mental health services is now a primary responsibility of many prisons today (Human Rights Watch, 2009). It is estimated that 804,000 people with severe mental disorders are admitted into jails annually, (McNiel & Binder, 2007; National GAINS Center, 2002). Steadman, Osher, Robbins, Case, and Samuels (2009) found that 14.5% of male and 31% of female U.S. jail inmates had a serious mental illness. These statistics are even higher in prison populations, as Petersilia (2003) estimates one in every six inmates has a mental illness. In addition to those incarcerated, Lamb and Weinberger (1998) assess that PMI comprise anywhere from 7% to 18% of all arrested, jailed, in-prison or under-correctional supervision populations in the American system. Furthermore, as of 2003, the Human Rights Watch (2003) estimated the population of California state prisoners with a mental illness at 23,429, officially making the California Department of Corrections the largest provider of mental health services in the country.

Research also highlights a disparity that exists between the number of mental health resources that are needed in jails and prisons and those actually being offered. One in every eight state prisoners received mental health services in 2000 (Beck & Maruschak, 2001). However research finds that a significantly higher proportion of inmates are actually in need of such services because one in every six inmates is estimated to have a mental illness (Petersilia, 2003). Most correctional institutions do provide psychiatric medications such as antidepressants, stimulants, sedatives and tranquilizers for those with diagnosed disorders. More than 10% of all inmates were estimated to be receiving psychotropic medications in order to manage a mental illness in 2000 (Beck & Maruschak, 2001). Psychiatric medications are expensive for states and municipalities to provide, underlining the need for diversionary efforts to reduce unnecessary PMI incarceration. Additionally, while psychiatric medications are vital to many mental health treatment programs, they are only one component of an effective recovery. The vast majority of PMI benefit from a combination of therapies and medications rather than a single component (NAMI, 2011). Since PMI are better served outside the criminal justice system, recent efforts have been made to understand and address offender population disparities.

Existing (albeit limited) research acknowledges statistical disparities of PMI in the criminal justice system and attributes such disparities to a confluence of mental health policy changes that the justice system was ill-prepared to address. Scholars attribute the increasing rate of interaction between PMI and the criminal justice system to historical mental health policies (namely deinstitutionalization) and the theoretical framework known as the “criminalization hypothesis” (Morabito, 2007; Teplin, 1984). Law enforcement was unprepared and inadequately trained to handle the community influx of PMI following deinstitutionalization (Anderson & Lynch, 1984). Systemic changes overwhelmed community-based mental health treatment

resources and resulted in a higher percentage of PMI (representing various degrees of treatment compliance) living amongst the general and criminal populations.

The historical confluence of mental health policy changes and legal developments led to an increased frequency of PMI involvement in criminal offender populations and therefore higher probabilities of contact with law enforcement (Teplin, 1984). PMI come to the attention of police in a variety of ways, including engagement in criminal behavior and exhibiting behavior that may simply attract the attention of police (without being dangerous or actively criminal). Police-initiated contact (such as traffic stops), enforcement of court orders, provision of transport for emergency hospitalizations and responding to calls for service involving a criminal offense are all ways in which PMI are interacting with police (Finn & Stalans, 2002). Without effective treatment, PMI may exhibit behaviors that elicit police response. The courts and corrections systems were also unprepared to deal with such an influx of PMI and have been frocked with systemic problems managing PMI subsequent to an initial arrest. The various problems associated with law enforcement and the courts cause many to contend that a significant number of PMI are incarcerated as the result of a broken justice system that lacks a proper response to a population in need (Wells & Schafer, 2006). In recognition of this, the diversion of offender PMI populations has become a goal of the criminal justice system.

A variety of intervention programs have been developed that utilize law enforcement, the courts and correctional facilities to address offenders with mental illness. These collaborative efforts are known as diversion programs. Variations of diversion programs are outlined below in order to establish the larger context in which police are expected to specialize their response to PMI. While this work will explore police-based intervention programming in depth further on in



this chapter, the basic differences between other intervention strategies and their respective research gaps will be addressed first.

### ***Criminal Justice System Responses***

In order to improve the justice system's fragmented response to PMI, we have seen the development of specialized policing efforts (to be discussed at length later), mental health courts and correctional classification and treatment initiatives known as diversion programs. Diversion programs generally fall into one of two basic categories: post-booking and pre-booking programs. The basic difference between the program types is whether the initiative is aimed at those already in the formal criminal justice system (post-booking) or works to divert PMI from being arrested to begin with (pre-booking). Post-booking programs aim to, "identify and divert offenders after they have been booked, while they are either in jail or in arraignment court," (Cowell, Bronert & Dupont, 2004, p. 294). Evaluations of such programs have already begun, as researchers are anxious to know if and how diversion initiatives ebb the flow of PMI into the criminal justice system. However, it is also important to examine the fundamental, subject-level attitudes and decisions involving such initiatives in order to explore an aspect of implementation that may influence program effectiveness. This research works to examine some of the influences that shape officer attitudes and therefore contribute to the collective understanding of what diversion initiatives are most effective and why.

#### **Jail-based Diversion Initiatives**

Jail-based diversion programs, also referred to as reentry programs, are aimed at successfully transitioning once-incarcerated persons back into the community with a lowered risk of recidivism. Based on the belief that effective mental health treatment will lessen the likelihood of PMI criminal offending; these specialized diversion programs aim to enhance

access to treatment while incarcerated and once released. Primarily, these programs use probation and parole officers as active participants helping (or even mandating) PMI (access to and continued participation in) community-based treatment (Lamberti, Weisman & Faden, 2004; Wilson & Draine, 2006).

Previous studies have used two primary criteria to qualify initiatives as diversion programs: whether the program is aimed at diagnosing PMI and whether the program starts providing mental health services during incarceration and continues subsequent to a PMI's release (Wilson & Draine, 2006). In a 2006 study, fifty (50) such jail and prison based reentry programs were identified and analyzed in hopes of developing a typology for corrections-based reentry programs. Through this analysis, Wilson and Draine (2006) noted that a fundamental, defining characteristic of the programs was whether they were directed by the criminal justice or mental health system. Most programs are predominantly led by one system or the other, with insufficient collaboration between the two. The majority of existing programs (37 of the 50 programs studied) were led by the criminal justice system rather than the mental health system and many of the programs had very limited mental health collaboration components (Wilson & Draine, 2006).

While these findings suggest that the justice system has taken increased initiative to address the needs of incarcerated PMI, they also underline the failure of the criminal justice and mental health systems to fully share the associated challenges of mental health treatment. "Providing mental health services is not the main function of the criminal justice system; yet it is clear that this system is assuming more responsibility for the treatment of people with mental illness within their system" (Wilson & Draine, 2006, p.877). Jail-based diversion programs (although distinct in certain programmatic elements) are largely criminal-justice led, criminal-

justice funded and limited to addressing PMI already at the last stage of the criminal justice process.

### **Mental Health Courts**

A relatively recent and promising specialized strategy aimed at reducing the number of criminalized PMI is the development of Mental Health Court (MHC) initiatives. Established as an alternative to the traditional criminal adjudication process, MHC aim to increase adherence to mental health treatment, decrease criminal recidivism and achieve therapeutic goals that vary by jurisdiction, (McNiel & Binder, 2007). The Bureau of Justice Assistance (BJA) describes mental health courts as specialized dockets which employ a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses” (p.VII). MHC provide the opportunity for offending PMI to work with a court team composed of a judge, court personnel and treatment providers who supervise and sanction one’s adherence to a pre-defined treatment plan in order to avoid incarceration (Lamb & Weinberger, 2008). Existing (but limited) research is promising, suggesting that MHC systems can significantly reduce recidivism and provide a more therapeutic alternative to incarceration (Christy, Poythress, Boothroy, Petrila, & Mehra, 2007; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2005; Trupin and Richards, 2003).

### **Police-based Diversion Initiatives**

In addition to these post-booking initiatives working to address PMI already present in the criminal justice system, pre-booking programs are increasingly being used to ebb the flow of PMI into the system. Pre-booking programs are generally characterized by the specialized training initiatives provided to law enforcement aimed at avoiding arrest and introducing PMI to

treatment. The Bureau of Justice report (2008) defines specialize law enforcement based response programs as those that meet three criteria:

“Programs which enhance traditional law enforcement roles in order to provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illness...programs that when appropriate, establish a link for these individuals to services in the community and programs that are based in law enforcement agencies with strong collaborative ties to mental health partners, other criminal justice agencies, and community members,” (BJA report, 2008; p. 1).

Dean, Steadman, Borum, Vesey & Morrissey (1998) identified three general models of programs that mental health and law enforcement initiatives generally reflect and these models are acknowledged and described by Hails & Borum (2003). *Police-based specialized response units* involve sworn officers who receive specialized training on mental illness and substance addiction in order to serve as the primary first-line responders to calls for service involving the mentally ill (Dean et al, 1998). These police-based specialized response units are comprised of specially-trained officers who also serve as liaisons between the law enforcement and mental health communities. The Memphis Crisis Intervention Team (CIT) program is an example of a police-based specialized response unit model. A second model uses mental health professionals (not sworn officers) to work for law enforcement agencies and consult with officers responding to mental health calls. This model, referred to as *police-based specialized health responses*, provides patrol officers with on-site or telephone consultation for handling calls with the PMIs (Hails & Borum, 2003). A third (and more traditional) model establishes cooperative agreements between police and “mobile mental health crisis teams” and operates independently of the local law enforcement agency (Dean et al, 1998). Research has yet to establish a consensus on the

extent these three models have been implemented or perceived as successful by officers or communities (Sellers, Sullivan, Veysey & Shane, 2005; Dean et al, 1998).

The most common pre-booking programs are variations of the Crisis Intervention Team (CIT) initiative that seeks to provide advanced training to law enforcement for assisting persons with mental illness during emergency and routine calls for police service (Dean et al, 1998). Police-based diversion programs such as CIT are popular because police are seen as the gatekeepers to the justice system, (Menziez, 1987). Therefore, law enforcement is often asked, or even expected, to be involved in programs and response alternatives aimed at reducing the presence of PMI throughout the criminal justice system. While these programs are becoming more prevalent (as this literature review will discuss further on) there is still much to learn about police-based diversion initiatives and how they function.

The majority of attention and research regarding these programs is based on evaluating their effectiveness and analyzing dispositions of PMI and police interactions for success stories. Research has yet to establish a basic understanding of how programmatic components relate to one another. Studies analyzing incident dispositions and macro-level “success” provide critical knowledge about what works and what does not. This knowledge can in turn be provided to agencies for allocating resources and implementing initiatives successfully. However, it is also important to examine the current condition of mental health resources and the attitudes police have regarding such services. Examining the basic programmatic components helps to identify why initiatives are effective and provides a more comprehensive understanding of mental health and criminal justice dynamics. This work specifically underlines the need to elucidate the attitudes police officers have towards these programs they are facilitating. To better understand

how police are positioned to respond to PMI and participate in such initiatives, a general framework of policing practices, organizations and interactions with PMI is provided below.

### **Policing PMI**

As first-line responders, police officers face a broad range of calls for service involving citizens in the community and provide a wide array of public safety duties (Arcaya, 1989). An increasing number of these calls for service involve PMI. Dean, Steadman, Borum, Veysey & Morrissey (1999) found calls involving PMI consume a disproportionate amount of patrol time, making up at least 7% of all police calls for service. Additionally, there are many reasons police may interact with PMI aside from direct calls for service. Finn and Stalans (2002) refer to police-initiated contact (such as traffic stops), enforcement of court orders, provision of transport for emergency hospitalizations and responding after the commission of a crime as examples of interactions with PMI that are not initiated by behaviors associated with mental illness.

As previously outlined in this work, the criminal justice system has largely assumed the burden and cost of mental health care for a significant subset of PMI who are increasingly coming into contact with police (Steadman, Morris & Dennis, 1995). The dynamic of increased populations, strained services and the fact that the police are readily available to handle various social ills and public safety tasks results in law enforcement being the primary response to situations involving PMI (Wells & Schafer, 2006). Traditionally, police did not assume specialized approaches to these interactions, a reality that is often attributed to the existing disparities of offender populations and referred to as the criminalization of PMI (Morabito, 2007). A number of studies have examined the traditional police response to PMI.

### ***Traditional Police Response to PMI***

To begin, the majority of officers agree that interactions with PMI represent a significant portion of police response efforts, including habitual calls for service from some individuals (Wells & Schafer, 2006). In addition to perceiving PMI as a drain on time and resources, police have also developed a sense of anxiety and stigma with regard to such calls for service. While the majority of police interactions with PMI are based on relatively non-violent means such as minor crimes or general order maintenance calls, studies have found that police are concerned with regard to their personal safety on calls involving PMI (Wells & Schafer, 2006). These officer safety concerns are attributed to police officer's perceptions of a person's disturbed behavior, how dangerous they appear to be and a general negative stigma about mental illness (Link, Cullen, Frank & Wozniak, 1987).

