Police Intervention in Mental Health Crisis: A Case Study of the Bloomington
Crisis Intervention Team (CIT) Program

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Police Intervention in Mental Health Crisis: A Case Study of the Bloomington Crisis Intervention Team (CIT) Program

Owing to the closure of state mental hospitals and limited funding for mental health programs, police increasingly must respond to calls involving persons in mental health crisis. Unfortunately, police officers often do not have the skills or the resources to respond effectively.   As a result, many mentally ill persons are arrested and subsequently incarcerated leading to an endemic problem of jails and prisons acting as "the new asylums." In many communities, police and mental health service providers have joined forces to address this problem. One response, which first emerged in Memphis, Tennessee, is Crisis Intervention Team (CIT) training for police officers. Programs modeled on the Memphis CIT training have been adopted across the United States. Indeed, several states are currently considering mandating that all state and local police agencies provide CIT training to their officers. As the program has spread, however, police agencies have adapted the Memphis Model in different ways. As a result, there is no national model or standard for what constitutes CIT training. In particular, there are questions about what the role of mental health advocates should be in designing the CIT training, whether all police officers in a department or only volunteers should receive CIT training, and how the training can be adapted for cities of different size. Moreover, little is known about whether CIT training actually improves police officers' responses to persons in mental health crisis. Building on two pilot studies this research combines qualitative and quantitative data to address these questions of content and effectiveness. This study examines the larger community context of one CIT program through interviews and focus groups with police officers, medical personnel and community

members. In addition, this study utilizes data from officer-completed incident response sheets to examine the effects of CIT training. Specifically, the study addresses (1) whether CIT training affects how frequently officers report persons as having a mental illness, (2) how officers respond to and resolve incidents involving persons whom they believe to be in mental health crisis, and (3) whether there are differences in responses between CIT and non-CIT trained officers.

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Chapter 1: Introduction and Literature Review

1.1 Introduction

Owing to the closure of state mental hospitals and limited funding for mental health programs, police increasingly respond to calls involving persons in mental health crisis. Unfortunately, police officers often do not have the skills or the resources to respond effectively. As a result, many mentally ill persons are arrested and subsequently incarcerated leading to an endemic problem of jails and prisons acting as "the new asylums." In many communities, police and mental health service providers have joined forces to address this problem.

Over the past 20 years, state and local police agencies have developed programs to improve officers' responses to calls involving persons with mental illness. Crisis Intervention Team (CIT) training, developed in Memphis, Tennessee, has emerged as the leading police response model. The objectives of the Memphis Model of CIT are to help officers recognize symptoms of mental illness, increase their use of mental health alternatives to arrest, and promote the physical safety of both officers and mentally ill citizens during police interactions. The Memphis Model has been endorsed by mental health providers, mental health advocates, and many police agencies (Bowers, 2001; Compton, 2008; Hails, 2003; Munetz, 2006). As a result, it has gained recognition as the exemplary program for improving police interactions with mentally ill citizens.

Despite its rapid spread, little is known about the CIT implementation process, the organizational linkages the program establishes, and whether CIT training actually improves police officers' responses to persons in mental health crisis. In addition, while most police agencies purport to implement the Memphis Model of CIT, it is unclear whether the core elements (Dupont, Cochran & Pillsbury, 2007) of the program are

adhered to or whether, and how, the agency adapts the model to fit local needs. The purpose of this study is to help fill this gap in knowledge about a significant criminal justice policy innovation through an intensive case study of one CIT program.

Building on two pilot studies and drawing on Watson's et al. (2008) and Morabito's (2007) multi-level conceptualization of CIT, this case study explored the community and organizational context in which the program was implemented and further managed and effects of the Bloomington CIT program. As part of the multi-level conceptual framework of analysis, this study utilized focus groups and interviews to explore the meaning the policy makers, officers, mental health professionals and community members attach to the implementation of the CIT program and the community context in which the program functions.

In addition, this study analyzed data from officer-completed incident response sheets to examine the effects of CIT training. Specifically, the study utilized multivariate statistical techniques to address 1) whether CIT training affects how officers respond to and resolve incidents involving persons in mental health crisis, and 2) whether there were differences between CIT and non-CIT trained officers.

The overall purpose of this study is to provide an in-depth examination of one Crisis Intervention Team training program. Through the use of mixed-methods, the CIT implementation process is explored and mental health crisis call outcomes are examined.

1.2 An Overview of the Memphis Model of CIT

As a result of the deinstitutionalization of the mentally ill, police are increasingly required to confront mental health crisis in the field. Current research indicates that police departments around the country have seen an increase in the number of hours police officers spend dealing with mentally ill individuals on the street. For example

Reuland and Cheney (2005) report that "the New York Police Department responds to a call involving a person with mental illness every 6.5 minutes"; in Florida, police officers transported individuals with mental illness for involuntary confinement and examination over 40,000 times in one year; and in 1996, Los Angeles police officers spent over 28,000 hours a month on calls involving the mentally ill (Reuland & Cheney, 2005). In their ground breaking work, Teplin & Pruett (1992) established that police arrested persons with mental illness at a significantly higher rate than non-mentally ill persons or acted as street corner psychiatrists by informally handling a situation rather than transporting persons to mental health facilities (but see Engle & Silver, 2001 challenging the criminalization of mental illness hypothesis). Police officers often chose arrest or informal measures to control a mental health crisis because there were few alternatives available.

This problematic situation was confirmed when a mentally ill man was fatally shot by police officers in Memphis, Tennessee. Directly after this event, the Director of the Memphis Police Department publicly reported:

- The police department was ill equipped to handle the seriously mentally ill
- Family members of the mentally ill distrusted police
- The criminal justice system and the mental health system were adversaries
- Police response to crises involving the mentally ill often resulted in injury and arrest (LDDA, 1998)

Following this report, an alliance was formed between the Memphis Police Department, the National Alliance on Mental Illness (NAMI) and area mental health services that resulted in the Crisis Intervention Team (CIT) program that is currently being modeled by police departments across the United States. The Memphis Model of CIT was designed to train police officers to be "first responders" for calls involving

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persons with mental illness. In addition, one key component of this model was the

collaboration between the police department and area medical facilities; area medical

facilities agreed to provide access to mental health services when officers identified that

medical intervention was required and to accept individuals for assessment and treatment

24 hours a day, 7 days a week, allowing the officer to return to the street.

The Memphis Model of CIT training was originally based on a 40-hour class that

officers would volunteer to attend. The training had four main goals (LDDA, 1998):

- To help police officers recognize symptoms of mental illness
- To help police officers recognize alcohol and drug addictions
- To help police officers gain an appreciation for consumer and family members' perspectives
- To help police officers gain verbal de-escalation techniques

In addition, the program had three overarching objectives:

- Increase officer and civilian safety
- Diversion from incarceration in jail to mental health treatment facilities
- Positive outcomes for subjects and reduced need for officer intervention
    - Decrease symptoms of mental illness, arrest rates and drug/alcohol use
    - Increase consumer satisfaction with police and mental health services

Over time, police departments across the United States adapted and implemented

the CIT training; it is estimated that over 400 CIT programs are operating in the United

States (Oliva, 2008; Compton, 2008). Nonetheless, since there is not a national standard

for CIT training, many police departments across the country have opted to retain the

overarching goals of the Memphis Model, while at the same time adapting the content of

the training to fit the needs of the local police department and local community

(Compton, 2008; Hails & Borum 2003; also, personal conversations with police

administrators).

While research on CIT is limited, there is a growing body of literature that examines pre- and post-booking programs designed to divert subjects from jail, officer attitudes and perceptions of persons with mental illness, and a small body of literature examining arrest of persons with mental illness. The few studies that are available on CIT have predominately utilized police officer and consumer self-report and pre/post CIT training surveys. Many of the studies do not focus specifically on examining the CIT program, the programs impact on mental health crisis outcomes, or the context within which the CIT program functions. While research on CIT is still in its infancy, many police agencies have or are considering its implementation. Given the fervor with which this program is adopted, it is increasingly important to systematically examine the research that has been conducted and consider directions for future research. The following review provides an assessment of the available literature that is relevant to CIT and its outcomes, and reviews suggested directions for future research.

1.3 Literature Review

1.3.1 Program Comparisons

In order to determine which response model might be the most effective in responding to mental health crisis calls, Steadman (2000) examined disparate programs: the Memphis, Tennessee police-based-specialized response (CIT), the Birmingham, Alabama police-based specialized response through community service officers, and the Knoxville, Tennessee mental-health-based specialized response. The Knoxville model, where a team of mental health professionals responded to police calls for support, was found to be the least effective of the three models. Steadman (2000) reported that approximately 40% of mental health crisis calls received a specialized response (p. 647) and that police expressed frustration about the long delays in the support team's arrival

on the scene. In addition, 36% of the cases supported by the medical team on the scene were referred to other mental health specialists for further intervention (p. 647-648).

The Birmingham model, where community service officers respond to police calls for support, had an even lower rate of response (28%) due to the lack of alternative dispositions which severely restricted specialized response; however, this model resulted in 64% of the incidents being resolved on the scene and requiring no further intervention (Steadman, 2000, p. 647-648).

The Memphis Model of CIT, where specially training police officers responded directly to the mental health crisis call, resulted in a 95% response rate, tended to stabilize on the scene less than the other sites (23% of calls), and were more likely to transport the person in crisis to a mental health treatment facility (75% of cases). Thus, Steadman (2000) suggests that the Memphis Model of CIT is more effective than the other response strategies (p. 647-649).

In 2003, Lattimore et al. compared eight pre- and post-booking strategies. Lattimore et al., found that subjects in both the pre- and post-booking programs were similar on most mental health indicators, with the exception of measures of social functioning and substance abuse. This study concluded that each of the response strategies targeted different populations. Subjects in the pre-booking programs tended to be

> "more educated, more involved with employment, and generally more satisfied with their lives, health, and finances…were less often arrested, less involved with treatment…less likely to use emergency rooms for mental health problems, less likely to be prescribed psychotropic medications, and less seriously involved with drugs and alcohol"(Lattimore et al., 2003, p. 58).

In comparison, the subjects in the post-booking programs tended to be "more functionally impaired," requiring greater supervision and coercion to comply with mental health treatment (Lattimore et al., 2003, p. 58). Lattimore et al. concluded that deciphering whether one strategy was more effective than the other was not yet possible with current data as each program targeted markedly different populations.

The Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion acknowledges that "pre- and post-booking diversion programs tend to target different populations" (TAPA, 2004, p. 5); however, their study did not make a distinction between these strategies. Instead, looking at groups that were diverted from jail and groups that were not diverted from jail, they found that diverted subjects spend more time in the community and received significantly more mental health treatment. Interestingly, however, there were no significant differences in improved mental health symptoms; both diverted and non-diverted groups "improved mental health symptoms over time" (p. 6). In addition, both groups had similar arrest rates in the 12-month follow-up (p. 6). The overall conclusions of this study suggest that jail diversion programs are effective in reducing subjects time spent in jail but that it is unclear whether those diverted actually receive the mental health treatment they need. Even with this shortcoming, TAPA (2004) suggests that "jail diversion results in positive outcomes for individuals, systems, and communities" (p. 7) because jail diversion "does not increase public safety risk…jail diversion programs link divertees to community based services…[and] in general lower criminal justice costs" (p. 7). They do however, acknowledge that "the additional treatment cost is often higher than the criminal justice savings in the short-run" (p. 7).