Arcaya (1989) recognized a tendency of police to develop anxiety related to the chance of becoming victims of irrational violence and associates this fear with lower levels of officer self-efficacy in calls for service with PMI. Often times, these calls appear to be routine and are classified as domestic disputes or disturbances. However, once an officer arrives on scene and begins to interact with a subject, it may become apparent that he or she has a mental illness. Officers who are not familiar with mental illness or who are unprepared to interact with those in crises can feel inadequately equipped or supported to deal with the crises involving PMI (Hails & Borum, 2003). In addition to these feelings of inadequacy and lack of support, calls for service involving PMI are generally more time consuming than other calls, resulting in officer frustrations with attempts to access professional assistance (Hails & Borum, 2003).

Therefore, a set of practices (both informal and formal) for handling potentially (or perceived) dangerous situations or subjects are developed as a result of officer anxieties,

perceptions and frustrations. These practices are generally developed as a response adaptation to the increasing number of emergency calls involving PMI and the limited range of disposition options police have at hand (Wells & Schafer, 2006). Police discretion plays an important role in managing crisis or arrest situations, as officers generally determine a course of action from one of several options including settling the interaction informally, arresting the PMI or initiating access to a hospital or mental health facility (Freeman & Roesch, 1989; Green, 1997; Kalinich & Senese, 1987; Sellers, Sullivan, Veysey & Shane, 2005).

However, many mental health emergency systems create significant barriers to care by leaving police responsible for the custody and behavior of PMI, establishing unrealistic admission criteria and failing to successfully organize the delivery of care (Dupont & Cochran, 2000). Officers who bring PMI to a hospital (in an effort to avoid arrest) are often turned away by staff if the PMI is intoxicated, impaired, or suffering from any number of other medical conditions, resulting in police having to shop around for an entry point into the mental health system (Dupont & Cochran, 2000). The relationship between police and hospital staff may also influence access to treatment, especially if staff are resistant or unwelcome to law enforcement.

Research has recognized hospital staff and clinicians' perceptions that police exercise excessive influence on admission decisions and bring in criminals that staff do not want to deal with. Watson, Segal & Newhill (1993) documented and tested these assertions, eventually concluding that police do not exercise undue influence on dispositions nor where the subjects they brought in anymore "criminal" than others. However, just because research has shown a perception to be unfounded, does not mean that beliefs and behaviors automatically change. Police may still be treated in unwelcome or even hostile manners by hospital staff in some facilities, which could influence their attitudes about the hospital or their decision to use the



facility in the future. Additionally, hospitals often require police to maintain custody of a PMI (even if no arrest was made) throughout the course of a hospital check-in or stay. Dupont and Cochran (2000) point out that hospitals do not enforce this practice for nearly any other medical condition, and the practice of making police responsible for PMI brought into hospitals is “perhaps the single most critical factor in maintaining the tendency to criminalize mental illness” (p. 343). If police know they will be responsible for PMI throughout the process, they are more likely to choose a different disposition option, such as arrest and transport to the local jail.

Without convenient or accessible non-jail placement options of mental health facilities, officers must choose to arrest or find an informal way of reaching an incident conclusion. Wells & Schafer (2006) detail some of these informal dispositions, including police releasing PMI to families and friends, providing PMI with mental health referral information or even ignoring situations involving PMI. A more disturbing trend is police initiated transport of PMI to another jurisdiction so troublesome persons become another agency or community’s responsibility (Wells & Schafer, 2006). Informal practices are abandoned by officers when not feasible and arrest is often used as an alternative. Dupont & Cochran (2000) argue that arrest is often seen by law enforcement as the most convenient, efficient, and practical option for police, even though it may not best serve the needs of PMI. In many environments, such as rural and small-town communities, arrest may be the only option in lieu of any mental health treatment centers (Kane & Ennis, 1996). The confluence of limited arrest alternatives and increasing emergency calls for service involving PMI highlighted the need for diversion efforts involving police, especially as the law enforcement community faced growing criticism for their handling of some incidents.

The way in which police handle an incident involving a disturbed person (specifically their use of force) can bring criticism upon officers and departments and many communities have

had highly publicized incidents in which excessive or deadly force was used on a PMI in crisis (Hails & Borum, 2008). One of these incidents, the 1988 Memphis Police Department case in which officers shot and killed an individual with a history of mental illness and substance abuse who was wielding a knife, was the launch for the original CIT model (Dupont & Cochran, 2000). Such events sparked public interest in the amount of discretion police have when interacting with citizens and communities began calling for change. The traditional police response to PMI was seen as failing to address a special-needs population (Wells & Schafer, 2006). The dramatic and publicized nature of these events brought harsh criticism upon the law enforcement community and has resulted in some agencies being publicly criticized or even sued for failing to provide adequate training for officers (Hill & Logan, 2001). Furthermore, agencies are judged on their ability to develop and operate programs to address the needs of the public and ensure appropriate responses to calls for service (Hails & Borum, 2008).

### ***Crisis Intervention Team (CIT) Initiatives***

Therefore it became crucial for officers to have the knowledge and special skills for properly addressing the needs of an emergent population (Bahora et al., 2008). In response, police-based diversion programs were developed in an effort to equip police officers with knowledge and training on mental illness and arrest alternatives. As previously discussed throughout this work, the Crisis Intervention Team (CIT) program was one such pre-booking diversion strategy aimed to provide a more specialized response to the increasing interaction of police and PMI. The original Memphis model of the Crisis Intervention Team (CIT) was developed in 1988 by the Memphis Police Department in partnership with the Memphis chapter of the National Alliance on Mental Illness (NAMI), the University of Memphis, and the University of Tennessee to enhance collaborations between law enforcement and mental health

systems (Steadman, et al., 2000). A primary goal of CIT is to enhance the rate at which police facilitate PMI referral to mental health treatment (Steadman et al., 2000). CIT aims to increase PMI access to treatment by educating officers' about mental disorders, teaching and practicing de-escalation skills and familiarizing officers with mental health resources in their communities. However, an officer's on-scene decision is ultimately contingent upon an officer's familiarity with non-jail options and the availability of mental health treatment resources (Bittner, 1967; Green, 1997; Henriques, 2002; Morabito, 2007; Patch & Arrigo, 1999; Ritter et al., 2001; Teplin & Pruett, 1992). Community-based mental health treatment resources may influence the disposition an officer chooses when encountering a PMI. However, mental health services (especially those offering long-term care) are limited and some communities do not have an emergency psychiatric service resource (Lurigio, 2011). Therefore, officer behavior may vary based upon the community resources. It is unclear how CIT training influences police discretion. This work will contribute to the literature on this topic by assessing the basic attitudes police have regarding their emergency psychiatric hospitals, known as ERFs.

Presently, various forms of the CIT program are being implemented on state and local levels to provide advanced training to law enforcement in order to offer more appropriate and proper care to PMI and substance addicts requiring emergency attention by public safety professionals (Bahora, et al., 2007). Training is being implemented regardless of the mental health resources in the area, based on the notion that CIT training is better than no training at all. The State of Georgia has fashioned a form of CIT, adapted from the original Memphis model, which is currently available to public safety agencies statewide. The Crisis Intervention Team of Georgia's website identifies themselves as a, "collaboration of professionals committed to assisting persons with mental illnesses and other brain disorders," specific to their interactions

with the police, probation, and emergency response agencies, (<http://www.ganet.org/gbi/CIT/index.html>). The program offers a 40-hour certification course including factual information on various mental illnesses and instructional practice of verbal de-escalation techniques. The Georgia CIT program has progressed well, working towards their goal of training 20% of Georgia's law enforcement officers (Oliva & Compton, 2008). To date, more than 3620 Georgia law enforcement officials from more than 145 agencies have been trained in CIT (P. Strode, personal communication, September 9, 2010).

However, these strategies have been developed and continue to be implemented without first establishing a basic understanding of programmatic components, such as how those working in each program view the initiative. It is important to examine how police officers judge assess interactions with PMI and how on-scene assessments are related to the disposition an officer eventually chooses (Ritter, Teller, Marcussen, Munetz, & Teasdale, 2011). Specifically, this work examines how CIT has been widely implemented without first examining what attitudes police officers (the primary facilitators of CIT) have regarding the hospitals and resources CIT stresses. Police are increasingly expected to play a central role in diverting PMI from the justice system; yet police-initiated intervention programs are being implemented without knowing enough about the dynamic context of these interactions, including how police officers view the intervention.

Research related to the collection of CIT models, including Georgia's program, is in short supply, with most of the few studies focused on assessing whether CIT reduces the rates of PMI arrest. Only a small handful of studies address specific programmatic elements that contribute to the understanding of how police behavior is influenced and the role mental health facilities assume in CIT implementation. Research has examined how CIT training influences the

confidence and knowledge police officers have when handling calls involving PMI. Studies generally use the terms *self-efficacy* and *desired social distance* when describing measures of police anxieties and confidence levels when interacting with PMI. Self efficacy “provides an approach to predicting behavior change by assessing an individual’s belief in his or her ability to successfully perform a specific task in a specific setting,” (Bahora, et al., 2007). Throughout the present literature, self-efficacy is a measure of how confident police are in successfully handling calls for service with PMI (Bandura, 1982; Bandura, 1986; Bahora, et al., 2007). Desired social distance is another commonly used measure of negative stigma, defined as the degree of understanding and intimacy that characterize social relations (Park, 1924).

Bahora, et al. (2007) used a measure of social distance to estimate police officers’ comfort level, or how close a person is willing to be to someone with a mental illness. This measure of social distance has been used extensively throughout studies of mental illness and specialized programs such as CIT (Compton, Esterberg, McGee, Kotwicki & Oliva, 2006; Bahora, et al., 2008), hypothesizing that CIT programs are successful if officers report higher levels of self efficacy and lower levels of desired social distance in interactions with PMI. Research found that CIT training significantly improved officers’ self-efficacy with regard to calls for service involving PMI or substance abusers and significantly lowered officers’ desired social distance regarding PMI (Bahora, et al., 2008). These attitudinal changes are used to support the argument that CIT training would improve police interactions with PMI, and enhance the safety of subjects and officers yet further research is needed to test these presumptions (Bahora, et al., 2008). A more recent assessment of CIT success by Compton et al. (2006) surveyed officers of CIT programs within Georgia to look at changes in knowledge, attitudes, and stigma related to schizophrenia and other mental illness as well as substance abuse. CIT

training was found to improve officers' knowledge regarding mental illness, attitudes regarding the perceived aggressiveness of PMI and levels of support for local treatment programs (Compton et al. 2006).

In another evaluation of the effectiveness of specialized PMI response models (including CIT), Borum, et al. (1998) surveyed officers from three different police departments, each representing a unique specialized response to PMI. These three models were termed "police-based specialized police response," "police-based specialized mental health response," and "mental-health-based specialized mental health response," and were defined based upon the personnel who develop the initial program partnerships and who do the actual first-line intervention responding (Borum, et al., 1998 p. 395). The study qualitatively appraised the three respective models used by the three urban departments in Birmingham, Alabama, Memphis and Knoxville, Tennessee and included a survey of police officer perceptions with regard to their mental health facilities and the effectiveness of their respective departments' response models.

In an effort to broaden the Borum, et al., (1998) study, Sellers, et al. (2005) collected the same survey data on officer perceptions from the Newark Police Department, an agency that has no specialized response to situations involving PMI. In lieu of a specialized response team, police in Newark "simply work effectively and directly with local emergency response personnel and hospitals" and have a lower estimated arrest rate than many departments with specialized approaches to offending PMI (Sellers et. al, 2005, p. 656). Officers from all four departments<sup>7</sup> differed slightly with regard to their personal confidence in handling such calls, with police in Knoxville having the highest personal preparedness levels followed closely by Memphis and Newark, while officers in Birmingham having the lowest levels. Overall, police officers in

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<sup>7</sup> Participant data from Newark was reviewed in conjunction with data from the Borum et al. (1998) study to allow for analysis of all four departments in the Sellers, et al. (2005) study.

Memphis (where the CIT model is used) reported the most positive assessments of their departments' response to PMI, suggesting that CIT models enhance police officer preparedness and keeping the PMI population out of jail (Sellers et al., 2005).

However, of the other three departments, Newark Police (where no specialized response model is used) had comparable rates of perceived departmental effectiveness in meeting the needs of PMI, and the third highest perception of keeping PMI out of jail. Overall, Newark officers were in the middle or lower end of responses, leading to the conclusion that a traditional response to PMI can be effective when police have good relationships with their local mental health resources. These findings are important for two primary reasons, the first being that of specialized responses to PMI, CIT models yielded more positive police perceptions of effectiveness and mental health resource helpfulness. Presumably, more positive perceptions are indicative of more effective programs. Secondly, the relatively comparable findings of Newark's traditional response model suggest that the relationship between police and hospitals may be more significant than other factors associated with specialized models. While relationships between police and hospitals may be enhanced by specialized initiatives, Sellers et al. (2005) research suggests that such relationships are not necessarily dependent on CIT to be effective. Lastly, these two studies provided some of the only existing knowledge regarding officer perceptions of hospital and mental health system helpfulness that this study seeks to expound upon (discussed further on in this chapter).

A handful of studies specifically evaluate CIT programs, but few address programmatic elements. Teller, Munetz, Gil, & Ritter (2006) examined the effectiveness of CIT by examining incident dispositions between CIT and non-CIT officers within the Akron, Ohio Police Department, finding that CIT officers were more likely than non-CIT officers to transport PMI to

treatment in lieu of incarceration. Elaborating on this research, Ritter et al. (2011) examined the relationship between how a call for service involving a subject believed to be a PMI is dispatched (defined and assigned to a patrol officer) and the disposition the assigned CIT officer pursues. In other words, Ritter et al. (2011) examined the relationship between what a CIT officer is told to expect about a call for service (from a call-taker, referred to as “dispatch”), their assessment once on-the-scene of the call, and the ultimate disposition they choose. How a call for service was dispatched (i.e. suspected mental illness, suspicious person, or general calls for assistance) and the CIT officer’s on-scene assessment are related to the ultimate decision of whether to facilitate access to treatment (Ritter et al., 2011). Additionally, CIT officers’ were able to identify PMI regardless of how the initial call was dispatched; meaning CIT officers relied on their own assessment rather than the initial call-taker. Furthermore, a CIT officers’ assessment of an individual influenced their disposition decision, suggesting officers who are trained to understand mental illness will be more likely to consider assisting a PMI access treatment over other disposition options like arrest (Ritter et al., 2011). While these findings would support the continued expansion of CIT training, it is also important to assess the current treatment resources available to police.

When reviewing evaluations of CIT, it is also important to note how contextual variables and agency priorities may have significant influence on the implementation or applicability of such programs. Current research that establishes CIT programs as successful is limited to larger, more urban law enforcement agencies and communities (Compton, et al., 2006; Steadman, et al., 2000). These research studies have predominately overlooked rural, small-town agencies and the unique contextual variables associated with them. However, these studies are often cited as support for the implementation of CIT across all agencies (Oliva & Compton, 2008; Steadman,



et al., 2000). It is flawed to assume that acceptance and adherence of CIT training principles in one context or setting would similarly apply across all settings.

Furthermore, the Georgia CIT program utilizes local mental health community partners as instructors and intake specialists; presenting trainees with viable community partners to use in lieu of arresting PMI (<http://www.ganet.org/gbi/CIT/index.html>). This means that current CIT initiatives in Georgia rely heavily on mental health service providers in the community; services that many rural, small-town communities may not have. While CIT training continues to spread throughout Georgia, individual localities needed to work towards ensuring adequate services (e.g., emergency receiving facilities) and the partnerships (e.g., no-refusal policies) necessary for successful diversions (Oliva & Compton, 2008). The status of available mental health care in rural and small-town areas of the country (and Georgia) is currently unknown and included in the proposed future research section of this literature review. For further information on mental health services in the rural south, see Kane & Ennis (1996).<sup>8</sup>

This work highlights existing knowledge gaps, as studies have prematurely evaluated CIT success before clarifying how components of CIT influence one another. Specifically, research has yet to comprehensively elucidate the basic attitudes police have with regard to mental health facilities in their jurisdictions. Since behavior is influenced by attitude, it is important to first assess the attitudes police have about the emergency rooms and mental health facilities available to them. A handful of studies have examined CIT from an officer-level perspective, with some even exploring the basic knowledge police have with regard to mental illness. While these

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<sup>8</sup> Kane and Ennis (1996) studied mental health services present in the rural areas of the American South and addressed the service issues associated with PMIs living in rural communities. Their work recognized proposed initiatives at the time in order to weigh the strengths and weaknesses of such programs aimed at serving rural areas (Kane and Ennis, 1996).

findings are important, they fail to fully assess the attitudes and outlook police have about the mental health system, therefore making premature assumptions and generalizations.

### ***Current Knowledge Regarding Police Officer Perceptions***

It is important to outline what research has found with regard to contemporary police officer perceptions and attitudes. Wells & Schafer (2006) explored police officer's perspectives of their interactions with PMI and evaluated police training programs aimed at enhancing an officer's ability to handle crisis situations or mental health issues using a unique and detailed point of view that accounted for police officers perspectives on incidents involving PMI. The CIT model enhances the ability of police to identify PMI and determine an appropriate response based upon the context of the incident, improves officers' awareness of local treatment services and increases officers' confidence in handling calls involving PMI and their families (Wells & Schafer, 2006). While existing research touts CIT models as 'promising', studies have yet to elucidate how police receive and enact CIT principles in their daily work. Previous studies have not analyzed how components of CIT influence one-on-one interactions therefore this work will take a step towards understanding how police perceive their local hospitals and mental health systems. Of the several studies that used a police point of view in order to understand and evaluate the unique perspective with which law enforcement handles situations involving PMI, only two studies have provided an initial assessment of how police officers perceive their local mental health entities.

The Borum, et al. (1998) survey of officers from three different departmental specialized response models was the first to examine police officer perceptions of their hospital and mental health system "helpfulness." As previously mentioned, this study was followed up by Sellers, et al. (2005) to include a fourth department that did not have a specialized response protocol for

PMI. In addition to being asked about their specific interactions with cases involving the mentally ill and their perceived effectiveness of their department's program model. Participating officers from all four departments were surveyed about their perceptions regarding their local mental health provider's system. About half of the officers from all three departments described interactions with PMI as either a "moderate" or "big" problem for their respective agency and more than half of all the respondents reported feeling "well prepared" for responding to PMI (Borum, et al., 1998 p. 398). The study also evaluated the perceived helpfulness of emergency rooms and the mental health system for situations in which police are interacting with PMI. Of the three departments, officers from Knoxville reported the most negative perceptions, with only 15% viewing their mental health system as "moderately" or "very" helpful. Knoxville officers had a significantly more positive perception of emergency rooms, with 38% reporting ERs as "moderately" or "very helpful," but the majority of officers still perceived their mental health entities as less than moderately helpful (85% for the mental health system and 62% for ERs).

Participants from the Memphis Police Department, which uses CIT (also from which Georgia's program was adapted), had higher reported rates of mental health entity helpfulness than the other two departments. Memphis officers who were not CIT trained had more positive perceptions of facility helpfulness than other departmental models in Birmingham and Knoxville. Memphis officers with CIT training certifications had the highest reported perceptions, with 69% reporting both emergency rooms and the mental health system as "moderately" or "very helpful" suggesting that CIT-trained officers perceived emergency rooms to be more helpful than police in the other jurisdictions as well as non-trained officers from their same jurisdiction (Borum, et al., 1998 p. 399). While these two studies provided the only evaluation of officer perceptions of

hospitals and mental health systems to date, there is a definite need for a more thorough and modern assessment of police attitudes.

This work will expound upon Borum et al. (1998) and Sellers et al. (2005) by examining a variety of police officer attitudes and perceptions of different mental health treatment resources. Previous research was limited to studying the perceptions of police operating in major urban areas. Mental health receiving facilities vary by setting in terms of their services, emergency intake protocols and responsiveness to law-enforcement mental health referrals and an officer's perception of such services may vary as well. Hospitals and mental health facilities are central to the success of CIT initiatives because they are posited as alternatives to arrest and beneficial to PMI in crisis. The experience an officer has with such facilities likely influences their perception of the hospital and the mental health system as a whole.

It is important to elucidate police perceptions of mental health facilities because previous studies have found police may use their discretion to divert PMI from hospitals if they feel prior referrals to a facility were mishandled (Sellers, et al., 2005; Finn & Sullivan, 1989; Green, 1997). Additionally, Bittner (1967) found police officers generally try to find practical solutions to calls for service that balance their time away from other patrol duties and chronic calls for the same situation, meaning an officer's perception about the expediency and helpfulness of hospitals would be influential in their decisions involving PMI. Knowing that police discretion may be influenced by the perceived efficiency of mental health facilities underlines the need to thoroughly assess the attitudes police have regarding hospitals.

While previous research has shown CIT training efforts to be effective in educating officers about mental illness and therefore improved their ability to identify behaviors related to certain disorders, police officer attitudes and performance have also been noted as resistant to

change (Hails & Borum, 2008). Thus, research publicizing the promise and success of training programs like CIT may not be sufficient to adequately effect change in how police interact with PMI. Draine, Wilson and Pogorzelski (2007) noted that the popularity of CIT is centered on training and education as a means for changing police behavior, without any direct focus on changing the availability of treatment access and links to emergency mental health providers. If practitioners are solely focused on changing police behavior and evaluating the success of CIT models without changing the availability or quality of treatment, diversion initiatives are likely to fail because the mental health system will be unable to meet the needs of PMI and the police who facilitate access to treatment. In an effort to evaluate how these facilities are perceived, this comparative analysis will examine the attitudes police have with regard to their hospitals and mental health systems. This work will help improve our understanding of the current context in which police officers make decisions and provide a basic foundation for future research on police interactions with the mental health system.

## CHAPTER III

### METHODS

Research has found that CIT improves the knowledge and attitudes police have specific to mental disorders and reduces police officer stigma regarding PMI (Bahora, et al., 2007; Bahora, et al., 2008; Compton, Esterberg, McGee, Kotwicki & Oliva, 2006). However, research has not yet assessed basic components that likely influence effective implementation of the program, such as police attitudes regarding mental health treatment facilities. While many factors impact the decisions and behavior of police, research has yet to fully explore the intricacies and weight of these influences. Furthermore, mental health treatment resources, such as Emergency Receiving Facilities (ERF) and non-emergency treatment centers, vary significantly in terms of services, emergency intake protocols, and responsiveness to law enforcement. Presumably, officers could have a variety of attitudes regarding the different mental health facilities (namely ERF) that are available in their respective district.

While CIT improves some aspects of police attitudes, the program's success ultimately depends on the actual officer-level decisions of seeking alternatives to arrest, when appropriate. If these attitudes officers have towards hospitals and services are indeed a significant inhibitor to diversion, then training initiatives like CIT are not accomplishing their goals. Precious time, money and manpower resources may be misappropriated and PMI would be missing out on needed treatment. Yet little is known about officer attitudes and behavior in general (for exceptions, see Borum, et al., 1998 and Sellers, et al., 2005). Training, especially CIT, is being implemented throughout the country with little attention being paid to how police actually perceive their districts' mental health services.

Therefore, the purpose of this work is to explore the attitudes and perceptions police have regarding the hospitals and mental health systems available to them. Presumably, the attitudes an officer has regarding the available mental health system will influence their decision to use it as an alternative to arrest. Specifically, this research will establish a basic understanding of how positively or negatively police officers regard the hospitals and facilities they are told to bring PMI to and reveal what role CIT plays in shaping these attitudes.

### **Data**

The data were originally collected in 2010 by a research team at Emory University during a two-year National Institute of Health (NIH) funded study entitled, “Two Models of the Effects of Crisis Intervention Team (CIT) Training.” Led by Principal Investigator Michael Compton, MD, MPH, a total of 586 Georgia police officers were surveyed to assess their intentions regarding facilitating mental health referrals and utilization of CIT skills. The multi-phase study examined how police behavior (specifically facilitating mental health referrals for PMI) is influenced by a variety of factors. Participants in the study were from six (6) police departments in Georgia: Atlanta Police Department, Clayton County Police Department, Cherokee County Sheriff’s Office, Henry County Police Department, Rome Police Department and Savannah-Chatham Police Department. These departments have representatives on the CIT community advisory board and were able to help facilitate respondent recruitment within each department. Researchers sent emails to more than 800 CIT and non-CIT officers from the participating departments requesting participation in the original study.

Using psychometrically-sound instruments (tested in Phase One) data were collected with cross-sectional in-depth surveys (Phase Two) and a six-week longitudinal monitoring design (Phase Three). Phase Two survey data were collected from April through October 2010. The

cross-sectional in-depth surveys were self-administered in a group setting with approximately 20 to 30 officers, in a classroom setting. Basic demographic data were collected from each participating officer. Officers were also surveyed about the negative attitudes and misconceptions police have regarding mental illness (stigma), their attitudes towards police-referrals to mental health treatment, general knowledge about mental illness and their subjective norms (or perceived norms). Surveys measured officer's self-efficacy (a measure of self-confidence with their work) and desired social distance, using a variety of sound, previously-tested measures (Bahora, et al., 2007). As discussed previously, desired social distance is simply a measure of one's comfort level when interacting with a person or group, in this case, PMI. Lastly, officers were surveyed about their opinions about mental illness, their perceptions of their community's attitudes towards PMI and police officer perceptions of psychiatric treatments.

### **Sample**

For the purpose of this thesis, survey questions (collected during Phase Two) from the majority of the original survey participants analyze the differences in police perceptions of their respective local hospitals and mental health systems. Twenty-four respondents (all from the Atlanta Police Department) were excluded from this analysis because the series of twelve questions (from which this work's dependent variable was developed) were not included in their original surveys. Of those twenty-four officers, nineteen (19) officers were CIT-trained while the other five (5) were not CIT-trained. The number of police officers from each jurisdiction included in this analysis is: Atlanta Police Department (n=109), Henry County Police Department (n=97), Cherokee County Sheriff's Office (n=98), Rome Police Department (n=68), Clayton County Police Department (n=101) and Savannah-Chatham Police Department (n=89). Thus, a total of 562 officers are included from Phase Two of the original study. This research



uses a portion of the survey data collected during Phase Two to analyze the differences in police perceptions of their respective local hospitals and mental health systems. Respondents were asked about the hospitals and mental health systems in their jurisdiction but did not have to specify to which facility they were referring to. However, each department primarily uses one local ERF when transporting PMI, therefore it can be deduced that officers were referring to the following Georgia hospitals: Grady Memorial in Atlanta, Floyd Medical Center in Rome, Henry Medical Center in Stockbridge, Memorial University Medical Center in Savannah, Northside Hospital – Cherokee in Canton, and Southern Regional Health System in Riverdale. Open source material and officer accounts suggest that these six facilities vary from one another. While all six are publicly-accessible hospitals, they represent varying degrees of ER intake procedures and therefore varying degrees of law enforcement involvement in referrals.