1.3.2 Arrest Rates

In their ground breaking work, Teplin & Pruett (1992) found that police increasingly arrested individuals with mental illness or acted as street corner psychiatrists by informally handling a situation rather than transporting persons to mental health facilities. Police officers often chose arrest or informal measures to control a mental health crisis because there were few alternatives available. Teplin (2000) subsequently suggested that "while arrest was not a frequent disposition, the arrest rate for persons exhibiting signs of mental illness was greater than that of other citizens involved in similar types of incidents" (p. 10). Teplin (2000) argues that the high rate of arrest for persons with mental illness was directly related to stringent emergency psychiatric mental health codes that require a person be "a danger to self or others" and hospitals hesitation to accept "dangerous" patients (p. 10).

CIT programs were established to increase the facilitation of hospitalization and, thereby, reduce arrest. However, there is conflicting evidence as to whether CIT reduces arrest rates for persons in mental health crisis. As discussed under *program comparisons* above, TAPA (2003), suggest diversion programs reduce the amount of time spent in jail. However, this study utilized subject self-reports and did not directly compare actual arrest rates.

In another self-report study, Lattimore et al. (2003) indicate that subjects "diverted early in the process by police (i.e., pre-booking) reported fewer arrests and were less likely to have been arrested for more serious offenses" (p. 42). In addition, pre-booking subjects reported fewer "multiple arrests" in the past 12 months (p. 45).

In the 2001 FBI Law Enforcement Bulletin, Bower et al. reported that of the 3,257 CIT calls in Albuquerque, New Mexico during 1999, police arrested fewer than 10 percent of the subjects and transported 48 percent of the subjects to local mental health facilities (p. 2). While this statistic appears impressive, the study is limited as there is no comparison in arrest rates between CIT and non-CIT officers or between pre-CIT implementation and post-CIT implementation; thus, it is not known whether the implementation of the CIT program is responsible for the arrest outcomes or if there is any difference in the CIT trained officers or non-CIT trained officers call outcomes. In addition, Bower reports that 45% of the CIT calls involved suicide attempts or threats (p. 2). It is difficult to say whether these types of calls are affected by the implementation of a CIT program.

Skeem and Bibeau's (2008) study of the Las Vegas CIT program found that a high percentage of CIT cases (45%) were suicide attempts or threats. They also found that subjects were a threat to others in 25% of the cases and that responding officers' use of force was strongly related to officers' perceptions of subjects' potential for violence. CIT officers appeared conservative in their use of force; however, no comparison on CIT training status was available (pp. 202-203).

According to the Las Vegas study by Skeem and Bibeau, arrest rates in CIT cases were low at 4%. However, they acknowledge the limitation of this finding as there was no control group for comparison (pp. 203-204). In Fisher et al's (2006) study of arrest rates among a statewide mental health cohort, they found that 27.9% of subjects were arrested at least once in the 10 year period studied. Approximately 16% were arrested for

a public order offense, with other serious crimes against persons standing at 13.6% (p. 1625).

The most statistically rigorous study to date examining CIT call outcomes suggests that there are "no significant changes in the rate of arrests by time or training" (Teller et al., 2006, p. 232). Teller et al., examined Akron, Ohio police dispatch logs two years prior and four years after the implementation of the Akron CIT program. The initial analysis of data suggests that CIT trained officers were actually more likely to arrest than non-CIT trained officers (p. 236). Teller et al., suggest that dispatchers may be sending CIT officers to the most difficult to handle cases where officers may have less discretion (p. 236). The significantly higher arrest rate by CIT officers "disappeared after calls handled by emergency medical services were excluded from the analysis" (p. 236). In addition, arrest rates might have increased due to the coinciding implementation of the Mental Health Court and the CIT program. Teller et al. suggest that "knowledge of the [Mental Health Court] program and the fact that it may help individuals who may otherwise be resistant to treatment to live successfully in the community may result in CIT trained officers' choosing arrest in selected cases" (p. 236).

As noted in this discussion, studies examining arrest rates for mental health crisis calls offer conflicting and inconsistent results. In addition, many of the studies have serious methodological shortcomings, such as lack of comparison groups. Given the limits of and contradictions in the data, it is difficult to make a causal inference regarding arrest rates.

1.3.3 Police Officer Perspectives

There are four main articles from 1981 to 1997 that describe the initial research on police officer perceptions of persons with mental illness and how those perceptions affected officer decision-making. During their study on police-referred psychiatric emergency patients, Sheridan & Teplin (1981) described police as being highly effective in "locating and responding" to persons in mental health crisis, while at the same time "reassuring…other community members affected by such patients' behaviors" (p. 146). In addition, upon examining officers' response to, or perception of, the implementation of a police reception program at the hospital, officers "showed no resistance to changing long-established transportation designations and established rapport quickly with the [programs] psychiatric emergency personnel" (Sheridan & Teplin, 1981, p. 146).

The problem arose, however, that police officers were not trained to identify or respond to mental health crisis calls. In a later study, Teplin (1984) discovered that officers often failed at identifying a person as mentally ill (p. 799) and struggled with the hospitals stringent requirements for patient admission into the mental health system (p. 800). Thus, police officers often made the decision to arrest rather than struggle with the mental health system (Teplin, 1984, pp 799-800). Teplin & Pruett (1992) confirmed this finding in their article titled, "*Police as Streetcorner Psychiatrists.*" They found that police had developed "a shared understanding of how things *should* be done in order to *manage* the mentally disordered citizen" (p. 140). This meant that the probability of an officer initiating a mental health detention was small as they were reluctant to deal with the "structural constraints governing hospitalization" (p. 140).

Since Teplin & Pruett's foundational work on police encounters with persons in mental health crisis, a small body of research using survey questions and responses to vignettes has examined police perceptions of persons in with mental illness and the impact of CIT training on those perceptions. Watson et al. (2004 & 2004) conducted two studies using vignettes to examine police officer perceptions of persons in mental health crisis. In contradiction to their hypothesis, Watson et al. (2004) found that subjects label of mental illness did not significantly affect officers' responses in situations where an arrest may be warranted (p. 383). This is contradictory to Teplin's (1984) & Teplin & Pruett's (1992) work where it appeared that persons with mental illness were arrested more often. Watson et al. (2004) suggests the discrepancy may lie in officers having less discretion in certain cases where arrest may be warranted; thus, it may be that the type of offense discussed in the vignette rather than the label of mental illness may have instigated the arrest response (p. 383). In a second, similar study, Watson et al. (2004) measured officer perceptions and attitudes about persons described in vignettes. The results of this study indicate that police officers view persons with schizophrenia as being less responsible for their situation, more worthy of help, and more dangerous than persons for whom no mental illness was provided" (p. 49).

In their work on social distance, Bahora et al. (2008) utilized officer responses to vignettes on a pre/post CIT training survey. Social distance, in this context, was "a measure of social distance estimates one's comfort level, or how close a person is willing to be to someone with a mental illness" (p. 160). Bahora et al. found that there were no differences between officers' scores of social distance for age, race/ethnicity, marital status, educational attainment, yearly income, or number of years working as an officer

(p. 164). However, scores were "nearly significant" for gender: females tended to have lower social distance scores than males (p. 164). Bahora et al. also found that "social distance scores were not associated with personal history of ever having received or currently receiving psychiatric treatment, or having a family member or friend in the mental health profession" (p. 164). In contrast, however, they did find that officers who had a family member who has received mental health treatment had lower scores on social distance (p. 164). This finding was endorsed in a presentation by Watson (verbal communication, CIT conference, Atlanta, 2008) where she reported finding that having a family member with mental illness does affect officer's attitudes toward subjects with mental illness. She suggested that effectiveness as a CIT officer may be enhanced by the officer's having a direct, personal association with a person who has a mental illness. In addition, Bahora et al. found that "social distance scores significantly decreased following completion of CIT training" (p. 164). Thus, it appears that CIT training has a significant effect on officers' perceptions of persons with mental illness.

Two other studies evaluated officer attitudes towards mental illness pre/post CIT training. Compton (2006) administered a pre/post test to 159 officers before and after attending CIT training in Georgia. The results indicate that officer's attitude toward aggressiveness among persons with schizophrenia improved post training, and that officer's demonstrated increased knowledge and decreased social distance about and toward persons with schizophrenia (p. 1200). Compton also reports there are no significant associations between knowledge of schizophrenia and social distance. However, on the pre-test, officers who reported personally knowing a person suffering from schizophrenia reported less social distance (p. 1200).

As part of a larger study, Ritter (2006) administered a pre/post CIT training questionnaire to examine "officers' perceptions of the [Akron, OH] program effectiveness…opinions toward mental illness, and…attitudes toward people with mental illness" (p. 4). Ritter found that CIT training affected officer's understanding of the causes of schizophrenia, their perceptions of dangerousness, and their perceived social distance from persons with mental illness, which the study found were positively associated with perceptions of dangerousness" (p. 7).

Borum et al's (1998) conducted an exploratory survey of Birmingham, Knoxville, and Memphis police officer perceptions of program effectiveness. As discussed earlier in this review, Knoxville had a mental-health-specialized response model, Birmingham utilized community service officers in a police-based-specialized response model, and Memphis utilized the CIT model. Questionnaires were distributed during roll call at all three locations, with a total sample size of 452 officers.

Results suggest that police encounters with persons in mental health crisis are quite common and pose a significant problem for the police department. However, CIT officers in Memphis were significantly more likely than non-CIT officers to feel well prepared to handle mental health crisis calls. Memphis CIT officers were also significantly more likely than non-CIT officers to express that the linkages between the mental health system and police departments were helpful; 71% of Memphis officers, regardless of CIT training, rated their departmental CIT program as effective overall. In contrast, slightly over 50% of Knoxville officers rated their specialized-mental-health-based response program as moderately to very effective and 40% of Birmingham officers felt their community-service-based response was moderately to very effective. As a

measure of effectiveness, officers were asked to rate how well the department's program was in keeping mentally ill people out of jail; Memphis officers were significantly more likely than Knoxville and Birmingham officers to rate their program as effective. While Memphis police officers felt the program helped to keep people with mental illness out of jail, 53.8% of the Memphis officers indicated the CIT program did not help to reduce the amount of time patrol officers had to spend on mental health related calls. Overall, Knoxville and Birmingham officers rated their programs as effective in maintaining community safety whereas the Memphis CIT program was rated as highly effective in this area (Borum et al. 1998, 397-401).

In a pre/post test survey, Wells (2006) examined CIT officers' perceptions of their ability to effectively respond to mental health crisis calls. The results suggest that officers perceive mental health crisis calls as an "appreciable part of their workload" and that repeat calls of this types were a moderate problem (p. 584). Officers' perceived mental health crisis calls as typically lasting two hours or less, and often involved general order maintenance rather than more serious crimes (p. 585). Regarding the disposition of calls, a majority of officers were dissatisfied with the options available to them and also report dissatisfaction with the mental health/police department linkages for service (p. 586-587). Officers indicated that "the process is too time consuming, there is a lack of available resources, and there is unwillingness among the service providers to evaluate and treat individuals with a mental illness who police contact" (p. 587).

Wells also found that CIT training affected officers' confidence in their ability to identify mental illness and to respond appropriately. Before training, only 10% of the officers felt strongly that they could identify a person with mental illness; after training,

over one-half thought they could do so. The pre-training survey results indicate that 64% of officers reported that they could not meet the needs of persons in mental health crisis compared to 92% post-training. In addition, prior to training, most officers indicated that they did not understand when to use an immediate detention order versus an emergency detention order; post-training all but one officer expressed an understanding of the differences between the orders and when to use them (p. 590-591).

Using focus group methodology, Hanafi et al. (2008) studied recently trained CIT officers understanding of mental illness and of how they respond when they encounter it in the field. Overall results indicate that CIT officers expressed an increased knowledge of mental illness, improved their ability to respond to mental health crisis calls, reduced stigmatization, increased officer empathy, and increased feelings of patience during mental health crisis calls. In addition, there appeared to be a redirection from arrest toward hospitalization, and an officer perception of being able to reduce the unpredictability of mental health crisis calls (p. 429-431).

Compton et al. (2008) examined issues of knowledge retention following CIT training. Officers (n=88) who had gone through CIT training the past three years completed an online survey. Compton et al's results confirmed their hypothesis that knowledge retention would decrease significantly in the months following training. This evidence supports the hypothesis that CIT training affects officers' perceptions of mental illness and how they respond to it. CIT training appears to increase officers' confidence in their ability to recognize signs of mental illness and their understanding of the causes. However, there is also evidence that knowledge gained from the training deteriorates

over time. Thus, Compton et al. concluded that officers would benefit from follow-up training.

1.3.4 Research Directions

Beginning in 1992, Teplin & Pruett proposed that further research on officer decision-making processes is needed and that studies should include rural as well as urban areas to determine the extent to which there are differences between urban and rural management strategies. Teplin & Pruett (1992) also argued for multi-jurisdictional studies to determine the impact of legal structures on police management of the persons in mental health crisis (p. 155).

More recently, in their examination of the criminalization hypothesis, Engel and Silver (2001) argue that it is important to examine the effects of officers' education, attitudes and decision-making processes in mental health crisis calls. In addition, they agree with Teplin & Pruett in arguing that different policing organizations may manage mental health calls in very different ways; thus further research comparing multiple sites and exploring the context of those differences may provide insight into mental health crisis call outcomes. Due to the relative rarity of mental health related calls, Engel and Silver (2001) recommend that data collection methods should oversample mental health calls for service to obtain a large enough sample to be representative of the police encounters with the mentally ill (p. 248).

Wells' et al. (2006) argues that "research must continue to measure the effects of CIT and other innovative police responses" (p. 596). Wells purports that in order to understand the overall effect of CIT and resulting dispositions, multiple perspectives

should be considered, including vantage points of the jails, mental health service providers, advocates of the mentally ill and mental health consumers (p. 596).

Despite the growing body of literature on officers' perspectives of mental illness, Compton et al. (2008) indicate there is very little evidence-based research on CIT or specialized responses to mental health crisis calls. In their literature review, Compton et al. (2008) indicate there were a total of 12 journal articles that specifically addressed CIT program outcomes. He suggests that "research is crucial, especially considering CIT is uncritically being touted as a model program and being adopted rapidly and broadly" (p. 53). Given the paucity of research on CIT, Compton et al. (2008) advocate for both the initial and long-term study of all aspects of CIT from patient's responses to program implementation, including for present purposes, especially, factors that strengthen or impede the program's full utilization and potential effectiveness; immediate, intermediate, and long-term outcomes for police officers; the manner in which officers apply their training in the field; potential benefits of CIT-associated partnerships in terms of reform of local mental health systems; attitudinal changes in mental health professionals, consumers, and families involved in CIT.

In Oliva & Compton's (2008) descriptive article on the evolution of implementation of the Georgia CIT program, they acknowledge the prominent dearth of research on CIT to date. They suggest that research should focus on officer-level outcomes rather than on officer attitudes and perceptions. In addition, patient-level outcomes as well as the ways in with CIT programs "stimulate system reform at the local level" (p. 44) needs to be evaluated.

Bahora et al. (2008) echo many of these suggestions indicating that larger sample sizes for officer-level outcomes are necessary. In addition, Bahora argues that research is needed in the areas of mental health crisis call outcomes with respect to number of arrests, pathways to mental health services, family-level outcomes and system-level outcomes (p. 166).

In general, the consensus of scholars studying police interactions with persons in mental health crisis needs to shift away from officer attitudes and perceptions of persons with mental illness toward evidence-based call outcomes. In addition, larger sample sizes and multi-site comparisons are needed before generalizations may be considered. Finally, as little is understood about how CIT is implemented in various jurisdictions and if, how, and why, the CIT model is adapted to meet local needs, more in-depth contextual analysis of program management, officer-level outcomes, and patient-level outcomes is sorely needed.

1.4 Theoretical Perspective

In the literature on CIT, little attention has been paid to developing theory or a conceptual framework within which to examine CIT implementation and functioning. Research on CIT, still in its infancy, has focused on officer attitudes towards and perceptions of persons suffering from mental illness. Currently, researchers advocate a shift away from this limited focus toward a larger focus on the context of CIT and resulting outcomes. In two separate articles, Watson et al. (2008) and Morabito (2007) provide a base conceptualization of how research might move in this direction.

Watson et al. (2008) provide a conceptual framework to analyze the "broader contextual forces that may shape implementation and outcomes" (p. 362) of police response to persons in mental health crisis. They provide a multi-level conceptualization

of an organizational model which connects contextual factors of crisis intervention to police intervention outcomes. The main components of the model (see Figure 1.1) include officer characteristics, officer's CIT training status, availability and perceptions of community treatment linkages, organizational factors including saturation and champions, community characteristics including social disorganization and crime rates, and resulting encounter outcomes (Watson et al., 2008, p. 363). They suggest that all of these factors play a large role in determining the effectiveness of a CIT program.

Figure 1.1 Conceptualization of effectiveness of CIT (reproduced from Watson et al (2008), p. 363)
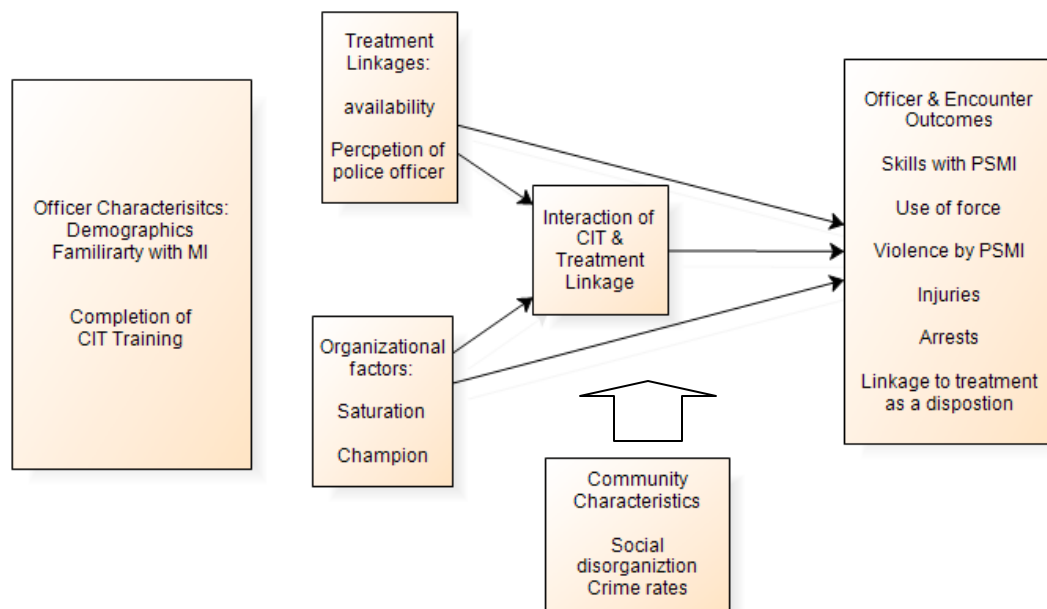
Watson et al. (2008) argue there may be specific officer characteristics that enhance crisis intervention outcomes. Of possible import are officer demographics, prior training, familiarity with mental illness and completion of CIT training (p. 363). Also important to the model is the level of CIT trained officer saturation (defined as the optimal number of CIT trained officers) in the department. It is hypothesized in the literature that 15 to 25% of the police departments officers be CIT trained; however, this

saturation level has yet to be empirically substantiated (Watson et al., 2008, p. 364). In

conjunction with the saturation level, Watson et al. argue that a key element in the

implementation of a new CIT programs is the presence of a champion. A champion of the

program may aid in motivating officers to participate in the program and see value in the

training and response alternatives (p. 364).

Watson et al's model of program effectiveness also identifies the importance of

cooperative linkages between the police department, medical and psychiatric treatment

facilities, and community members. They suggest that the availability of alternatives to

arrest (i.e. transport to a hospital) and the officer's perception of the viability of these

alternatives will impact the officer's decision-making process during encounters

involving persons in mental health crisis (p. 364-365). Other research confirms the

import of officer's perceptions of the organizational linkages and the effectiveness with

which these linkages function (Laberge & Morin, 1995; Morabito, 2007; Rogers, 1990;

Watson et al., 2008). According to Laberge & Morin's (1995) summary of available

research, officers' decisions to engage alternative options to arrest are highly affected by

the efficiency and effectiveness of those alternatives. For instance, an officer's decision

to arrest rather than instigate a treatment outcome may be affected by irritants including

long waiting periods at the hospital, complicated admissions procedures, questioning of

officers' judgment by medical staff, refusal of referrals, and ineffective treatment

outcomes resulting in a 'revolving door' in and out of the treatment facility (p. 402).

Rogers (1990) reported a similar problem indicating that officers receive very little

organizational back-up. The Memphis Model of CIT is designed to promote cooperative

linkages between treatment facilities and police departments and to address the problems

that officers face when attempting to instigate alternative options to arrest. While CIT program proponents have asserted that the CIT program strengthens organizational linkages and reduces officer irritants, no empirical study of the effect of these linkages on encounter outcomes has been conducted to date.

Morabito (2007) provides another conceptual framework that may be applicable to examining CIT. Morabito (2007) argues that Egon Bittner's (1967) framework of "horizons of context" may be useful in evaluating the decision-making process of police in crisis intervention encounters and the effect of the CIT program on those decisions (Morabito, 2007, pp. 1583-1585). The "horizon of context" framework consists of three parts: the scenic horizon, the temporal horizon, and the manipulative horizon.

The scenic horizon suggests that there may be a normal baseline of deviance that a community is willing to tolerate; this baseline of acceptable deviance will vary by community. In the context of encounters with persons with mental illness, a community may tolerate a certain amount of 'deviant' behavior before considering it to be a problem warranting police or medical intervention. The definition of what situation warrants intervention may be shaped by community and police and medical organizations. Morabito (2007) states that decisions to intervene in a situation are often shaped through community preferences (p. 1584) and may be heavily influenced by organizational linkages to services. Morabito (2007) describes the issues related to organizational linkages similarly to Watson et al. (2008) in that officers' perceptions of those linkages are important to their function and effectiveness. This suggests that the contexts in which police officers encounter mentally ill persons may be important to responses.

The second component of the theoretical framework is the temporal horizon. This horizon includes factors such as the officers' demographics, officers' inclination toward empathy versus cynicism, and the subjects' demographic and geographic characteristics. Similar to Watson et al's (2008) model, Morabito (2007) contends that the officers' age, gender, education and experience may affect whether they empathize with persons suffering from mental illness and may thus be more likely to accept alternative methods of responding to mental health crisis calls. In contrast, officer characteristics may sway attitudes toward cynicism where the officer may not empathize and may see little advantage in the available alternatives. In addition to the officers' demographics, the subjects' demographics may affect officer decision-making; officers' decisions may be affected by the subject's age, appearance, or knowledge of failed prior treatment.