This research will focus on a series of questions regarding officer's opinion of their hospital/mental health agency's responsiveness, efficiency, resistance to PMI intake, timeliness, and effectiveness. Additionally, respondents were asked to rate their levels of comfort and attitudes related to using non-law enforcement mental health resources. Some respondents have been trained in CIT, while others have not; further isolating factors that influence officer-decision to arrest or refer PMI to treatment.

**Table 1.1 Sample by Department and CIT Training Status (N=562)**

<b>Department</b>	<b>CIT</b>	<b>Non-CIT</b>	<b>Total</b>
Atlanta Police Department	43	66	<b>109</b>
Henry County Police Department	36	61	<b>97</b>
Cherokee County Sheriff's Office	34	64	<b>98</b>
Clayton County Police Department	48	53	<b>101</b>
Rome Police Department	33	35	<b>68</b>
Savannah-Chatham Police Department	39	50	<b>89</b>
<b>Total</b>	<b>233</b>	<b>329</b>	<b>562</b>

### Measures

#### *Dependent variable*

**Police attitudes.** Two sets of survey questions, one based on a five-point Likert scale and a second based on a four-point Likert scale, measure the attitudes police have with regard to their jurisdictions' hospital and mental health system. The dependent variable measures developed from these questions are examined at a .05 alpha level. For the purposes of this study, these twelve questions are coded in two ways for two different analyses. A description of these measures for the first part of the analysis is included below.

The first set of five questions (with answers ranging from 1=always to 5=never) asked respondents to give their opinion of their jurisdictions' hospital/mental health agency for the times when they transported a PMI to a hospital for psychiatric evaluation and treatment. This set of questions is unique because officers were asked to rate hospitals based upon their experience when transporting a PMI. These five questions are: (1) *The hospital/mental health agencies were responsive to my requests to deal with the person,* (2) *The hospital's/mental health agency's responses were efficient,* (3) *The hospital/mental health agencies were resistant to dealing with the person,* (4) *The hospital's/mental health agency's responses took longer than it should have,*

and (5) *The hospital's/mental health agency's responses were effective*. Questions one, two and five were reverse-scored so that higher scores reflect more positive responses. In this way, the lowest possible sum of responses, or "score" would be a five (having selected a one on the five point Likert scale for each of the five questions). Conversely, the highest possible score of twenty-five (reflecting the most positive attitude) would result from an officer selecting a five on the Likert scale for each question. Each respondent's scores for the first set of five questions were summed and divided by twenty-five (the number of possible points) in essence, producing a "grade" that is used to analyze the attitudes officers have with regard to their hospital or mental health agency. For the purposes of this work, the term Emergency Receiving Facility (ERF) will be used to refer the hospital or mental health agency because police officers in these six departments primarily use one designated ERF for transporting PMI. As such, a new variable, referred to as *Attitude toward Emergency Receiving Facility*, was created that represents the average score for these five responses.

In a second set of related questions, officers are asked to rank how true they found seven (7) statements about the mental health system (MHS) or mental health resources in their respective community to be. Unlike the first set of five (5) questions, these statements do not ask respondents to recall times when actually transporting a PMI. Therefore, these responses are not limited to actual experiences. Respondents could rate their opinion from one to four, with one being "not at all true" to four being "very much true". These questions included: (1) *The MHS in my district efficiently processes police referrals*, (2) *The MHS in my district appropriately processes police referrals*, (3) *The MHS in my district provides effective solutions for managing mental health calls*, (4) *The MHS in my district is cooperative with law enforcement*, (5) *The MHS in my district is willing accept violent persons*, (6) *I feel comfortable accessing MH*

*resources to resolve mental health/disturbance calls, and (7) The MHS in my district has adequate resources to respond to individuals that do not meet emergency criteria but need mental health services.* Just as in the first set of five questions, higher scores for these responses reflect more positive attitudes. For instance, if an officer indicated that the statement “the MHS in my district is cooperative with law enforcement” to be “very much true”, this question will be scored with a four (to reflect a more positive response). Since these seven questions feature a four-point Likert scale, the lowest possible sum of responses, or “score” would be a seven (having selected a one on the four-point Likert scale for each of the seven questions). Conversely, the highest possible score of twenty-eight (reflecting the most positive attitude) would result from an officer selecting a four on the Likert scale for each question. Each respondent’s scores for the second set of seven questions was summed and divided by twenty-eight (the number of possible points) in essence, producing a “grade” that is used to analyze the attitudes officers regarding to their local mental health system. These seven items were scaled for each respondent by summing each individual response and dividing by the seven questions in the set, thus yielding a new variable, referred to as *Attitude toward Mental Health System*. This is the second dependent variable measure tested across departments and training variables.

Since these two measures are scaled (using the survey questions), a Cronbach’s alpha statistic was used to check the reliability the dependent measures. The Cronbach’s alpha statistic measures the internal consistency of a measure or how correlated a set of items in a group are. The value of the Cronbach’s alpha statistic increases when items in a test or survey are correlated to one other (Tavakol & Dennick, 2011). *Attitude toward Emergency Receiving Facility* (Cronbach’s alpha .791) and *Attitude toward Mental Health System* (Cronbach’s alpha .840) were deemed consistent as scaled variables.

This study's dependent variable of "officer attitudes" consists of two measures: *Attitude toward Emergency Receiving Facility* (developed from the set of five questions) and *Attitude toward Mental Health System* (developed from the set of seven questions). This study examines if and how officer attitudes vary by departmental jurisdiction, CIT training, or other factors, described at length below. Of the total 562 officers included in this study, some did not answer more than one of the twelve questions from which the dependent variable is constructed. Therefore, nine officers who didn't answer two or more of the twelve questions were excluded from this part of the analysis.

### ***Independent Variables***

#### **Demographics characteristics.**

Basic demographic data including age, gender, race, marital status, education level, and collective household income were collected. Descriptive statistics for the sample's demographic data can be found in Table 1. Respondents' ages ranged from 22 to 72, with an average age of 37. The sample is predominately male (81%) which is consistent with the most recent national average of 88.2 % for police officers in the U.S. (Federal Bureau of Investigation, 2010). Sixty-two percent of the sample were white, 34% were African-American and less than 5% were of other races such as Asian or Hispanic. Therefore, race was recoded as a dichotomous variable (1=white). Similarly, marital status was also recoded into a dichotomous variable. Divorced, widowed, single and separated responses were collapsed into a "not married" category (=0) and the category married/living with a committed partner remained the comparison (=1). This re-code provides a more effective measure of having a committed, domestic partner, a factor that may influence respondent behavior. Sixty-five percent of the sample were married or living with a committed partner.

Education level was originally measured with six possible responses to officer's highest level of education completed: having completed high school/GED, attending some college but not obtaining any degree, obtaining an Associate degree, obtaining a Bachelor degree, obtaining a Master degree, or Other. Every officer in the sample had a high school degree or the GED equivalent. Forty-one percent of the sample had attended some college yet had not obtained a degree. Of those who obtained a degree, approximately 10% had an Associate degree and 25% had a Bachelor degree. Only 6% of the sample had a Master degree and less than 2% of the respondents fell in the other category. Therefore, education level was re-coded into a dichotomous variable where no college degree(=0), and obtaining a college degree or more(=1). A review of the eight "other" responses showed that two respondents had PhDs, four respondents' listed technical or trade schools, one listed military experience and one listed a truck driving school. Therefore, the two respondents with PhD's who originally responded as "other" were re-categorized as having obtained a degree (=1), two respondents who listed technical college training were counted as attending some college (=0) and the other four respondents were re-coded as having no degree but completing high school (=0). Thirty-five percent of the sample had obtained an Associates or Bachelor degree and 6% had obtained more advanced college degrees.

Lastly, respondents reported their household's income for the previous year. Categories for annual household income were: less than \$30,000, \$30,001- \$40,000, \$40,001-\$50,000, \$50,001-\$60,000, \$60,001-\$70,000 or greater than \$70,000. The original income data were categorical, therefore this work cannot determine where respondents fell within each \$10,000 range. For instance, 140 of the respondents originally categorized themselves in the \$40,001-\$50,000 range which includes the national average. This work is unable to determine what

portion of those 140 officers fell closer to the top of the range. Only 14% of the sample reported an annual household income of less than \$40,000 while approximately 21% earned between \$40,001 and \$50,000. Thirty-eight percent of the sample (the largest categorical percentage) reported earning more than \$70,000 annually. Therefore, for the purposes of this work, the categories were dichotomized, with below \$60,001(=0) and more than \$60,001(=1). In comparison to the national average of \$49,445 (DeNavas-Walt, Proctor, & Smith, 2011), 65% of the sample had an annual household income that was higher than the U.S. Census Bureau's estimates for the average household income in 2010.

**Personal Exposure to Mental Illness.** In order to account for the exposure police officers may have to PMI personally, in addition to occupational exposure, respondents were asked a series of four questions. The questions were: *(1) Have any of your family members ever received or are they currently receiving treatment for a mental health problem (such as therapy, counseling, or medicine for mental or emotional problems)? (2) Have you known someone within your circle of friends who has been or is currently receiving treatment for a mental health problem (such as therapy, counseling, or medicine for mental or emotional problems)? (3) Have you ever received or are you currently receiving treatment for a mental health problem (such as therapy, counseling, or medicine for mental or emotional problems)? (4) Have you or any members of your family or any of your friends been active as either a professional or volunteer helper in the field of counseling, therapy, psychiatry, psychology, or social work?* Respondent answers were coded as no=0 and yes=1 for all four of these questions. Thirty-six percent of the sample reported having a family member receive past or current mental health treatment and 42% of the officers knew a friend who had received or was receiving treatment. Only 14% of the sample

reported having personally received mental health treatment. Lastly, 32% of the sample reported themselves or family members as having worked or volunteered within fields related to the mental health system.

**Law Enforcement Experience.** To measure the experience each officer has within law enforcement, researchers measured how long each had been a police officer (years on force) and their current rank. The original survey asked officers to write-in their rank, which resulted in dozens of slightly varied responses. For this study, each response was reviewed and categorized into a dichotomous variable: supervisory staff=0 and patrol officer=1. In this way, rank measures whether each respondent is primarily a patrol officer without supervisory duties or part of each agency's command staff. Sixty-eight percent of the sample consisted of patrol officers. Respondents averaged 10 years of police experience, ranging from 9 months to 44 years.

The distinction between patrol and supervisory staff may be significant and is an important element to examine. While supervisory officers may initially be thought to have less interaction with PMI on calls for service (presuming they have additional roles or duties that take them away from patrol initiatives) they may influence patrol officer decisions in a noteworthy way. Supervisors, especially those directly supervising patrol officers (i.e. Sergeants, Corporals) are often called to the scene of incidents that patrol officers deem to be more sensitive, serious in nature, or non-routine. Furthermore, officers with less experience are more likely to call their supervisors to a scene for which they are uncomfortable handling. Therefore, supervisors may in fact handle more calls for service involving PMI. Additionally, supervisors are responsible for enforcing departmental protocols and command staff expectations. Should an agency, especially one active in CIT initiatives, decide to promote facilitation to treatment in lieu of arrest (when



appropriate), supervisors are expected to carry out departmental “top-down” orders. In other words, while patrol officers have a significant amount of discretion, they do answer to a supervisory staff, which may influence their attitudes and decisions. The majority of respondents in this study are patrol officers rather than supervisors. Approximately 70% of the CIT officers and 68% of the non-CIT officers in this study serve a patrol function. This work examines the role rank plays with regard to shaping attitudes about hospitals and the mental health system.

**Training.** While this study focuses on Crisis Intervention Team (CIT) training, other types of training officers received that involved special populations or policing techniques were measured. Presumably, other types of training can influence officers in different ways and could possibly be related to the attitudes they have about mental health facilities. In order to control for these various influences, officers were asked a variety of questions related to their training histories. First, respondents were asked if they were certified CIT officers (having completed the 40-hour POST-certified course). Forty-one percent of the sample was CIT trained. Officers who were CIT trained were also asked whether their participation in CIT was voluntary (self-selected) or the result of being assigned or told to attend by their agency. Sixty-seven percent of the CIT officers reported that they voluntarily took the training rather than being told to enroll. CIT officers also reported when they had completed their CIT training (measured in months since CIT training). CIT officers reported an average of 27.6 months since the completion of their CIT training. However, responses ranged from completing CIT 22 years prior to participating in the study to completing CIT in 2010, the same year as participating in the study. It was noted that a single officer reported completing CIT 22 years ago, which would be the same year CIT was started in Memphis. For the purposes of this study, that single case will be excluded from the

analysis since it presents such an outlier. Of the 233 CIT-trained officers in the sample, 42 reporting having completed their CIT training in 2010, the same year as the study. Therefore, I reviewed these 42 responses, and determined the number of months between their completion of CIT and their participation in the survey. Eighteen respondents completed CIT the month prior to participating in the survey and an additional 15 respondents completed CIT two months prior to participating in the survey. For those officers who are not CIT trained, respondents were asked about their exposure to fellow-CIT officers (within the past two years) by hours per week. Respondents that are not CIT trained could rank their exposure to CIT officers as: none, less than 4 hours per week, 4 to 20 hours per week, and more than 20 hours per week (on average). Thirty-seven percent of non-CIT officers had no exposure to CIT officers, 28% averaged 4 hours per week and 35% had more than 4 hours per week.

All the responding officers were also asked, "*Aside from CIT training, over the past two years have you had any training related to mental illnesses?*" Thirty-two percent of the total sample reported receiving training related to mental illness (other than CIT) within the last two years. This question is especially important for the 329 officers who were not CIT trained because one of this study's primary research questions is whether mental illness training results in significantly different attitudes regarding the mental health system. To test this question accurately, this work could not simply measure attitudes between CIT officers and non-CIT officers because some non-CIT officers reported receiving alternative training on mental illness. Therefore, this variable was recoded to reflect three training measures: those trained in CIT(=1), those not trained in CIT or mental illness(=2), and those not trained in CIT who received mental illness training within the last two years(=3). It should be noted that this question was open to respondent interpretation and officers who indicated that they had received "other mental illness

training” were asked to describe such training. Written responses for this question varied widely and were reviewed for the purposes of this work. Many of the respondents listed annual in-service trainings, their original police academy instruction, or routine roll-call training but there are no proper ways to categorize these.

### **Plan of Analysis**

The goal of this study was to assess police attitudes with regard to their local hospitals and mental health system and whether CIT training is significantly correlated with such attitudes. It was expected that such attitudes would vary between departments (because each use different ERFs) and vary between officers trained in CIT and not trained in CIT, whether within the same department or across all departments. Therefore, police from all six departments were compared across and within agencies, controlling for CIT and related training. Since there are six departments being examined in light of three conditions, (CIT-trained and non-CIT trained with or without other mental illness training) and some variables were limited to specific groups of respondents, multiple ordinary least squares (OLS) regressions were used to test for possible correlations. This regression assumes the normal distribution of each variable, which were first examined using histogram plots. In addition to multiple OLS regressions, multiple independent t-tests were run to examine differences in officer attitudes within departments.

To begin, this study examines how CIT and non-CIT officers vary from one another based on the independent variables such as officer demographics, law enforcement experience and exposure or familiarity with the mental health system. Bivariate analysis of the categorical variables is examined using chi square tests. Some continuous variables, such as age and length of time being a police officer, were examined using t-tests. This first step of the analysis explores

if and how CIT officers vary from one another before being their measures of attitudes are examined. The next step of this research consists of the multiple OLS regressions.

A series of three OLS regressions were run for both of the two dependent variable measures (*Attitude toward Emergency Receiving Facility* and *Attitude toward Mental Health System*) for a total of six OLS regressions. Multiple regressions were needed because some independent variables are not measures of the whole sample. In the original survey, most questions were answered by all respondents however, a handful of questions were addressed specifically to either CIT-trained officers or non-CIT-trained officers. For instance, only officers who indicated they were trained in CIT were asked whether they volunteered for the training, or how long it had been since they completed the course. Therefore, regressions were divided to account for variables which all respondents answered, variables only answered by CIT officers, and variables only answered by non-CIT officers. Therefore some independent variables apply to selected groups of respondents while other variables were answered by all the officers. To address this, three OLS regressions (one for variables which account for all the officers, another including variables which only address CIT-trained officers, and a third to include a single variable which only describes non-CIT-trained officers) were run for each of the two dependent variable measures.

As a result, a total of six OLS regressions were run to determine whether correlations between the independent variables and the two measures of officer attitudes exist. These OLS regressions were important in order to control for the many other variables that could be associated with more positive or negative attitudes police have regarding hospitals and mental health facilities.

While the first phase of the analysis examined how police attitudes vary across the whole sample, (between the six departments and between training experiences) the second part of the analysis examined how police attitudes vary within each of the six departments. In order to properly examine the variables on the smaller, intra-departmental level, independent t-tests were conducted to examine differences in officer attitudes that may exist within each of the six departments. Additionally, since each of the twelve questions refers to a specific aspect of the mental health system; each question was also examined individually. This comparison will provide insight on whether the means for individual questions vary significantly by department or CIT-training-status.

For this second phase of the analysis, the scores for each response were again averaged for the set of five questions asking respondents to rate their jurisdictions' ERF (for the times when they transported a PMI to a hospital for psychiatric evaluation and treatment) on a scale of one to five and the seven questions asking officers to rank how true they found statements about the MHS on a scale of one to four. This analysis examined the degree to which CIT training is associated with officer attitudes within each of the six departments. A series of independent sample t-tests compared the mean scores of the two groups (CIT-trained and non-CIT-trained) for *Attitude toward Emergency Receiving Facility* and *Attitude toward Mental Health System* within each of the six departments.

**Table 1.2 Descriptive Statistics for Attitude toward Emergency Receiving Facility and Attitude toward Mental Health System (Dependent Variables)**

Questions	Mean	Range	s.d
<b>ERF Questions -- (rated on 1-5 point scale of "always"-"never")</b> Questions one, two and five were reverse scored so that higher scores reflect more positive responses. "For the times when you transported a PMI to a hospital for psychiatric evaluation and treatment, please give your opinion to the following five items"			
1.) The hospital/mental health agencies were responsive to my requests to deal with the person,	3.93	1-5	0.87
2.) The hospital's/mental health agency's responses were efficient,	3.52	1-5	0.89
3.) The hospital/mental health agencies were resistant to dealing with the person,	3.82	1-5	0.88
4.) The hospital's/mental health agency's responses took longer than it should have,	3.11	1-5	1.06
5.) The hospital's/mental health agency's responses were effective.	3.40	1-5	0.84
The scores for this set of questions were summed and divided by the total number of possible points for this set of five questions (25 possible) yielding a scaled "grade" used as the dependent variable, <i>Attitude toward ERF.</i> <i>Attitude toward Emergency Receiving Facility</i>	0.71	0.32-1.0	0.13
<b>MHS Questions -- (rated on 1-4 point scale of "not true at all" – "very much true")</b> "Please indicate how true each statement is to you"			
1.) The MHS in my district efficiently processes police referrals,	2.76	1-4	0.76
2.) The MHS in my district appropriately processes police referrals,	2.83	1-4	0.70
3.) The MHS in my district provides effective solutions for managing mental health calls,	2.56	1-4	0.82
4.) The MHS in my district is cooperative with law enforcement,	3.11	1-4	0.75
5.) The MHS in my district is willing accept violent persons,	2.61	1-4	0.94
6.) I feel comfortable accessing MH resources to resolve mental health/disturbance calls,	2.90	1-4	0.87
7.) The MHS in my district has adequate resources to respond to individuals that do not meet emergency criteria but need mental health services.	2.56	1-4	0.88
The scores for this set of questions were summed and divided by the total number of possible points for this set of seven questions (28 possible) yielding a scaled "grade" used as the dependent variable, <i>Attitude toward MHS.</i> <i>Attitude toward Mental Health System</i>	0.69	0.25-1.0	0.15

**Table 1.3 Descriptive Variables of Law Enforcement Officers (both CIT and non-CIT trained) (n=562)**

<b>Variable Description</b>	<b>Proportion or Mean</b>	<b>Range</b>	<b>s.d.</b>
<b>Demographics</b>			
Age	37.06	22-72	8.7
Gender (1=male)	0.82	0-1	0.39
Race (1=white)	0.62	0-1	0.48
Marital Status (1=married)	0.65	0-1	0.47
Education Level (1=college degree)	0.41	0-1	0.49
Annual Household Income (1=\$60,001 or more)	0.53	0-1	0.50
<b>Personal Exposure to MI</b>			
Past/Present Family Treatment (1=yes)	0.36	0-1	0.48
Past/Present Self Treatment (1=yes)	0.14	0-1	0.34
Past/Present Friends Treatment (1=yes)	0.42	0-1	0.49
Past/Present Involvement in MHS (1=yes)	0.32	0-1	0.47
<b>Law Enforcement Experience</b>			
Years on Force	10.05	0-44	7.8
Rank (1=patrol officer)	0.68	0-1	0.46
<b>Training Related to CIT</b>			
CIT Training (1=yes)	0.41	0-1	0.49
Volunteered for CIT? (1=yes)	0.67	0-1	0.47
Months since CIT Training	28.7	0-264	26.7
Exposure to CIT Peers (if not already CIT, n=329)	--	0-3	1.1
None (=0)	0.37		
Up to 4 hrs/week (=1)	0.28		
4-20 hrs/week (=2)	0.19		
20+ hrs/week (=3)	0.16		
Received other Mental Illness Training? (1=yes)	0.32	0-1	.46

**Table 1.4 Descriptive Statistics of Law Enforcement Officers by Department (both CIT and non-CIT trained) (N=562)**

Variable Description	Atlanta PD n=109	Clayton Co. PD n=101	Cherokee Co. SO n=98	Henry Co. PD n=97	Rome PD n=68	Savannah-Chatham PD n=89
<b>Demographics</b>	Proportion or Mean	Proportion or Mean	Proportion or Mean	Proportion or Mean	Proportion or Mean	Proportion or Mean
Age	36.4	36.9	36.8	36.8	41.3	35.1
Gender (1=male)	.78	.87	.6	.85	.79	.72
Race (1=white)	.24	.57	.87	.82	.80	.49
Marital Status (1=married)	.58	.61	.71	.71	.78	.54
Education Level (1=college degree)	.54	.37	.32	.32	.38	.51
Annual Household Income (1=\$60,001 or more)	.55	.60	.58	.52	.46	.42
<b>Personal Exposure to MI (1=yes)</b>						
Past/Present Family Treatment	.30	.34	.41	.33	.40	.39
Past/Present Self Treatment	.11	.16	.11	.11	.10	.21
Past/Present Friends Treatment	.38	.40	.42	.38	.49	.52
Past/Present Involvement in MHS	.37	.38	.24	.24	.29	.38
<b>Law Enforcement Experience</b>						
Years on Force	9.9	9.6	10	9.7	13.7	8.4
Rank (1=patrol officer)	.86	.63	.56	.64	.62	.74
<b>Training</b>						
<i>CIT Training Variables</i>						
CIT Training (1=yes)	.39	.48	.35	.37	.49	.44
Volunteered for CIT? (1=yes)	.88	.54	1.0	.36	.33	.90
Months since CIT Training	27	22.5	37	26.5	29.5	32.6
Exposure to CIT Peers (if not already CIT)	n=66	n=53	n=64	n=57	n=37	n=52
None = 0	.53	.25	.25	.46	.30	.42
Up to 4 hrs/week = 1	.15	.36	.30	.27	.32	.31
4-20 hrs/week =2	.17	.21	.23	.16	.19	.14
20+ hrs/week = 3	.15	.19	.22	.11	.19	.14
Other MI Training? (1=yes)	.14	.38	.47	.34	.35	.24



## CHAPTER IV

### RESULTS

As previously outlined, the goal of this study was to assess the attitudes police officers have with regard to their local hospitals (ERFs) and mental health systems. Specifically, this study sought to determine whether these attitudes vary significantly by department (since each have different hospitals in their jurisdiction) or vary significantly (across and within departments) based upon mental illness training officers have received, specifically Crisis Intervention Team (CIT) training. It was hypothesized that attitudes would vary between departments, since the six departments included in the study used ERFs that have varied emergency room protocols regarding PMI. It was also hypothesized that attitudes would differ based upon mental illness training. Specifically, this work hypothesized that officers who were trained in CIT would have more positive attitudes of their ERF and the mental health system than those without CIT training (regardless of having received other mental illness training) within departments and across the entire sample. Previous research has found CIT models yield more positive police perceptions of mental health resources as compared to other specialized police-based diversion models (Sellers et al., 2005). This work expounds upon this research by examining the difference in attitudes between officers who have been trained in CIT or not.

To begin, this study examined how CIT and non-CIT officers varied from one another based on the independent variables including demographics, law enforcement experience and exposure or familiarity with the mental health system. Categorical variables were examined using chi square tests, while continuous variables were examined using t-tests. CIT and non-CIT officers varied significantly in the degree of exposure they reported having to mental illness. Using the chi-square test of correlations, two variables (*Past/Present Personal MH Treatment*

and *Past/Present MH Treatment of a Family Member*) were significant at the .05 level, one variable was significant at the .01 level (*Gender*) and one variable was significant at the .001 level (*Past/Present MH Treatment of a Friend*). The results of the bivariate analysis are presented in Table 1.4.