The third component of the theoretical framework is the manipulative horizon. This horizon includes concern for community safety and elements of the mental health crisis call, including the severity of the situation and the subject's immediate behavior. Morabito (2007) suggests that officer decision-making options may be severely restricted due to the severity of the crime committed or the immediate or immanent violent behavior of the subject. Other variables in the manipulative horizon that may come into play are the officers concerns over time and efficiency with which the call may be completed and whether alternative resources are available to solve the current crisis. Watson et al's (2008) and Morabito's (2007) conceptual frameworks include remarkably similar characteristics, except in one area. Morabito's framework includes factors related to the crisis call; for instance, the manipulative horizon takes into consideration the

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severity of the call, safety of the community, and the subject's behavioral characteristics. In Watson et al's model, the influence of mental health crisis call characteristics is absent.

Combining Watson et al's model and Morabito's crisis call characteristics provides a power conceptual model for analysis (see Fig. 1.2). The adoption of this overall framework of analysis will provide a "powerful basis from which to explore police response to people with mental illness" (Morabito, 2007, p. 1586), the effects of the CIT program, and the community and organizational context in which the program was implemented and managed.

Figure 1.2 Conceptualization of CIT with addition of influence of Crisis Call Characteristics
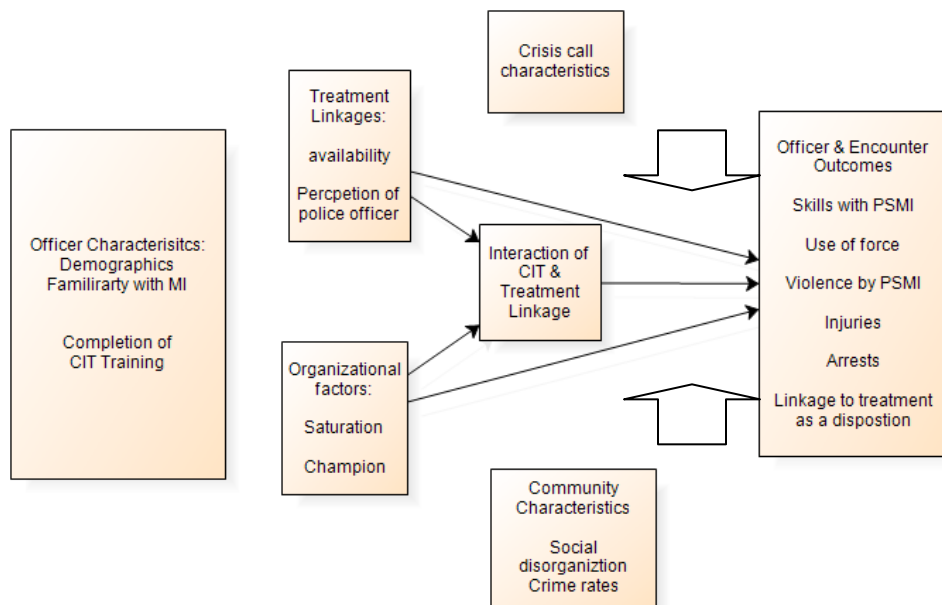
1.5 Summary

While the Memphis Model of CIT training was established over 20 years ago, there is very little research establishing whether the program is effective in meeting its goals and objectives. Anecdotal evidence and limited research suggests that CIT training

is effective in (1) reducing arrests, (2) reducing injuries to both officers and subjects, and (3) increasing the utilization of immediate detentions in a hospital. Much of the research supporting these claims lacks control groups, comparisons between CIT and non-CIT trained officers, or pre/post CIT implementation. Therefore, the claims made about CIT program effectiveness have yet to be fully tested.

According to the research on program comparisons, the Memphis Model appears to be more effective than other programs or response strategies in facilitating mental health treatment alternatives to jail. However, research suggests that disparate response strategies, such as pre- and post-booking programs intending to diverting subjects with mental illness from jail to a hospital target different populations. While CIT clearly targets the population of persons with mental illness, it is unclear whether CIT targets cases that would have resulted in arrest or hospitalization regardless of whether the officer received the specialized training. It is possible that CIT may predominantly target cases where arrest would not be the primary response, for example, cases of suicide attempts or threats. Thus, it is unclear whether the Memphis Model of CIT or other adapted models change the way in which officers resolve cases through arrest or mental health alternatives.

There is conflicting evidence on whether the CIT program is effective in reducing arrests and subsequently increasing the use of mental health alternatives. The Albuquerque, New Mexico study indicated that fewer than 10% of cases resulted in arrest. The Las Vegas, Nevada study reported that 4% of subjects were arrested. The Akron, Ohio study suggests that CIT officers might actually arrest subjects more often than non-CIT trained officers. Given the limited and conflicting evidence on arrest rates,

it is challenging to state with confidence that CIT is actually the cause of these low arrest rates. As noted above, there are no comparisons between CIT and non-CIT trained officers' responses, and there is potential that CIT calls in general would not typically result in arrest regardless of the officers CIT training status.

Officers' perceptions of mental illness have been the focus of most of the research on CIT.   The predominate methodology utilized in research on officers' perceptions of mental illness includes the use of officer training surveys, officer responses to vignettes and officer survey data. These methodologies, while producing informative results, are limited in that they examine hypothetical events and potentially biased self-report data.

One of the goals of the CIT program is to increase officers' abilities to recognize mental illness. There are conflicting reports regarding whether a label of mental illness affects an officers response. A 2004 study suggests the label of mental illness does not affect officers' responses; two other studies contradict this report suggesting that the label does matter, especially the label of schizophrenia and its effect on perceptions of dangerousness. Limited research suggests that CIT may strengthen officers' ability to recognize mental illness, but it is unclear if, and how, effective CIT training is in increasing recognition due to the lack of significant research utilizing control or comparison groups.

The paucity of research, the conflicting results of available reports, and the use of non-quasi-experimental data does not provide substantial support for the anecdotal claims of CIT program effectiveness. Research needs to shift away from vignettes and survey methodology towards quasi-experimental research with control or comparison groups. In addition there is need for contextual analysis of CIT programs to examine various CIT

models including if, and how, they are adapted to meet local needs, and, subsequently,

affect officers' responses to and resolutions of mental health crisis calls.

1.6 Research Questions

This study provides an intensive case study of the Bloomington Indiana Police Department's CIT program and the community context in which this program functions. The first part of this case study examined the CIT implementation process and subsequent management of the program. The second part of this case study analyzed data from officer-completed incident response sheets to examine the effects of CIT training on mental health crisis calls. This two part study addresses the following main questions:

- What was the program implementation process; how, why and by whom was the CIT program adapted to address specific community needs?

- What community and organizational linkages arose due to the implementation of CIT and how are these linkages perceived by stakeholders.

- Does CIT training affect how officers respond to and resolve incidents involving persons in mental health crisis? Are there differences between CIT and non-CIT trained officers?

Utilizing interviews and focus groups this research focuses on conceptualizing and analyzing the broader contextual forces in which the Bloomington CIT program functions. In addition, the study examines the effect of CIT training on crisis call outcomes.

Chapter 2: CIT Implementation

2.1 Research Setting

Bloomington, located in the county seat of Monroe County, sits in the southern region of Indiana. The city of Bloomington was established in 1818 with approximately 30 families settling the area. Shortly after, in 1824, a state seminary opened, with an enrollment of 10. This seminary subsequently transformed into Indiana University, which currently has enrollment levels just over 40,000. The college town environment brings diverse art and culture to the city. The Jacob School of Music holds the Opera Theatre and public performances numbering over 1000 each year. The Buskirk-Chumley Theater is a community theater which holds over 200 public performances each year. In addition, Bloomington is known for the Lotus festival of World Music which draws musical artists from around the world. Bloomington is also the home of the Ganden Dehling Buddhist Temple.

In addition to the establishment of the seminary, early growth in the area was spurred by the arrival of the New Albany and Salem railroad in 1854. The arrival of the railroad brought commercial establishments such as hotels, an iron foundry and cabinetmakers. Bloomington was also a way station on the Underground Railroad during the Civil War. By 1900, Bloomington was home to prosperous industry including a limestone quarry. The Sanders Quarry is famous for its high quality limestone and has been used in buildings such as the Empire State Building, The Pentagon, and was used extensively in Chicago's rebuilding after the Great Chicago Fire. This quarry reached popular fame from the 1979 film *Breaking Away* where the main character and his friends swam in the local quarry. Today, Bloomington has a strong industrial presence with

major employers such as Baxter BioPharma Solutions, Cook Group Incorporated,

General Electric, Hoosier Energy, and Otis Elevator (see Bloomington Tourism Center).

According to the U.S. Census Bureau, the population in Bloomington in 2000 was

69,291. The racial makeup of the city was 87% white, 4.2% black, 5.3% Asian, 2.5%

Latino or Hispanic, and 1% other. Of those 25 year or older, 16.3% are high school

graduates, and 54.8% have a Bachelor's degree or higher. The per capita income (1999)

was $16,481, with 29.6% persons below the poverty line.

According to an online article, titled *History of BPD* by Officer Lloyd Hawkins,

the Bloomington Police Department (BPD) was established in 1899. Beginning in 1910,

BPD police officers wore uniforms for the first time and the current officer badge still

resembles the original 1910 badge. The BPD purchased its first police vehicle in 1916

and its first motorcycle in 1922. From 1958 to 1973 the BPD was responsible for the

ambulance service. Police officers, while not trained as medics, operated the ambulances

until the service was taken over by the Bloomington Fire Department. In 1987, the BPD

established its first organized field training program.

Currently, the BPD employs 92 sworn officers and 36 civilian employees. BPD

has a Critical Incident Team, which handles hostage and emergency situations, a K-9

unit, and participates in a multi-jurisdictional Dive Team. BPD also cooperates with the

Indiana University Police Department and the Monroe County Sheriff.

In 2005, the Monroe County Criminal Justice Coordinating Council began

investigating CIT training and whether the program might benefit the police and

community. The BPD agreed to implement the CIT program, established a CIT

committee, and had the Field Training Officer conduct the first CIT training session in

June 2006. Approximately 53% of the BPD police force received CIT training as of April 2009. In addition, dispatchers, emergency first responders, and officers from surrounding cities, such as Ellettsville, have attended BPD CIT training sessions. Indiana University Police and the Monroe County Sheriff's departments were invited to participate in training but declined.

The Captain of the BPD and members of the CIT committee decided that a research agenda was important to the implementation process. This chapter focuses on the implementation of CIT in Bloomington and examines the wider community context within which the program functions and is further managed.

2.2 Methodology

The following description and analysis of the process of implementing the CIT program draws on interviews and focus groups between June and August 2009. Information from the interviews and focus groups was subsequently organized, coded, and analyzed with NVivo 8 (a qualitative software program). The purpose of this analysis was to provide a description of the CIT implementation process and to examine the community context in which the program was established and now functions.

Everyone who could be identified as having taken part in the initiation, planning, and subsequent implementation of CIT training was interviewed. These stakeholders included the BPD Police Chief, the BPD CIT Coordinator, members of the BPD CIT Committee (which include representatives of the National Alliance on Mental Illness (NAMI)), Bloomington Hospital administrators and physicians, Center for Behavioral Health representatives, members of the Monroe County Criminal Justice Coordinating Council, and police administrators. The purpose of these interviews was to gain insight into the stakeholders' opinions about the CIT implementation process.

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I conducted the interviews face-to-face with the stakeholders at a location of the stakeholder's choosing. Four interviews were conducted in private conference rooms or offices at the police station, one was conducted at a local Starbucks, one was conducted at a local deli and the remainder (4) where conducted in the interviewees' private offices. The interviews were semi-structured utilizing an interview schedule. The interview schedule was predominately followed during the interview; however, the method did allow for deviation from the scheduled topics allowing for natural conversation between the interviewee and myself (see interview schedule included in appendix B).