**Table 1.5 Bivariate relationships between CIT or Non-CIT trained officers by independent variables**

Variable Description	CIT trained		Non-CIT trained		Chi square or <i>t</i>
	% or Mean	n	% or Mean	n	
<b>Demographics</b>					
Age	37.49	231	36.71	329	$t = -1.05$
Gender (1=male)	38.1%	174	61.9%	283	$\chi^2 = 10.94^{**}$
Race (1=white)	42%	142	58%	202	$\chi^2 = 0.15$
Marital Status (1=married)	41.8%	152	58.2%	212	$\chi^2 = 0.07$
Education Level (1=college degree)	43.8%	102	56.2%	131	$\chi^2 = 0.88$
Annual Household Income (1=\$60,001 or more)	41.5%	151	58.5%	213	$\chi^2 = 0.00$
<b>Personal Exposure to MI</b>					
Past/Present Family Treatment (1=yes)	49.3%	99	50.7%	102	$\chi^2 = 8.06^*$
Past/Present Self Treatment (1=yes)	52.6%	40	47.4%	36	$\chi^2 = 4.61^*$
Past/Present Friends Treatment (1=yes)	50.6%	120	49.4%	117	$\chi^2 = 14.57^{***}$
Past/Present Involvement in MHS (1=yes)	46.1%	83	53.9%	97	$\chi^2 = 2.47$
<b>Law Enforcement Experience</b>					
Years on Force	7.36	232	8.00	322	$t = -0.21$
Rank (1=patrol officer)	42.7%	161	57.3%	216	$\chi^2 = 0.69$

\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

With regard to the first hypothesis that officer attitudes about local mental health facilities vary by department, there were two measures of police attitudes examined. The measures are: attitudes about the local ERF of officers who have transported a PMI, and attitudes about the local mental health system (MHS). These two dependent measures were compared using multiple bivariate analyses of the six police departments. Comparing all possible combinations of these groups and conditions would result in dozens of ratio, or t-tests.

Conducting so many individual comparisons also increases the odds of enacting a type one error in which the null hypothesis is falsely rejected. In order to avoid this, multivariate regressions were run for both dependent variable measures. In the original survey, most questions were answered by all respondents. However, a handful of questions were addressed specifically to either CIT-trained officers or non-CIT-trained officers, therefore some independent variables apply to selected groups of respondents. To address this, three OLS regressions (one for variables which account for all the officers, another including variables which only address CIT-trained officers, and a third variable which includes variables which only describe non-CIT-trained officers) were run for each of the two dependent variable measures. Therefore, a total of six OLS regressions were run to examine the first two research hypotheses.

To begin, three OLS regressions were run to test for correlations between the independent variables and one of the two dependent measures, *Attitude toward Emergency Receiving Facility*. Again, this variable is comprised of the mean score of the five questions asking respondents to give their opinion of their jurisdictions' ERF for the times when they transported a PMI to a hospital for psychiatric evaluation and treatment. The first OLS regression examined the correlation between those independent variables which all respondents answered and the dependent measure, *Attitude toward Emergency Receiving Facility*. The independent variables included in this regression were: age, gender, race, marital status, education level, annual income, having family members with past or present mental illness, having friends with past or present mental illness, having personal past or present experience with mental illness, having past or present involvement with the mental health system, number of years employed as a police officer (time on force), rank, name of their current police department, status of CIT-training status, and receipt of other mental illness training within the past two years (aside from CIT).

From this regression, four variables were significantly correlated with *Attitude toward Emergency Receiving Facility* at the .05 alpha level. A respondent's age ( $p < 0.05$ ,  $t = 3.19$ ), race ( $p < 0.05$ ,  $t = -2.57$ ), friendships with persons who have been treated for mental health problems ( $p < 0.05$ ,  $t = 2.27$ ) and rank ( $p < 0.05$ ,  $t = 2.02$ ) are significantly correlated with the attitudes officers had regarding the hospital or mental health agency they used when transporting PMI for a psychiatric evaluation or treatment. This suggests that attitudes towards ERFs are higher for older officers, non-white officers, and patrol (non-supervisory) officers. Concordantly, police who reported having friends previously or currently seeking mental health treatment were associated with lower attitudes. The results of this regression are included in Table 1.6.

To continue examining officer's *Attitude toward Emergency Receiving Facility*, another regression was run using the independent variables listed above in the first regression and those independent variables which applied only to CIT-officers: whether CIT officers volunteered for the training or were told to attend (self-selection), and the span of time between completing CIT training and participating in the study (months since CIT). From this regression, two variables were significantly correlated with *Attitude toward Emergency Receiving Facility* at the .05 alpha level. Just as in the previous regression, a respondent's race ( $p < 0.05$ ,  $t = -2.31$ ) was significantly correlated with the attitudes officers had regarding ERFs. Whereas age, rank and having friends who have received mental health treatment were found to be significant in the first regression; these variables were no longer significant amongst CIT officers when CIT-specific training variables were accounted for. Officers who volunteered for CIT, referred to as self-selected, were also significantly correlated ( $p < 0.05$ ,  $t = 2.16$ ) with their attitudes towards hospitals at the .05 level. This suggests that officers who self-selected for CIT training had higher attitudes towards

ERFs than those who did not volunteer for CIT training. The results of this regression are included in Table 1.7.

The results of the two regressions in Table 1.6 and 1.7 suggest that while CIT training overall is not a significant predictor of attitudes towards ERFs, whether or not an officer self-selects for the training is significant. In order to complete examining officer's *Attitude toward Emergency Receiving Facility*, a third regression was run using the single independent variable which applied only to non-CIT-trained officers: exposure to CIT officers. This single variable (applying to non-CIT officers) was not significantly correlated with *Attitude toward Emergency Receiving Facility* at the .05 alpha level (not pictured).

**Table 1.6 OLS regression predicting officer *Attitude toward Emergency Receiving Facility* by Independent Variables Attributed to All Respondents**

	<b>Attitude toward Emergency Receiving Facility</b>			
	<b>B</b>	<b>S. E.</b>	<b>t</b>	<b>Sig.</b>
<b>(Constant)</b>	.641	.038	16.7	0.00
<b>Age</b>	.003	.001	3.19	0.00*
<b>Gender (1=male)</b>	.025	.016	1.59	0.11
<b>Race (1=white)</b>	-.036	.014	-2.57	0.01*
<b>Marital Status (1=married)</b>	.003	.014	0.21	0.83
<b>Education Level (1=college degree)</b>	-.021	.012	-1.77	0.08
<b>Annual Household Income (1=\$60,001 or more)</b>	-.010	.013	-0.77	0.45
<b>Personal Exposure to MI (1=yes)</b>	--	--	--	--
<b>Past/Present Family Member Treatment</b>	.021	.014	1.52	0.13
<b>Past/Present Self Treatment</b>	-.022	.018	-1.22	0.22
<b>Past/Present Friends Treatment</b>	-.029	.013	-2.27	0.02*
<b>Past/Present Involvement in MHS</b>	-.020	.013	-1.56	0.12
<b>Years on Force</b>	-.002	.001	-1.68	0.09
<b>Rank as Officer or Command (1=patrol)</b>	.029	.014	2.02	0.04*
<b>Henry County PD</b>	-.029	.021	-1.40	0.16
<b>Cherokee County SO</b>	-.035	.022	-1.60	0.11
<b>Rome PD</b>	-.010	.023	-0.45	0.66
<b>Clayton County PD</b>	-.014	.020	-0.73	0.47
<b>Savannah-Chatham PD</b>	-.012	.020	-0.61	0.55
<b>CIT Training (1=yes)</b>	-.001	.012	-0.06	0.95
<b>Other Recent MI Training? (1=yes)</b>	.011	.013	0.82	0.41

$R^2 = 0.10$ , ( $n=553$ ,  $p < .05$ )

**Table 1.7 OLS regression predicting officer *Attitude toward Emergency Receiving Facility* by Independent Variables Attributed only to CIT-trained Officers**

	<b>Attitudes Towards Emergency Receiving Facility</b>			
	<b>B</b>	<b>S. E.</b>	<b>t</b>	<b>Sig.</b>
<b>(Constant)</b>	.627	.056	11.153	0.00
<b>Race (1=white)</b>	-0.04	0.01	-2.57	0.01*
<b>Self-selected for CIT –Training? (1=yes)</b>	0.05	0.02	2.16	0.03*
<b>Months since Completion of CIT (1=yes)</b>	-4.04	0.00	-0.94	0.93

$R^2 = 0.13$ , ( $n=229$ ,  $p < .05$ )

Note: While the above regression (Table 1.7) included all the same variables as shown in Table 1.6, only those variables with significant findings were re-featured.

In addition to examining officer attitudes about their districts' hospital based upon past experience transporting PMI, a second dependent variable measure was created using an average score of the of the 7 survey questions regarding the mental health system. As previously detailed, these statements asked officers to rank how true they found seven (7) statements about the mental health system (MHS) or mental health resources in their respective community to be. All seven questions were reverse scored in order to have higher scores reflect more positive attitudes and averaged by dividing the sum of responses by the total possible score of twenty-eight. This yielded a new variable, referred to as *Attitude toward Mental Health System*.

In order to examine if and how these same three categories of independent variables are correlated with the second dependent variable measure of officer attitudes, *Attitude toward Mental Health System* three additional OLS regressions were conducted. Just as before, one OLS regression examined the correlation between those independent variables which all respondents answered and the officers' *Attitude toward the Mental Health System*. The independent variables, attributed to all respondents, that were included in this regression were: age, gender, race, marital status, education level, annual income, having family members or friends with past or present mental illness, having personal past or present experience with mental illness, having past or present involvement with the mental health system, number of years employed as a police officer (time on force), rank, name of their current police department, status of CIT-training status, and receipt of other mental illness training within the past two years (aside from CIT). From this regression, three variables were significantly correlated with *Attitude toward MHS* at the .05 alpha level. A respondent's gender ( $p < 0.05$ ,  $t = 2.26$ ), race ( $p < 0.05$ ,  $t = -2.05$ ), and rank ( $p < 0.05$ ,  $t = 2.72$ ) were significantly correlated with the attitudes officers had regarding the mental health system in their district. This suggests that male officers, non-white

officers and patrol officers have higher or more positive attitudes towards their local mental health system. Results of this regression are presented in Table 1.8.

Another OLS regression was run in order to examine if officer attitudes towards their district's MHS was correlated with the two independent variables applying only to CIT-officers: self-selection and months since CIT. This regression included the independent variables listed above (those applying to all respondents) and those independent variables which applied only to CIT-officers. From this regression, five variables were significantly correlated with *Attitude toward Mental Health System* at the .05 alpha level. Gender ( $p < 0.05$ ,  $t = 2.24$ ) and rank ( $p < 0.05$ ,  $t = 2.42$ ) remained significant in this regression. Self-selection (whether officers volunteered for CIT) was also significantly correlated ( $p < 0.05$ ,  $t = 2.55$ ) at the .05 level. Additionally, CIT-officers from Henry County Police Department ( $p < 0.05$ ,  $t = 2.15$ ) and Clayton County Police Department ( $p < 0.05$ ,  $t = 2.63$ ) had significantly higher attitudes towards their MHS. The results of this regression are included in Table 1.9.

Similarly to officer's attitudes towards ERFs, the results of these two regressions suggest that while CIT training overall is not a significant predictor of attitudes towards a MHS, whether or not an officer self-selects for the training is significant. Additionally, while race was found to be significant amongst all the officers, race was no longer found to be significant amongst the sub group of officers who were CIT-trained. In order to complete examining officer's *Attitude toward Mental Health System*, a third regression was run to examine the relationship between exposure to CIT-officers and officer attitudes towards their districts' mental health system (not shown). This single variable (applying to non-CIT officers only) was not significantly correlated with *Attitude toward Mental Health System* at the .05 alpha level.



**Table 1.8 OLS regression predicting officer *Attitudes towards Mental Health System* by Independent Variables Attributed to All Respondents**

	Attitudes Towards Mental Health System			
	B	S. E.	t	Sig.
(Constant)	.592	.043	13.9	0.00
Age	.001	.001	1.06	0.29
Gender (1=male)	.040	.018	2.26	0.02*
Race (1=white)	-.032	.015	-2.05	0.04*
Marital Status (1=married)	.000	.015	-0.01	0.99
Education Level (1=college degree)	-.009	.013	-0.57	0.52
Annual Household Income (1=\$60,001 or more)	-.002	.014	-0.16	0.87
Personal Exposure to MI (1=yes)	--	--	--	--
Past/Present Family Treatment	.008	.015	0.53	0.56
Past/Present Self Treatment	-.011	.020	-0.56	0.57
Past/Present Friends Treatment	-.025	.014	-1.76	0.08
Past/Present Involvement in MHS	.005	.014	0.33	0.74
Years on Force	.000	.001	0.09	0.93
Rank as Officer or Command (1=patrol)	.043	.016	2.72	0.01*
Henry County PD	.027	.023	1.14	0.26
Cherokee County SO	.028	.024	1.18	0.24
Rome PD	.034	.025	1.36	.174
Clayton County PD	.033	.022	1.50	0.13
Savannah-Chatham PD	.017	.022	0.77	0.44
CIT Training (1=yes)	.008	.013	0.63	0.53
Other Recent MI Training? (1=yes)	.008	.014	0.54	0.59

$R^2 = 0.06$ , (n=553,  $p < .05$ )

**Table 1.9 OLS regression predicting officer *Attitudes towards Mental Health System* by Independent Variables Attributed only to CIT-trained Officers**

	Attitudes Towards Mental Health System			
	B	S. E.	t	Sig.
(Constant)	.536	.062	8.62	.000
Gender (1=male)	.057	.025	2.24	0.03*
Rank as Officer or Command (1=patrol)	.058	.024	2.418	0.02*
Henry County PD	.081	.038	.206	0.03*
Clayton County PD	.087	.033	2.63	0.01*
Self-selected for CIT –Training? (1=yes)	.062	.025	2.55	0.01*
Months since Completion of CIT (1=yes)	-1.79	0.00	-0.01	0.99

$R^2 = 0.12$ , (n=229,  $p < .05$ ) - Note: While the above regression (Table 1.9) included all the same variables as shown in Table 1.8, only those variables with significant findings were re-featured.

It is important to note that the six OLS regressions described above examined different measures of officers' attitudes controlling for all the independent variables, including the police department and whether or not officers had CIT training. These analyses addressed both research questions one (do officers' attitudes regarding their jurisdiction's mental health facilities vary by department?) and two (does CIT training, influence the attitudes officers have regarding the hospitals and mental health system in their jurisdiction?). While it was hypothesized that attitudes across the entire sample would vary between departments and based upon CIT training, the results of the individual OLS regressions fail to support either of these hypotheses. The analyses did highlight several factors that have significant predictive value regarding officer attitudes, including factors such as an officer's age, race, gender, exposure to mental disorders (such as knowing friends who have experienced a mental disorder) and whether or not an officer volunteered for CIT training.

With regard to the third research hypothesis that CIT training influences officer attitudes about local mental health resources within each of the six departments, a bivariate analysis was conducted. Eleven cases were missing one or more answers to the five ERF-related questions or the seven MHS-related questions. Given the small number of questions that comprise the ERF and MHS scales, and that only eleven cases were missing answers on any of the twelve questions, these eleven cases were excluded from this analysis, resulting in a sample of 553 officers. Independent samples t-tests were run to examine police officer attitudes by CIT training status within each department. For this step of the analysis, responses to the five ERF questions and seven MHS questions were averaged by summing the Likert scale responses for each question and dividing by the total possible score for that set of questions. In this way, the same dependent measures of *Attitude toward Emergency Receiving Facility* and *Attitude toward*

*Mental Health System* were used for this phase of the analysis. For each department, two independent samples t-tests were run (one for both dependent measures of attitude), resulting in a total of twelve t-tests.

When examining whether CIT-training was associated with more positive attitudes of the ERF or the mental health system, only one of the six departments, Rome Police Department, showed a significant degree of association between CIT training and police attitudes. Rome police officers who were not CIT-trained ( $M=.74$ ,  $SD=.131$ ) had more positive attitudes regarding their local mental health system than CIT-trained officers ( $M=.66$ ,  $SD=.125$ ),  $t(66)=2.46$ ,  $p=.017$ . The results of the independent samples t-tests comparing *Attitude toward Mental Health System* by CIT-training status for each department is shown in table 2.0. CIT training was not associated with significantly different Rome PD officer attitudes of the ERF (not pictured). CIT training was not associated with significantly different officer attitudes of the ERF or the MHS in any of the other five departments (results not shown).

**Table 2.0 Results of Independent Samples T-Tests Examining *Attitudes towards Mental Health System* by CIT-Training Status for Six Departments (N=553)**

Department	CIT Trained Officers (n=229)			Non-CIT Officers (n=324)				
	Mean	SD	df	Mean	SD	df	t	p
Atlanta PD (n=106)	0.68	0.17	82.0	0.70	0.16	82.0	0.42	0.99
Henry Co. PD (n=93)	0.70	0.13	80.0	0.68	0.15	80.0	-0.80	0.41
Cherokee Co. SO (n=97)	0.68	0.14	66.0	0.68	0.14	66.0	0.02	0.98
Rome PD* (n=68)	0.66	0.13	66.0	0.74	0.13	66.0	2.46	0.02*
Clayton Co. PD (n=101)	0.72	0.14	99.0	0.69	0.16	99.0	-0.99	0.33
Savannah-Chatham PD (n=88)	0.70	0.15	71.6	0.67	0.12	71.6	-0.86	0.40

\*  $p < .05$

Lastly, the twelve questions comprising the dependent variable measure of police attitudes were also examined individually. Since each question referred to a slightly different issue regarding the responsiveness, efficiency, resistance, timeliness, or effectiveness of the local ERF or the district's mental health system, comparing the means of the individual questions highlights problematic areas. For instance, the single question to have the lowest average response (therefore representing the most negative attitude) was "*the mental health system in my district is cooperative with law enforcement.*" While there were no statistically significant differences between the means of these questions by department (ANOVA), the questions can be noted as discussion points for future research and further investigation. Mean scores for the twelve questions (broken down by department) are presented in Table 2.1 and scaled "grades" of officer attitudes towards district ERF and mental health systems are provided in Table 2.2.

Table 2.1 Breakdown of Average Scores on 12 Survey Questions by Department and Overall (N=553)

Questions	Overall (N=553)	APD (n=106)	HCPD (n=93)	CCSO (n=97)	RPD (n=68)	CCPD (n=101)	SCPD (n=88)
<b>ERF Questions -- (rated on 1-5 point scale of "always"- "never")</b> Questions one, two and five were reverse scored so that higher scores reflect more positive responses. <i>"For the times when you transported a PMI to a hospital for psychiatric evaluation and treatment, please give your opinion to the following five items"</i>							
2.) The hospital/mental health agencies were responsive to my requests to deal with the person,	<b>3.76</b>	3.72	3.72	3.77	3.87	3.59	3.58
2.) The hospital's/mental health agency's responses were efficient,	<b>3.83</b>	3.83	3.82	3.89	3.90	3.91	3.64
3.) The hospital/mental health agencies were resistant to dealing with the person,	<b>3.82</b>	3.86	3.92	3.73	3.91	3.73	3.77
4.) The hospital's/mental health agency's responses took longer than it should have,	<b>3.11</b>	3.61	2.69	2.88	3.11	3.22	3.09
5.) The hospital's/mental health agency's responses were effective.	<b>3.61</b>	3.83	3.50	3.34	3.80	3.70	3.52
<b>MHS Questions -- (rated on 1-4 point scale of "not true at all" -- "very much true")</b> <i>" Please indicate how true each statement is to you "</i>							
8.) The MHS in my district efficiently processes police referrals,	<b>2.24</b>	2.28	2.28	2.22	2.13	2.10	2.42
9.) The MHS in my district appropriately processes police referrals,	<b>2.17</b>	2.17	2.18	2.11	2.310	2.09	2.36
10.) The MHS in my district provides effective solutions for managing mental health calls,	<b>2.44</b>	2.56	2.36	2.41	2.44	2.47	2.40
11.) The MHS in my district is cooperative with law enforcement,	<b>1.89</b>	1.90	1.89	1.98	1.85	1.86	1.84
12.) The MHS in my district is willing accept violent persons,	<b>2.40</b>	2.17	2.49	2.66	2.24	2.30	2.48
13.) I feel comfortable accessing MH resources to resolve mental health/disturbance calls,	<b>2.11</b>	2.22	2.16	2.11	2.10	2.02	2.01
14.) The MHS in my district has adequate resources to respond to individuals that do not meet emergency criteria but need mental health services.	<b>2.45</b>	2.50	2.53	2.33	2.43	2.48	2.42

**Table 2.2 Scaled “Grade” of Officer Attitudes towards ERF and MHS by Department and Overall (N=553)**

	Officer Attitudes towards ERF		Officer Attitudes towards MHS	
	<i>CIT Trained</i>	<i>Non-CIT</i>	<i>CIT Trained</i>	<i>Non-CIT</i>
<b>Overall (N=553)</b>	<b>0.71</b>	<b>0.71</b>	<b>0.69</b>	<b>0.69</b>
<b>Department</b>				
Atlanta PD (n=106)	0.73	0.73	0.67	0.69
Henry Co. PD (n=93)	0.70	0.70	0.70	0.68
Cherokee Co. SO (n=97)	0.69	0.68	0.68	0.68
Rome PD* (n=68)	0.70	0.73	0.66	0.74
Clayton Co. PD (n=101)	0.70	0.73	0.66	0.74
Savannah-Chatham PD (n=88)	0.71	0.71	0.71	0.67

## CHAPTER V

### DISCUSSION

This study examined the attitudes police have regarding the hospital and mental health system in their district when transporting PMI and the extent to which specialized training (namely CIT) influence those attitudes. This research assessed the attitudes police officers from six departments had regarding their district's hospital for times when they have transported a PMI in crisis, as well as their local mental health system in general. In addition to examining how CIT influences attitudes, this work also looked at other factors which may play a role in shaping how police view the available mental health resources in their district. Specifically, this research investigated whether police officer attitudes were different across jurisdictions or within jurisdictions, and whether CIT training was a primary factor in those differences. Officer-attitudes were assessed by examining how police judge the responsiveness, efficiency, and effectiveness of local hospitals and mental health resources.

While more than 400 CIT models are currently in operation, comparatively little research exists regarding CIT (Watson, Morabito, Draine, & Ottati, 2008). Of the limited research, recent studies have examined the effectiveness of CIT through officer on-scene incident dispositions (Ritter et al., 2011; Teller et al., 2006) but the majority of research has been related to how training influences officers' knowledge and understanding of mental disorders and self-confidence in responding to calls for service involving PMI (Bahora, Hanafi, Chien & Compton, 2008; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Wells & Schafer, 2006). However, research has yet to comprehensively evaluate the long-term effectiveness of such programs and has only begun to address officer-level dynamics such as attitudes, behaviors and police interactions with the mental health system.

Research has found mental health treatment services are a key component to the successful stabilization of mental disorder symptoms (Council of State Government, 2002). However, mental health services are not solely sufficient (Draine, Wilson, Pogerzelski, 2007). Police officers, in their unique capacity of serving their local communities, are needed to serve as catalytic facilitators to mental health services. As such, there has been a recent focus on police-based diversion programs, namely CIT. The police involved in these programs in turn rely on their local community-based mental health infrastructure.

Specifically, diversion programs require police to interact with mental health service providers when diverting offending PMI, and research has documented police to have a long-standing frustration with accessing mental health treatment for PMI in crisis (Bittner, 1967; Teplin & Pruett, 1992; Watson, Morabito, Draine, & Ottati, 2008). This frustration can be attributed to the availability of services as well as the perceptions officers have regarding the proficiency of the staff and the effectiveness of the treatment. Presumably, these perceptions and attitudes are closely tied to the actual decisions officers make regarding arrest versus referral dispositions. Therefore, it is important to assess the current perceptions and attitudes police have about their community mental health treatment options, specifically their Emergency Receiving Facility (ERF). The findings of this study stress the importance of having the criminal justice and mental health systems dedicate an increased degree of attention and time to their affiliation with one another. Research has acknowledged the overlap of the two systems, but this study serves to elucidate the officer-level attitudes about interactions between the systems.

This study proposed that officer attitudes about district mental health resources would vary between departments, since the six departments included in the study use different hospitals that are located in relatively different environments and communities. It was also hypothesized



that attitudes would differ based upon mental illness training, and that officers who were trained in CIT would have more positive attitudes of hospitals and the mental health system than those without CIT training (within departments and across the entire sample). The analysis made a distinction between hospitals and the mental health system as a whole, since police-referrals of PMI usually take place at emergency receiving facilities (ERF). Therefore, attitudes could be examined separately and as part of an overall attitudinal measure. In terms of attitudes about district hospitals and mental health systems, there were no significant differences across the six police departments. Generally speaking, police from all six departments had relatively comparable attitudes regarding their respective hospitals and mental health systems.

In terms of examining whether CIT training was associated with changes in officers' attitudes, analysis showed no significant difference in attitudes between CIT officers and non-CIT officers. CIT and non-CIT officers had similar attitudes towards their district's ERF and mental health system. CIT training was not associated with significantly different attitudes, and officers had the same average attitudes towards the ERF and mental health system regardless of training. Interestingly, the shared perception of the ERF was not particularly positive or negative, but rather neutral. On average, police officers in the sample gave their ERF a grade of C on a traditional letter-grade scale, regardless of training. While a traditional letter-grade of C is not overwhelmingly positive, it is passing and reflects a slightly positive attitude toward ERFs. Nearly all of the officers (97%) have transported an individual to a hospital for mental health evaluation or treatment. These findings indicated that exposure to the ERF does not translate to more positive attitudes about the ERF's responsiveness and efficiency as demonstrated by the mean score of the ERF scale. This is in keeping with research on the courts system. Individuals

with personal experience with the court system have lower opinions of it than those without personal experience (Olson & Huth, 1998).

As for officer attitudes towards their local mental health system, only 69% of officers have positive opinions about their districts' mental health system whether CIT trained or not. However, some differences were noted when examining the subgroup of CIT officers. For instance, CIT officers from Henry County Police Department ( ) and Clayton County Police Department had significantly higher attitudes towards their local mental health system than CIT officers from the other jurisdictions surveyed. These findings could be attributed to organizational differences (such as support from agency command staff) or jurisdictional differences (such as mental health facility availability) that were not considered in this analysis. Furthermore, this study does not have the appropriate measures to effectively explore and explain these differences. Future research is needed to further understand the precise differences between CIT officers from each of these departments.

The lack of a difference (between CIT and non-CIT officers) could be attributed to the fact that the six police departments included in this study are relatively pro-CIT, and therefore inherently comparable in their attitudes towards the mental health system. The attitudes are not overwhelmingly positive or negative for any of the six departments, but could reflect higher average attitudes than law enforcement agencies not involved in CIT at all. An additional explanation for the lack of differences between CIT and non-CIT officers is the fact that the non-CIT officers in this sample have a considerable amount of exposure to CIT-initiatives within their department and utilizing local mental health resources. More than sixty percent of the non-CIT officers reported having weekly exposure to fellow CIT-officers and almost the entire sample reported having transported a PMI to an ERF at some point within the last two years.