Focus group subjects (police officers who had completed the BPD CIT training) were contacted via a verbal request by the BPD CIT coordinator. The coordinator asked eight CIT trained officers to participate in each session. Eight officers (two female and six male officers) participated in the first focus group. For session two, five officers agreed to participate; all the participating officers in this group were males. The focus groups were held in a private conference room at the BPD headquarters on June 6 and June 11, 2009. The BPD CIT coordinator and other BPD administrators were not present during the focus groups.

In theory, the focus groups were designed to allow officers to converse on topics they found pertinent and to allow their conversation to transpire with little interjection on my part, though if there was a lull in conversation, I had at my disposal a schedule of questions to get the conversation rolling again. In practice, conversations did not flow naturally. Rather than a fluid conversation between participants, the officers relied on me asking questions and then their providing a response, with limited conversation between the participants. This was especially true for session two, where the atmosphere was

rather hostile, as the officers appeared rather unhappy about participating. Thus, session two followed the schedule of questions almost exclusively. Participants in session one conversed among themselves more so than did the session two participants; thus, session one was more "spur of the moment," resulting in conversation of interest to the officers and providing contextual information that was not prompted by my questions.

In addition to the focus groups and interviews, I reviewed the CIT training materials and sat in on training sessions. Reviewing and analyzing the training program helped me place comments from the focus groups and interviews in context. Moreover, the training evaluation allowed me to document how the BPD's training differed from the Memphis Model and provided contextual information about BPD's decision to deviate.

2.3 Implementation

In order to explore the context within which the CIT program was implemented, I was interested in why stakeholders thought a CIT program was necessary to begin with. Thus, the first question posed to the focus groups and the interviewees was "Prior to the implementation of the CIT program, what was the main problem you think the police department faced when dealing with mental health crisis calls?" In response, police administrators said that they did not think that BPD had many problems with the way officers responded to calls. As one interviewee responded, "I'm not sure we necessarily had a lot of problems. Our officers did get some training prior to CIT on mental illness and how they were supposed to react and respond." Although police administrators did not believe that officers' responses were a problem, they did believe that the Department had a communication problem. The main problem they believed they faced, and the main reason that they decided to implement the CIT program, was that they believed that community members did not understand what police officers 'do' or how they typically

handle mental health crisis calls. This misperception, in their view, resulted in

community criticism and political pressure for the police department to 'do something'.

One police administrator explained,

> What got us into CIT were outside forces pushing that we get CIT training. Our
> department trains more than any other law enforcement department in the county.
> We had protocols and policies in place already on how to respond to people with
> mental illnesses. But, because we are the largest [policing agency in the area] thats
> where the [community and political] focus shifted to. They [the Monroe County
> Criminal Justice Coordinating Council] wanted us to do it and there was a lot of
> pressure. We maintained for a long time that we had already trained in this and that
> we didn't have a problem.

Latent dissatisfaction coalesced into vocal criticism with an incident that occurred

on November 6, 2003, when a mentally ill man was arrested, taken to jail, and then

Tasered during an altercation at the time of booking. The man, who had a heart

condition, died. According to police administrators, some members of the community

raised the question of why the man had been taken to jail instead of the hospital

(stakeholder interview).

As this incident brought issues of mental health and criminal justice to the

forefront of political concern, members of the Monroe County Criminal Justice

Coordinating Council and other community stakeholders, including the prosecutor's

office, started investigating what one stakeholder described as "the problem of police

intervention." This scrutiny revealed the second problem that BPD faced, that is,

according to police administrators, when dealing with mental health crisis calls, not all

agencies were working together or operating "on the same page," when it came to mental

health crisis calls. Police administrators identified one of their main problems was the

lack of cooperation by Bloomington Hospital, the only local hospital with emergency

services for psychiatric cases. This lack of cooperation was later identified as resulting

from a lack of communication between BPD and hospital administrators and a lack of agreement on policies and procedures for officers bringing subjects to the hospital.

Officers in the focus groups identified the hospitals lack of cooperation as their main problem in dealing with mental health crisis calls. One officer stated, "The main problem I faced is the lack of the hospitals cooperation in taking subjects and, when they did accept them, I'd have to wait five or six hours for an evaluation to be done." Many of the officers echoed that they had experienced similar long waiting periods and also encountered negative attitudes from physicians.

From police administrators' point of view, the hospital was a large problem for the Department because there was no policy or procedure in place for officers to instigate an immediate detention, also called a 24 hour hold. In addition, the hospital did not have dedicated rooms in the emergency department where an officer could take a subject for evaluation; nor were there security measures in place at the hospital to handle these kinds of situations. The lack of dedicated space and hospital security resulted in officers waiting for long periods in the emergency room before the subject was evaluated by a physician. Hospital administrators confirmed that "the hospital's policy was that if an officer brought in a subject for evaluation the officer must stay with the subject for security purposes."

Officers also indicated that they were often reluctant to take a subject to the hospital because they felt the hospital would not admit the subject to the psychiatric ward; rather, officers perceived that the hospital would evaluate the subject and immediately release them. Thus, officers in the focus group unanimously agreed that they would often be called back the same night to deal with the same subject. They

expressed their frustration over the lack of physicians' willingness to accept and admit subjects they thought were in need of medical or psychiatric help.

One mental health advocate stated that "discovering all of these things galvanized the community and gave an opportunity for family members to express their discontent with the police and the hospital." She stated that these issues were not new, but there was no forum in which community members could express the problems they were having. Thus, "when the man was Tasered and died, we were afforded an opportunity to voice our concerns to persons in authority who might actually be able to do something about it." She went on to say that she knew many people in the community who felt concerned about "the lack of care that we have for individuals with mental illness" and that she knows many people that have had "run-ins with the police." This advocate shared her personal experience saying, "In fact, I have a brother who is schizophrenic, and I know how difficult it is to communicate with the police." She expressed that she was frustrated that officers would not utilize 24 hour holds as a mechanism of getting subjects into the hospital. After discussions with police administrators during CIT implementation meetings, she realized that the problem in getting people treated was really a problem with the hospital.

Another mental health advocate agreed, stating that the main problem the police department faced was a poor relationship with the hospital. She stated, "I think the hospital is the weak link. Not having someone come down and do an assessment quickly enough so that officers cannot be back on the beat I think is totally ridiculous." This advocate was very vociferous and adamant that the problem was not with the police, but with the hospital. She went on to say,

> The hospital is totally resistant. They are resistant to quality treatment of the psychiatric population. And, I think the people in charge at the hospital should be fired and move on. I believe that firmly. I have said it to their faces, and I would say it again to their faces. It is irresponsible that the hospital is the weak link.

Another third mental health advocate echoed this sentiment stating, "It behooves us as a community to try and monitor what's happening in our institutions and demand the best."

As these issues galvanized several members of the Monroe County Justice Coordinating Council and other community mental health advocates traveled to Fort Wayne, Indiana to examine the Fort Wayne CIT program in hopes that it might offer a solution to this community problem. One advocate described,

> We drove with some of the Fort Wayne officers to get their perspective on how things were working up there. We also went to a clubhouse, like a hanging out place for kids. They said that the way the police did things that it was very seldom that someone would end up in jail, especially those who would have been better placed in the hospital. It made a lot of sense, you know, because we don't want things to escalate. So, we came back here [Bloomington] and created a little task force, which I served on, and then got the police and others involved with bringing CIT to our community. [Once the task force was formed] we met for quite awhile, ending gradually, and I think rightfully so, with the police taking over and implementing the CIT program.

As the BPD began the implementation process, police and hospital administrators, reached an impasse with the hospitals refusing to conduct 24 hour holds when requested by police officers and their refusal to change hospital security policies with respect to officers bringing subjects in for evaluation. A mental health advocate and member of the CIT committee described the impasse stating,

> We just couldn't figure out a way. The hospital was resistant because they thought they would become the de facto dumping ground for anyone the police didn't want to deal with. So, we had an unusual situation where everyone but the hospital agreed that CIT would be good for our community, that we wanted police to receive this training and we wanted to try and improve the way mentally ill persons were treated in our community—but we would have to do it without the cooperation of the hospital.

One hospital administrator countered that,

> The only component that the hospital had been resistant to was that they had concerns about security. There were concerns that if an individual was brought in to the emergency room and the law enforcement officer left immediately and they became the hospital's security issue, what do we do if this guy checks out ok? If that person does not meet the legal criteria to be admitted, and it was really more of a criminal matter, then what? So, there were some discussions at that point between law enforcement, behavioral health professionals, and hospital security.

This administrator went on to say that,

> Many of our concerns were internal to the hospital process. Some individuals thought that if there was a psychiatric issue the officer should bring the subject directly to the [psychiatric ward] and bypass the emergency room altogether. Others were against this saying that the first response should be a medical evaluation as well as a psychiatric evaluation so the emergency room was the appropriate place for officers to bring subjects. So, you see, there were internal things going on that community members did not know about and it then appeared as if the hospital was resisting the CIT program. It is my opinion that when the whole process began there was not an adversarial relationship between the hospital and the police department. There just had to be a lot of changes and that takes time. I can see where there were adversarial overtones to it, but we needed to work through what was going to work for us as well as what was going to work for the police.

In addition to the tension between the hospital and the police department, there was community contention about BPD's choice to adapt the Memphis Model of CIT training. Police administrators felt that there "was a lot of fluff" in the Memphis Model training and that it would not fit the needs of the community. The Memphis Model of CIT training was designed for a large city, with multiple hospitals and other service organizations. Police administrators decided that while the Memphis Model might be working in Fort Wayne, there was little evidence to suggest that their training program was really any better than other training strategy. The CIT committee examined several different departments' training programs, which claimed to follow the Memphis Model of

training, but found that all were different and had been adapted to meet the needs of the individual police department and community.

As the literature review indicates, there is no standard Memphis Model CIT training. Moreover, there is little research to support the claim that the Memphis Model is effective in reaching its goals and objectives. Dupont, Cochran, and Pillsbury (2007) published a web document that outlines the core elements of the Memphis program, but includes little about specific content. Even this outline, however, was not published until a year and a half after Bloomington implemented its CIT training. Thus, many programs that purport to follow the Memphis Model may be adopting the core elements but filling in the blanks to fit the needs of the local community just as the BPD decided to do.

Nonetheless, community mental health advocates were concerned about BPD's decision to deviate from Fort Wayne's model of training. This concern arose, in part, because Fort Wayne's training claimed to be fully faithful to the Memphis Model and local mental health advocates touted Fort Wayne as the exemplary city. Instead, BPD's administrators chose to incorporate what they thought were the essential elements of the Memphis training model, but made changes with respect to hospital site visits for officers, role-playing during the training, and who among officers should be trained. In adapting the training from Fort Wayne, the BPD administrators decided to eliminate the site visits to the hospital. They made this change because there was only one hospital, which was not cooperating, and because all of the officers were familiar already with the hospital; thus, they saw no need to waste a full day of training.

The second area in which the BPD deviated from the Memphis Model was in replacing the role-playing exercises with contact exercises. In the Fort Wayne training,

officers were asked to role-pay encounters with hypothetical characters who were mentally ill and in crisis. The contact exercises that replaced role-playing consisted of small group discussions in which officers would read a scenario and then, as a group, decide the best way to approach the situation and how to best incorporate some of the new tools they had learned in the training. The exercise was similar to role-playing, except for the actual re-enactment of the scene in front of fellow trainees.

Most of the officers in the focus groups said they were thankful that they did not have to conduct role-playing exercises and felt the contact exercises accomplished the same goal, although these sentiments were not universal. One officer stated, "I think role-playing exercises would have been a better application. I think we did not get enough time to practice the new tools we had learned. I would have liked a little more application of the ideas." A few other officers chimed in that, if they were rookies, then role-playing may have been beneficial. However, because most of them were veterans, they felt that role-playing would have been a waste of time because they had already experienced so much of the "real thing on real crisis calls." The consensus was expressed by one officer's rolling his eyes and stating, "I don't want to do role-playing. It is not beneficial."