Also, the six departments featured in this study are very involved in the State of Georgia's CIT initiative, with command staff taking an active role in training their departments to adhere to CIT principles including seeking treatment-based alternatives to arrest, when appropriate. Therefore, officers in these six departments are perhaps already experiencing new departmental protocols with regard to PMI and leveraging district ERFs. Whether an officer has been through the 40-hour CIT course may not result in a marked difference in attitudes if the department as a whole has changed its policy. Rather, the department's involvement in the CIT program may enhance the experience and outlook of all officers. This notion that the prioritization of CIT or similar initiatives by command staff matters is discussed further below.

This study found no meaningful differences between the attitudes of CIT and non-CIT officers. However, of the CIT-trained officers, those who volunteered (self-selected) for the training, were found to have significantly different attitudes about the mental health system and mental health resources overall (at the .05 level) than CIT-officers who did not self-select for the training. This suggests that an officer's willingness to participate in training programs like CIT may be correlated with the attitudes they have regarding arrest-alternative resources, such as the local mental health system. Officers who self-select (volunteer) for specialized trainings like CIT have more positive attitudes towards ERFs and the mental health system, suggesting that self-selected CIT officers may possess certain character traits that make them more amenable to dealing with special populations, or non-law enforcement entities (like mental health facilities). This research only found that self-selected officers had more positive attitudes towards their mental health resources, which could be indicative of those officers being more receptive to CIT principles, namely referring PMI to treatment in lieu of arrest. However, additional research is

needed to determine whether these more positive attitudes are linked to higher rates of facilitating PMI access to treatment.

In addition to looking at how CIT-specific variables were associated with officer-attitudes, several other variables were found to be significant factors in determining officer-level attitudes about ERF and the mental health system. With regard to officer attitudes toward local ERF, officers' age was significantly correlated at the .05 alpha level. Age could be associated with higher attitudes because younger officers have unrealistic expectations of their local mental health infrastructure than older officers. Older officers may have more experience with such services (including personal experiences) and therefore have most positive reviews of an ERF. While age was not significantly correlated with officer attitudes towards the district's mental health system, an officers' gender was. Male officers had more positive attitudes towards their districts' mental health system than female officers however, female officers were more likely to have CIT-training than male officers. This suggests that a factor not well accounted for in this research is influencing the relationship between gender and whether an officer is CIT-certified or not. Previous research has explored the gender differences in attitudes of police, finding that female officers have different perceptions and attitudes with regard to calls for service involving special populations, such as incidents of domestic violence, than their male counterparts. Stalens & Finn (2000) found that while female officers may not differ in their arrest rates of domestic violence calls for service, veteran female officers did differ in their likelihood of recommending certain resources, such as battered women's shelters over marriage counseling. These differences suggest that female officers have different perceptions of some calls for service and have different attitudes regarding community-based resources for citizens. The root of these different perceptions has yet to be clearly defined, but research suggests that the different perceptions do

not result in different arrest decisions (Stalens & Finn, 2000). While Stalens & Finn (2000) examined incidents of intimate partner violence, these differences in attitudes can show that female police officers view community resources differently than male officers; a topic that would benefit from further examination.

Race was also significantly related to officer attitudes toward both their district ERF and mental health system. The relationship between race and attitudes toward mental health resources found here suggests that non-white officers have more positive attitudes of their ERF and local mental health system than white officers. This could be attributed to non-white officers having more experience with emergency rooms and hospitals in an unofficial capacity. Begley, Behan & Seo (2010) found that Hispanics were three times more likely to use emergency rooms and African-Americans were six times more likely to use emergency rooms in comparison to whites. An increased familiarity with emergency rooms may lower the expectations of non-white officers or give them a slightly more positive view.

Whether or not an officer reported having friends with a current or past mental disorder also was significantly correlated with attitudes towards the ERF. Officers who reported having friendships with someone who had been treated for a mental disorder had more negative attitudes about their ERF than other officers. Officers may have more critical or negative attitudes about an ERF in terms of having their friends and peers experiences because they have less intimate knowledge about the PMI and their treatment process. In other words, officers who have been treated themselves, or dealt with a family member's mental health treatment may look at emergency rooms in the context of the entire treatment process, which may temper their experience with an ERF, resulting in attitudes that are not as negative. Additionally, the friends respondents are referring to may be fellow officers, therefore enhancing respondents' frustration

with emergency room delays and problems. Officers may identify more with their friends and fellow officers than their own family members. Therefore hearing accounts of negative experiences involving a local ERF may bear more weight than familial or even personal experiences and result in more negative attitudes than officers who have family or personal experience with mental health treatment.

Lastly, officer rank was found to be significantly related to the attitudes officers had regarding both their districts' ERF and overall mental health system. Patrol officers had had more positive attitudes than officers serving in a supervisory or command staff role. These differences can be attributed (at least in part) to the fact that patrol officers transport PMI to ERF or other mental health facilities more frequently than supervisory officers. Patrol supervisors are often requested by first-responding officers during calls for service that require back-up, second opinions or involve special populations (such as PMI) for which the department may have specific protocols. Therefore, while supervisors generally have extensive experience handling calls for service involving PMI, patrol officers are more often transporting the PMI to the local ERF or other mental health services. Therefore, patrol officers have more frequent dealings with ERF intake procedures and mental health resources. This is a very important finding since the patrol officers who regularly deal with such facilities turned out to have slightly higher attitudes towards ERFs than their supervisors. Supervisors may have increased frustrations regarding the mental health systems' responsiveness and cooperation with law enforcement because they do not have as much direct experience with such facilities. This may suggest that the officers who use the facilities most actually have better, more positive attitudes, which is a promising finding.

While patrol officers had more positive attitudes than supervisors, it should be noted that of the twelve survey questions included in this study, the question with the lowest score

(reflecting the most negative attitude) was, “*the MHS in my district is cooperative with law enforcement*”, with a score of 1.89 on a 4-point scale (recall from Table 1.2 on page 76 and Table 2.1 on page 90). This suggests that there is still room for improvement with regard to police attitudes towards their local mental health system. Additionally, supervisors have more direct communication with command staff personnel who dictate the regulations and protocols for their respective departments. The six departments included in this study have progressive CIT initiatives which are reflections of Chiefs’ and Sheriffs’ expectations and direction for their officers. As such, while supervisors may hold less positive perceptions of their districts’ mental health resources than the patrol officers who may use them more frequently, supervisors may have more influence on the actual protocols of the department.

**Implications** CIT initiatives are making progress by way of changing officer-level attitudes about individual PMI (Bahora, et al., 2007; Bahora, et al., 2008; Compton, Esterberg, McGee, Kotwicki & Oliva, 2006). However, the findings reported here suggest that CIT training does not necessarily lead to improved officer attitudes about the mental health system and its facilities. This research found almost no significant difference in the attitudes CIT-trained officers had towards district ERF and the local mental health system. Only in one of the six departments studied was there a significant difference between the attitudes of CIT-officers and non-CIT officers; the non-CIT officers had more positive attitudes about their local mental health system than CIT-officers. The six departments studied had nearly identical attitudes of their mental health resources, which would barely be considered passing on a standard grading scale.

Officers who opt to transport a PMI to access mental health treatment by way of an ERF or other facility are encountering a system entirely different from the criminal justice system they are familiar with. The mental health system has its own bureaucracy and problems as outlined

throughout this study. These problems can negatively impact the overlapping interactions with the criminal justice system. Should officers who are trying to do “the right thing” be met with resistance, they may become frustrated and develop negative perceptions of the entire mental health care system. It then becomes increasingly difficult to keep officers interested or willing to go along with the diversion strategies (like CIT) aimed at stopping the revolving door of the criminal justice system. Officers who grow too discouraged or frustrated by the hospitals will likely revert to using the criminal justice system which they are more familiar with and retain the most control. However, it is also important to note that these two systems are inherently different and some friction between the two is natural. The mental health system is (and should continue to be) primarily focused on serving PMI rather than meeting the needs of police. This work does not suggest that this focus should shift. Ideally, mental health and criminal justice personnel will recognize that these two efforts are not mutually exclusive of one another and be able to make small adjustments and agreements that benefit personnel from both, therefore ultimately benefiting PMI.

If one were predicting police behavior based solely on the attitudes of officers documented in this study, it would seem unlikely that officers would elect to use their districts’ ERF or mental health resources to handle calls for service involving PMI. However, there are other factors to consider when predicting an officers’ decision to arrest or seek alternative dispositions. First and foremost, while police have a significant amount of discretion in their course of duty, they still answer to supervisors and command staff. Thus, officers often refer to departmental policy and protocols when making decisions. How a department defines and enforces its procedures for interacting with PMI (if such a procedure is even articulated) presumably has significant influence on officer-level decisions.



In addition to command staff needing to clearly articulate protocol to their own officers, it is also critical that law enforcement agency heads spend time and attention building a collaborative relationship with their local mental health resources, namely the ERF. The relationship between the criminal justice and mental health systems needs a substantial amount of attention in the form of building collaborations, communicating, funding, and time spent on addressing these issues. On a local level, police departments and hospitals need to invest in their relationship with one another. Simply formulating an agreement or memorandum of understanding (MOU) without constant attention from both parties will likely be insufficient to sustain a productive relationship. Training police officers on the importance of facilitating PMI access to treatment without an established mental health treatment infrastructure will be limited. Personnel in both systems need to be educated on one another's policies and state laws and regulations. Practitioners should examine what officers find most positive and negative about their districts' facilities in an effort to improve the experiences police have when transporting PMI. To date, many communities are beginning this process of building an ongoing collaboration between mental health and criminal justice professionals. Several of the departments included in this study are taking active roles in addressing these issues and cooperating with their districts' ERF to simplify the process of facilitating PMI access to treatment.

### **Limitations and Recommendations for Future Research**

This research used previously collected data, which presents certain limitations. First, the survey questions used in this study were designed for the original data collection and as such, are worded in a manner that leaves some answers open to interpretation. For instance, five questions asked respondents to give their opinion "*for the times when you transported a person with a*

*mental illness to a hospital for psychiatric evaluation and treatment.*” The six police departments included in this study each use one primary ERF for the vast majority of their PMI treatment referrals (per departmental policy). However, other hospitals are available in some of these jurisdictions therefore it is possible that officers could have used hospitals other than the six primary facilities referred to in this research. It is the belief of the researchers though that the vast majority of respondents were referring to the primary hospital in their jurisdiction. While researchers can infer that officers were referring to their primary ERF, officers did not name the hospital.

Additionally, there were some questions that would have augmented this analysis that were not included in the original research. Researchers were unable to follow-up with any officers to clarify responses or obtain certain portions of missing data. The missing data, as noted previously, consists of twenty-four Atlanta Police Officers who were not asked the set of twelve dependent variable measure questions. These twenty-four officers, who were included in the original study, were excluded from this secondary analysis entirely.

The six departments included in this research are from urban and suburban regions of Georgia. Future research would benefit from further exploring police departments and mental health resources in rural environments. The status of available mental health care in rural and small-town areas of the country (including Georgia) is currently unknown and the availability of such services has significant implications on CIT implementation and policing PMI. For further information on the history of mental health services in the rural south, see Kane & Ennis (1996).<sup>9</sup> Furthermore, research has established that policies, principles and policing styles vary across

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<sup>9</sup> Kane and Ennis (1996) studied mental health services present in the rural areas of the American South and addressed the service issues associated with PMI living in rural communities. Their work recognized proposed initiatives at the time in order to weigh the strengths and weaknesses of such programs aimed at serving rural areas (Kane and Ennis, 1996).

settings and find that specific contextual variables influence an agency's focus and resource allocation (Khuns, Maguire & Cox, 2007; Payne, Berg & Sun, 2005). Therefore, it would be an error to generalize findings on CIT (that are the result of studying urban and suburban departments) to rural and small-town environments and law enforcement agencies. Lastly, this research did not assess actual officer disposition decisions. Future research focused on the impact of CIT on the disposition of calls for service involving PMI is warranted. Attitudes could then be examined in conjunction with actual arrest data to assess the role officer-level attitudes play in an officer's decision to arrest or transport to treatment.

Simply put, officers do not have very positive attitudes towards the ERF they use to transport PMI or their districts' mental health system. More concerning is the fact that the departments included in this research are comparatively pro-CIT and more progressive in their approach to addressing the needs of PMI than many agencies in Georgia. Therefore, these attitudes may be more positive than many police departments without any specialized approach or initiative with the mental health system. In a sense, these departments may be "setting the bar" with their attitudes, and it is likely that officers from departments without any involvement in CIT have even more negative attitudes than the ones analyzed in this study. As previously stated, future research is needed to assess the attitudes officers from rural departments and agencies without any involvement in CIT initiatives have about their mental health resources. However, should this be the case (that the departments in this study may be the best-case or most positive standard) than there is a long way to go in improving the attitudes and experiences officers have with the mental health system. Either way, it is clear that negative officer-attitudes, such as those documented in this study, speak to the need for increased attention to the practices in each system that can be improved upon.

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