As time passed, many of the concerns about BPD's adaptations in training content evaporated. Many mental health advocates and members of the Monroe County Criminal Justice Coordinating Council stated they were no longer concerned about BPD's adaptations of CIT training once they saw that police officers were open to the idea of learning more about how to handle mental health crisis calls. One interviewee discussed

a case that happed before the implementation of CIT, where she had been reluctant to call

police. In this case, a woman was

> [V]ery, very paranoid and by herself in her home. She barred the door and would
> not let anyone in. When the police arrived they would just do this series of
> escalating actions that would make her more paranoid and become more and more
> resistant. However, after CIT, we can now feel more confident that officers are not
> going to escalate the situation and will have a treatment outcome as the primary
> goal.

Most of the interviewees agreed that the BPD had made appropriate changes to

the training program. By the time of the interviews, three years after the implementation

of CIT, most felt that adapting the program had been good idea. One police administrator

likened the idea of adapting the CIT program to progress made on automobiles. He

stated,

> I don't see a problem with that at all. As a matter of fact, I think the parallel that I
> would draw to this is that anything that was developed and made it has a lot of work
> that goes into it to get it up and running. We should always look at improving it.
> The parallel that I'll run is with the automobile. How far would we be behind if we
> were still operating vehicles that were made a decade ago? Clearly somebody saw a
> need, and saw that some of the changes were needed and were really great. So let's
> keep the ball rolling. Let's improve on it. Let's continue to make it better. I think
> we should always, always try to make it better. I don't think anyone should be put
> off that we looked at the Memphis Model and said, 'Hey, this is a great thing but
> let's improve upon it.'

In addition to the changes made in CIT training content, BPD decided to train all

of their officers, rather than a few volunteer officers. A police administrator explained,

> I said look, I understand that the goal of the Memphis Model is to get officers who
> want to do it. So, my argument to people is that if I had a whole department that
> didn't want to do it [take the training] should we not do it? So we had officers that
> did not want to go the this training, but we did make them go through the training.
> Those officers responded that they didn't want to do it, but did find that the training
> was really good. It's like anything. You can think of anything you don't like to do
> but there are certain things you just have to do. An officer cannot pick and choose
> the calls they get. If we train them all, they may not like it, they may not like to do
> it, but they have to. At least they have that training so that they can recognize the
> signs; they'll be able to communicate and they might know something about

medication; they might know what resources are available. So it just boggles my mind that there are people that would not want police officers to get this training. And we did [train everyone], we took a lot of heat over that point. It became a hot political issue. The activists made it very public. The Mayor, it was very nice, we had the Mayor's total support for what we thought would be best for the department. He was even surprised that there were people that were critical of us that we would train everyone. That just doesn't make any sense. And really, that's such a huge impact on resources for us to do that. But, it's important enough because you just never know when you might encounter someone that's in the middle of a crisis.

While some community activists still believe that in order to have a "true CIT model, you can only train volunteer, veteran officers," most mental health advocates and mental health professionals now applaud BPD for expending the resources to train all officers. Indeed, having trained all BPD officers has, in the eyes of one advocate highlighted another problem: BPD is the only policing agency in the area to complete CIT training. The Monroe County Sheriff and the Indiana University Campus Police Department have not participated in CIT training. Although these agencies were invited to participate in the BPD training, they declined the invitation. The advocate stated that because of the success of BPD in training almost all of its officers "we are now telling everybody that if you've got a problem you should call 911 and ask for a CIT officer." But because only city police are receiving this training people are calling in from the county or to campus police, asking for a CIT officer to come, and being told from the dispatcher that they have no idea what CIT is or what the caller is talking about. The advocate stated,

The reality is that it's [the possibility of getting a CIT officer] only true for people in the city and not for people in the county. It's a problem because people are not aware of this and it's causing a lot of confusion. So, there is a major communication and linkage problem.

While this linkage problem has yet to be solved, both the focus group members and the interviewees talked about other institutional linkages The discussions focused on

the successful linkages made between the police department, the hospital, and other community service agencies. The consensus was that CIT was directly responsible for establishing communication between institutions, for establishing effective processes that involved multiple agencies, and for changing stakeholder attitudes from negative to positive.

The most important linkage that CIT established was with the hospital. Prior to and during the early stages of implementation, the police saw the hospital as uncooperative. However, as time has passed, communication between police and hospital administrators improved and policies and processes acceptable to both agencies were implemented. For instance, one of the early contentions was that the hospital would not accept officers bringing in subjects for a 24 hour hold. According to Indiana Statute IC12-26-4, law enforcement officers have the authority to transport an individual with a mental illness who is considered dangerous and in need of immediate hospitalization and treatment to a medical facility where the person may be detained for up to 24 hours for medical evaluation. Police administrators brought this statute to hospital administrators' attention, and then worked with them to establish effective processes for accommodating officers' legal authority to bring subjects to the hospital.

Hospital administrators acknowledged their resistance to the immediate detention policy was that it was an internal security problem for them. At the time of BPD's implementation, the hospital had not worked out its internal processes for where police should bring subjects (the psychiatric ward or the emergency room) and had not completed discussions with hospital security on this issue. In addition, there was concern

over issues of paperwork and what legal information was needed to complete a 24 hour hold.

At the time of the interviews, three years after implementation, it appeared that these problems had been worked out. The hospital now has a separate designated room that they call the "quiet room," where officers can bring subjects in for evaluation. The agreement between BPD and the hospital is that police officers are required to stay for 15 minutes; emergency room physicians have 15 minutes to respond to the quite room to conduct an evaluation and make a determination if the subject will be admitted. If an emergency room physician cannot respond within 15 minutes, hospital security is suppose to take over allowing the police officer to return to their duties on the street.

Officers in the focus groups indicate that the process of immediate detentions at the hospital has been an extremely useful tool and the process has been effective. Officers indicated that rather than spending 5-6 hours in the emergency room "baby-sitting" they can now get out of the hospital in one hour or less—including time to complete all the paperwork.

Officers also indicated that the attitudes of physicians have improved. One officer described the improvement saying,

> There is definite improvement in the way the hospital is in that it has led to a different attitude for physicians and officers. I know before the attitude of physicians was definitely, if you can take them to jail do that and for God's sake don't bring them to the hospital. But now, because of the hospital change, that whole attitude has changed. Now it's not the black hole that you never come back out again. It's like my case for example, I'm thinking along the lines of okay, I can talk to the doctor here now, and he can say, let's do this, let's do that. I might not have thought that way several years ago. So, I think if nothing else CIT has changed a lot of attitudes about the way we deal with people. I don't think the jail first attitude is necessarily there any more as it might have been at one time. You know, in the past, the jail was 15 minutes and you are back out on the street and the hospital was three or four hours. So, you know, which one would anyone choose?

Because of CIT, the choice is now clearly to go to the hospital because you can get in and out quickly and with better responses from the physicians and staff.

Hospital administrators agreed that the mechanisms in place for communicating with the police department and for handling subjects that officers bring in has greatly improved due to the CIT program. One hospital administrator explained,

We know we can communicate with the police through the Monroe County Criminal Justice Coordinating Council meeting every other month. And, police administrators know they can call any time if they have an issue. In a lot of ways, the process has been streamlined for everyone. I think that the difference is that when field officers haven't received any training, I think it hinders the assessment because of the language, the lingo; those officers who have been through the training…the communication between them and the emergency room staff seems to just go smoother. We are now seeing this to be a problem for officers from other counties that have not had the CIT training. The hospital staff expects the officers to know and understand the lingo and know the new processes. Officers from other counties are now at a disadvantage and hospital staff gets frustrated dealing with them.

The interviews and focus group discussions indicated that CIT improved the hospital staff and police officer attitudes toward dealing with cases of mental health crisis and improved the processes by which cases are handled and people treated. Through the implementation of CIT, police administrators were able to satisfy community and political pressure to 'do something.' They were also able to establish linkages and improved communication with the hospital. This resulted in officers indicating that they are happy with the reduction in time that it takes to conduct an immediate detention, and therefore, are more willing to take a subject to the hospital.

Hospital administrators and physicians appear more cooperative and willing to work with police officers when they arrive in the emergency room. They also suggest that, due to the implementation of CIT, that internal hospital processes have been improved. They also are happy with the improved avenues of communication to the

police department and the Monroe County Criminal Justice Coordinating Council.

Community mental health advocates are happy as well with the results of the

Bloomington model of CIT training and the overall implementation of this program.

Chapter 3: Crisis Intervention Team Incident Outcomes

3.1 Purpose of CIT Outcomes Study

The purpose of this study is to examine officers' responses to calls involving persons with mental illness. The objectives of the CIT program are to help officers recognize symptoms of mental illness, increase their use of mental health alternatives to arrest, and increase officer safety. Thus, the specific research questions are:

- Does CIT training affect the frequency with which officers report persons as having a mental illness?

- Does CIT training affect how officers respond to and resolve incidents involving persons in mental health crisis?

- Is there a difference in how CIT-trained and non-CIT trained officers resolve incidents involving mental health crisis?

3.2 Methodology

Information on officers' responses to mental health crisis calls come from data collection forms (CIT Statistics Sheet, version 3, see appendix) that were completed by officers immediately following any incident in which they came into contact with a person the officer believed suffered from a mental illness. Officers came into contact with subjects in various ways; most incidents involved officers being dispatched to the scene and some incidents involved officer observation or the subject making a complaint at the police station. The BPD dispatch procedure did not identify particular calls as mental health crisis calls; thus, normal dispatch procedures did not change due to the implementation of the CIT program. Rather, officers were dispatched to all calls following normal procedures, regardless of their CIT training status. This is different from some CIT programs where dispatchers identify a call as a mental health crisis and specifically dispatch a CIT officer. The BPD procedure of dispatching officers regardless

of CIT training status and not directly identifying an incident as a mental health crisis or CIT call meant that officers directly identified calls as involving a mental health issue and officers self-selected to complete a CIT statistics sheet.

Between June 28, 2006 and April 20, 2009, BPD officers completed 668 CIT statistics sheets. The variables measured with the CIT data collection form include such information as the officers CIT training status, demographic information for both officer and subject, the nature of incident, whether threats, violence or weapons were involved, prior contacts, drug or alcohol involvement, medication compliance, complainant relationship, behaviors evident at time of incident, techniques and equipment used to control the situation, injury during police intervention, officer perceptions of symptoms and behaviors, where and by whom the subject was transported, and the case disposition. A full list of variables can be found in appendix C. Because one limitation of previous research has been the lack of comparison between CIT and non-CIT trained officers, the data collection form included the officer's CIT training status, enabling comparisons between CIT and non-CIT trained officers who were willing to complete the CIT data collection forms.

3.3 Officer and Subject Demographics

The Bloomington Police Department (BPD) employed 92 sworn officers, including 80 male and 12 female officers. The racial make-up of the sworn officers was 86 Caucasian, 4 Black, 1 Hispanic, and 1 Asian. Approximately 53% (n=49) of the BPD officers received CIT training as of April 2009. The minimum length of time CIT trained officers were employed by BPD was 1.41 years and the maximum was 33.46 years, with an average number of years employed of 12.39, with a standard deviation of 8.34.

Table 3.1

Characteristics of Officers Responding to Crisis Calls		
Variable	N	% calls responded to by:
Officer Demographics		
Age		
0-25	148	26.1
26-29	145	25.6
30-35	121	18.1
36-39	34	6.0
40-45	77	13.6
46-49	15	2.7
50+	26	4.6
Gender		
Male	481	82.1
Female	105	17.9
Race		
Asian	1	0.2
Black	13	2.3
Caucasian	540	94.4
Hispanic	3	0.4
Latino(a)	13	2.3
Other	2	0.3
CIT training status		
CIT trained	322	50.5
Non-CIT trained	329	49.5

Table 3.1 indicates the demographics of officers who responded to the mental health crisis calls. One-half of the calls (51.7%) were responded to by officers between 21 and 29 years old and the majority of the officers were Caucasian males. Approximately one-half of the calls were responded to by CIT trained officers.

Table 3.2

Characteristics of Subjects		
Variable	N	% calls by subjects:
Age		
0-19	44	6.9
20-29	209	33.0
30-39	105	16.6
40-49	163	25.7
50-59	80	12.6
60-69	19	3.0
70-79	11	1.7
80+	3	0.5
Gender		
Male	338	51.3
Female	321	48.7
Race		
Asian	10	1.5
Black	35	5.4
Caucasian	597	91.3
Hispanic	8	1.2
Other	4	0.6

Of the 668 calls, officers recorded the age of the subject in 634 of the incidents.

The range of ages was 13 to 82. The mean age was 36.62 with a standard deviation of 14.

The modal age was 20.

Time Call Received

Table 3.3

Characteristics of Crisis Calls			
Variable	N	Mean	SD
Time call received (time of day)	668	13:10	7.22
Officer response time (in minutes)	475	7	8
Length of call (in minutes)	234	28	5

Officers were asked to record the time they received the call from dispatch and

the time they arrived at the scene.

The average time of call received from dispatch was 13:10 hours with a standard

deviation of 7.22, which suggests the calls were spread out evenly throughout the day.

However, fewer calls were received in the early morning (roughly between 05:00 hours and 10:00 hours) with an increase of activity during the mid-morning to late afternoon. There was relatively few calls received from dispatch during the evening hours with an increase in the late evening (around 22:00 hours).

Officer Response Time

Officers recorded the time they received the call from dispatch and the time they arrived at the scene. The "time to respond" variable was defined as only those calls where an officer had to respond to a scene location other than the police station (there were several instances where a subject walked into the police station and an officer assisted them). In addition, there were several instances where the "time to respond" was calculated as zero. These were excluded from this analysis as it was not clear whether the times recorded were inaccurate or if the officer witnessed the situation so that no dispatching call was issued. Based on this definition, there were 475 cases included in this variable. The average response time for these 475 cases was 7 minutes, with a standard deviation of 8 minutes. The minimum was 1 minute and the maximum was 1 hour 6 minutes. The median and mode were 5 minutes.

Length of Call

The length of call is defined by the time the officer completed the call minus the time the officer arrived on the scene. Officers recorded this information in 234 of the cases. The average length of call was 28 minutes, with a standard deviation of 5 minutes. The minimum length of call was 2 minutes and the maximum length was 5 hours 57 minutes. In sum, the total time spent on the 234 crisis calls was approximately 194 hours. Police spent 100 of these 194 hours "baby-sitting" the subject at the hospital.

Frequency of Police Intervention

Figure 3.1
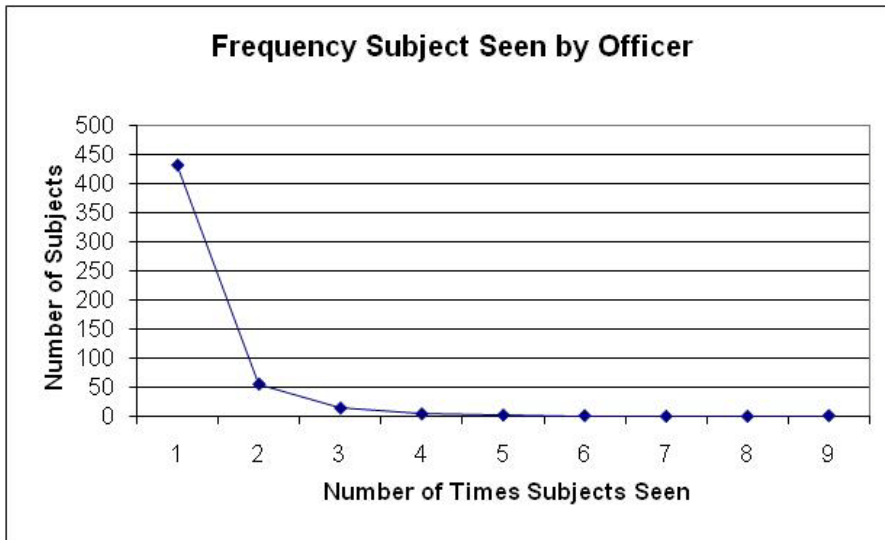
Officers responded to a total of 668 calls that involved mental health crisis or mental health issues between June 28, 2006 and April 20, 2009. There were a total of 516 different subjects; 83.5% (n=431) of subjects required police intervention one time, 10.9% (n=56) of subjects required police intervention twice, 2.9% (n=15) of subjects required police intervention three times, 0.96% (n=5) of subjects required police intervention four times, .058% (n=3) of subjects required police intervention five times, 0.38% (n=2) of subjects required police intervention six times, 0 .19% (n=1) required police intervention seven times, .019% (n=1) required police intervention eight times, and 0.39% (n=2) required police intervention nine times. Thus, approximately 16% of subjects required two or more police interventions. This is four times the rate of what Skeem and Bibeau (2008) found in their study of Las Vegas CIT calls where 4% of subjects required police intervention two or more times (p. 202).

During the focus groups, officers indicated that the mental health crisis calls they responded to involved repeated contacts with the same subjects. However, these data

suggest that most subjects encountered police intervention only one time. Clearly there is a large discrepancy between the officers' perceptions of who they encounter and their reported contacts in these data. When, in focus groups, officers were asked about this discrepancy, one officer suggested:

> Honestly, I think the discrepancy is that the information we have to make a mental detention may be different than the information on a lot of calls that we go to. We may encounter the same person but we may not have enough information to warrant a mental detention, but yet [sic] we may still see the mental issue, but the officer is not filling out the CIT forms on suspicious person calls or whatever types of calls we go to. We may not be filling out the CIT forms every time we see a person with a mental health issue.
> I know from my own personal experience that I have dealt with people who I have done a mental detention on before. I know he has mental issues. Like last night, because of medication compliance and the kinds of problems the subject has, he walks around like a normal person. The problem was that he was drinking, and he was a typical person who was drunk. So, I did not bother to fill out a CIT form despite my knowing that he has mental health issues. However, he was not displaying anything like that [symptoms of mental illness] tonight.

Thus, it appears that despite the instructions to officers to complete a form anytime they came into contact with a person with mental illness, officers were more likely to fill out a form when the particular incident was directly related to a mental health crisis. As the focus group officer stated, he did not complete forms for incidents involving public intoxication or other incidents where the subject did not display outward symptomatic behavior. Other officers in the focus group agreed that they did the same thing. Therefore, it is clear that the data collected only included incidents where the subject was in mental health crisis or the incident was directly related to a mental health issue. Given this, officers reiterated that they come into contact with the same mentally ill individuals over and over; however, the need for police action is fairly rare. As the statistics indicated, very few subjects required more than one police intervention over a

three year period for a mental health crisis; however, it is possible that these same mentally ill subjects may have required police intervention on multiple occasions and may have been arrested without being identified as mentally ill; thus, it is unclear whether the CIT program's goal of diverting mental ill subjects from jail to the hospital is reached. A methodological question arises about how we define which subjects are mentally ill and which subjects are actually diverted due to their mental health issues. It is possible that mentally ill subjects engage in criminal behavior but are not identified by officers as either mentally ill or in mental health crisis and would thus not be included in data collected on CIT or mental health crisis calls.

This raises an interesting methodological issue where it is difficult to discern how officers identify a call as involving a subject with mental illness and if, and when, officers decided to complete a data collection form. Skeem and Bibeau examined only calls "that were handled by the CIT team" (p. 202). It is unclear whether CIT officers in their study were specifically dispatched to mental health crisis calls or how the incident was identified as a call involving a person with mental illness. It is possible that subjects in Skeem and Bibeau's study had additional police contacts or interventions that were never recorded. Given the disparity between Skeem and Bibeau's study where approximately 4% of calls were associated with two or more crisis events and my study involving 16% of subjects requiring repeated police intervention due to mental health issues, it is clear that the rate at which mentally ill subjects require police intervention and which subjects are actually diverted from the criminal justice system depends directly on how subjects and calls are defined and by whom these calls are identified.

Officers' Perceptions of Subjects Mental Illness

Table 3.4

Officer's Perceptions of Subjects Mental Illness		
	N	% of calls
Officer believes subjects suffers from:		
Psychiatric disorder	524	78.4
Developmental disability	14	2.1
Alcoholism	87	13
Drug addiction	50	7.5
Other	88	13.2
Subjects diagnosis (as percieved by officer)		
Autism	2	0.8
Bipolar disorder	72	29.3
Dementia	1	0.4
Depression	94	38.2
HIV positive	2	0.8
PTSD	4	1.6
Schizophrenia	71	28.9

On the CIT statistics sheets, officers indicated their beliefs that a subject suffered from a particular disease or disorder by placing a check mark in the box next to the appropriate option. Officers could check all boxes that apply.

Of the 668 calls, officers identified a diagnosis in 246 of the cases (i.e. the officer was informed that the subject had received a diagnosis from a medical professional, or the officer indicated their opinion as to what mental illness the subject might suffer from). Although the 246 cases fell into seven different diagnostic categories, nearly all (96.4%) were to three Axis I diagnoses, bi-polar disorder, major depression, and schizophrenia.

Incident Characteristics

Police encounter mentally ill persons for many different reasons. They may be responding to potential criminal activity, to problems of public order, or in their role of *parens patria*. The CIT statistics sheet asked officers to indicate the nature of the incident and the subjects' behaviors in twelve categories. Officers could check "all that apply."

Table 3.5

Nature of Incident		
Type of Incident	N	% of Calls
Disorderly/Disruptive	145	21.7
Drug-related	33	4.9
Judge Ordered Detention	8	1.8
Neglect of Self Care	55	8.2
Nuisance	28	4.2
Public Intoxication	32	4.8
Subject Complaint	35	7.5
Subject Request Intervention	28	6.4
Suicide	336	50.3
Theft/Property Crime	10	1.5
Threats of Violence toward Others	45	6.7
Welfare Check	96	20.6
Other	120	18

Table 3.5 indicates the percentage of calls by the type of the incident.

Approximately one-half of the calls involved incidents of suicide threats or attempts and

20.6% involved welfare checks. Approximately 21% of the calls involved incidents of

disorderly/disruptive behavior, but very few (6.7%) involved violence toward others.

Similar to my findings, Skeem and Bibeau found that 45% of CIT events were suicide

threats or attempts (p. 202). In contrast, however, their study found that 25% of calls

involved threats toward others. Skeem and Bibeau also reported that most of the incidents

involved minor to moderate risk of violence potential (p 203-204). Between their study

and the current study, there is a methodological difference in how violence potential or

threats to others is defined. I asked officers to indicate whether a subject actually

threatened another person; this resulted in 6.7% of incidents involving a threat toward

others. It is noteworthy that, as indicated in table 3.5, officers reported 21.7% of cases

being related to disorderly or disruptive behavior. It is possible that what was called

minor risk in Skeem and Bibeau's study may have been reported by officers in my study

as disorderly or disruptive behavior and was thus not classified as a threat toward others.

Clearly as research on CIT moves forward, there is need for further conceptualization on

how to measure threats toward others and how research defines and measures violence

potential.

Table 3.6

Behaviors Evident at Time of Incident		
Type	N	% of calls
Belligerent	106	15.9
Delusions	115	17.2
Depressed	308	46.1
Disorganized Speech	118	17.7
Disorientation/confusion	135	20.2
Hallucinations	37	5.5
Manic	123	18.4
Unusually Frightened/Scared	58	8.7

Table 3.6 indicates the percentage of calls by the type of behavior the subject

displayed at the time of the incident. Officers could check "all that apply." Almost one-

half of the calls involved subjects behaving depressed. Officers perceived approximately

34% of subjects as manic or belligerent and a little over 60% of the cases as involving

subjects experiencing delusions, hallucinations, disorganized speech, or

disorientation/confusion.

Table 3.7

Percent of cases where officer indicated subject use of Threat/Violence/Weapon		
	N	% of calls
Did subject use/brandish weapon?	66	10
What type of weapon?*		
Knife	46	6.9
Gun	12	1.8
Other	12	1.8
Did subject threaten violence?	70	10.8
Who was threatened?*		
Partner	10	1.5
Mother	6	0.9
Father	2	0.3
Brother	3	0.4
Sister	1	0.1
Other family member	2	0.3
Friend	5	0.7
Stranger	7	0.7
Officer	12	1.8
Other	21	3.1
*percentage out of all 668 cases		

On the CIT statistics sheet, officers were asked to indicate (by checking a box) whether or not the incident involved threats, violence and/or weapons. The officers were asked to indicate the following: if the subject brandished a weapon and, if they did, what the weapon was, if the subject threatened violence toward another person and, if they did, toward whom, and if the subject injured or attempted to injure themselves.

As indicated by in Table 3.7, approximately 10% of the calls involved the subject brandishing a weapon. The type of weapon brandished most often was a knife. Examining the call narratives from the CIT statistics sheets where a knife was involved indicates that the subject did not necessarily brandish the weapon against 'others', including the officer. Rather the knife was present at the scene and, as indicated in the officer's narrative of the situation, the subject typically utilized or threatened to use the knife in a suicide gesture or attempt.

In the few cases (n=70) where an officer reported subjects as threatening violence toward others, 34% of these cases involved threats toward intimates (family members or partners), 17% of cases involved threats toward officers, 10% of cases involved threats toward strangers, and .07% of cases involved threats toward a friend (see table 3.7). According to the narratives written by police officers, the threats toward others predominately occurred prior to police arrival at the scene. Very few incidents involved threats toward officers. One goal of CIT is to reduce injury to officers. These results suggest that officers rarely encounter threats of violence from subjects in mental health crisis.

In addition, of the 668 cases, officers indicated that 50.3% (n=336) of subjects attempted suicide or displayed suicide ideation. Thus, subjects rarely threatened others; instead, subjects demonstrated self-injurious behavior. One officer in the focus group stated that "suicide cases are the easiest crisis calls to respond to." Officers in the focus group agreed that suicide calls were easy because by the time they arrived on the scene the subject was ready to go to the hospital. Thus, there was little need for crisis de-escalation or police intervention beyond transporting the subject to the hospital.

Table 3.8

Other Incident Characteristics	N	% of calls
Evidence of drug/alcohol involvement	240	35.7
Medication compliance	88	13.9
Injury to*:		
Subject	44	6.6
Family member	2	0.3
Roomate	1	0.1
Girlfriend	1	0.1
Friend	1	0.1
Stranger	1	0.1
Officer	2	0.3
Type of Equipment/Technique used		
Handcuffs	172	25.7
Verbalization	236	35.3
OC Spray	0	0
Baton	0	0
Other (i.e. arm bar, leg restraints, open hand control techniques	35	5.2
Assessment of subject dangerousness		
Subject is danger to self	431	67.9
Subject is danger to others	100	15.7
Disposition of incident		
Immediate detention	296	44.3
Tranported to jail	24	3.6
Charges pending	26	3.9
Transported to hospital (requiring no further police involvement)	214	32
Subject stabilized on scene	54	8.1
Referral to mental health professional	26	3.9
Other	72	10.8

*many of the injuries were self inflicted occuring prior to police intervention

Officers indicated that 35.7% of the cases did have evidence of drug or alcohol intoxication. Of these cases, 60% (n=139) involved alcohol, 24.6% (n=59) involved an "other" drug, which included prescription drugs such as hydrocodone and Loritab, over the counter drugs such as Tylenol PM and Excedrin, and non-prescription drugs such as marijuana and cocaine, 13.8% (n=33) of cases involved both alcohol and drugs.

Officers indicated whether there were any injuries during the incident, who was injured, and the nature of the injury. There were only two injuries to officers. The majority of subject injuries were self inflicted suicide attempts occurring prior to police intervention. Overall, injury to subjects was a rare event and injury during police intervention was an extremely rare event for both officer and subject.

As indicated in Table 3.8, 25.7% of incidents required the use of handcuffs, 35.3% required the use of verbalization, and 5.2% required an "other" technique to control the subject during police intervention. It is possible that a case required more than one of the above techniques.

It is important to note, methodologically, that these measures specifically examine police actions or use of force *during police intervention to control the subject*. My conversations with the police chief prior to gathering data for this study revealed that the BPD policy is to handcuff all subjects during transport to either the hospital or jail. Thus, it was necessary to indicate on the data collection form that the measure for the use of handcuffs (i.e. the use of force) excluded handcuffing for mandatory transport. Another important difference in the Bloomington context is that BPD officers no longer utilize Tasers. Due to the fatal Taser incident at the jail in 2003, the BPD changed its equipment policy and no longer issued Tasers to officers.

The use of handcuffs in my study was high when compared with the use of handcuffs reported in Skeem and Bibeau's study. Skeem and Bibeau reported that officers used handcuffs in 4 out of 655 incidents and had a total of 36 cases where an officer used "any type of force [or] any degree of force" (p. 203); thus, a degree of force was used by officers in approximately 5.5% of the Las Vegas CIT cases. In my study, taking into consideration the use of handcuffs and any other measure of force (i.e. the "other" category, see table 3.8), approximately 40% of cases required some type of use of force. The discrepancy between my study and Skeem and Bibeau's study may be a result of the differences in samples.   Skeem and Bibeau's sample included only events where CIT trained officers handled the call. My sample included both CIT and non-CIT trained

officers who identified the incident as involving a subject with a mental health issue and where those officers self-selected to complete the data collection form. Thus, two methodological questions arise. First, how is the use of force being defined, who is defining it and how is it being measured. Clearly, the use of handcuffs as a measure of force needs to be scrutinized depending on the police departments transport and handcuff policy. Second, given the large discrepancy in the rates of use of force reported in my study as compared to Skeem and Bibeau's study, the sample from which these results are drawn should be considered. The types of calls that are identified as CIT calls require further conceptualization before generalizable conclusions can be drawn.

As noted in Table 3.8, officers indicated the final disposition of each case. Of the 668 cases, 44.3% of subjects were immediately detained through 24 hour hold at the hospital, 32% were transported to the hospital on a voluntary basis, 8.1% were stabilized on the scene requiring no further police involvement, 3.9% were referred to a mental health professional, and 3.6% were transported to jail. Twenty-six subjects were charged with an offense; 2 of these subjects were transported to the hospital and 24 subjects were transported directly to jail. Charge types included battery, criminal mischief, criminal trespass, disorderly conduct, disturbing the peace, illegal entrance of residence, intimidation, public intoxication, outstanding warrants, theft, and possession of controlled substance.

As noted in Chapter 1, research offers conflicting reports as to whether the goals of the CIT program in decreasing the use of arrest and increasing the use of hospitalization are met. Bower et al. (2001) found that in Albuquerque, New Mexico police arrested fewer than 10% of subjects and transported 48% of the subjects to a

medical facility (p. 2). However, Bower et al did not report whether there was any difference in arrest based on officer's CIT training status. Teller et al's (2006) research in Akron, OH, found no significant differences in arrest based on the officers CIT training status.   In contrast, Skeem and Bibeau (2008) found that CIT officers "resolved most of the incidents through hospitalization and rarely resorted to arrest" (p. 204).

Results from the current study indicate that over a 3 year period, 3.5% of crisis calls resulted in a disposition of arrest. There was a difference between CIT and non-CIT trained officers likelihood of arrest; non-CIT trained officers were slightly more likely to arrest than were CIT trained officers ($t=2.235$, $p=.026$). CIT officers arrested subjects in 2.2% of cases reported on compared to non-CIT officers arresting subjects in 4.9% of the reported cases. However, the results on arrest should be interpreted with caution. The event of arrest is extremely rare. The percent of arrests in this study was extremely low. As baseline data on arrest for crisis calls prior to the implementation of the CIT program was not available, it is unclear whether the low percentage of arrest is causally due to the CIT program. In addition, while this research indicates a difference between CIT and non-CIT trained officers, the sample size of arrests was very small. In addition, comparing this study's results with previous research is problematic as each study has very different samples. Additionally, every police agency has different arrest policies and procedures and had different access to mental health alternatives which may be complicated by the context in which the CIT program is implemented and further managed.

Despite the above discussion of samples, it is interesting to note that the arrest (4%) and hospitalization (74%) rates reported in Skeem and Bibeau's study is relatively similar to the arrest (3.6%) and hospitalization (76%) rates reported from my sample of both CIT and non-CIT trained officers' responses. While there is difficulty in a directly comparing these samples, noting the similarities in arrest and hospitalization raises the question as to whether CIT trained officers actually choose hospitalization as an alternative disposition to arrest any differently than do non-CIT trained officers. Unfortunately, conclusions at this point, with the given data, are not possible.

3.4 Officers' Perceptions of Mental Illness

3.4.1 Frequency of Reporting Mental Illness

One goal of CIT programs is to increase an officer's ability to recognize mental illness and subsequently use that knowledge when deciding a final disposition of a mental health crisis event. Most of the research on this topic includes vignette, focus group and pre/post CIT training surveys of officers. Watson et al (2004) found that the label of certain diagnoses in the vignette did not affect the likelihood of arrest. However, Watson (2004) found that officers' perceived subjects with schizophrenia as less responsible for their actions, were more worthy of help, but were more dangerous. Hanafi (2008) found that officers in focus groups appeared to have an increased ability to recognize and respond to subjects with mental illness, and appeared to divert such subjects toward hospitalization rather than arrest. In a pre/post CIT training survey of officers, Wells et al (2006) suggest that CIT training achieves the goal of increasing officers' ability to recognize mental illness. Skeem and Bibeau (2008) suggest that their sample of CIT calls included cases where the officer knew the diagnosed mental disorder or where the subject was actively hallucination or delusional at the scene. They claim that the known

mental disorder affected the likelihood with which subjects were prescribed psychotropic medication and of those subjects the likelihood that they were medication noncompliant. Skeem and Bibeau also assert that the known mental disorder affected the subjects' likelihood of intoxication. Finally, their results indicate that the final disposition of cases did not differ significantly based on the officers knowing the mental disorder, but that subjects' with a known mental disorder were rated by officers having lower violence potential.

According to the results of the current study, officers were instructed to complete data collection forms whenever they encountered an incident that involved a subject with a mental health issue. In this sample of 668 cases, CIT officers appeared more likely than non-CIT officers to indicate that the subject suffered from a psychiatric disorder (χ^2=4.258, p=.03, α=.05). CIT officers reported that 83% of the incidents involved subjects with a psychiatric disorder compared to non-CIT officers' reports at 76%. Thus, it appeared that CIT officers are more likely to recognize mental illness. However, logistic regression with CIT training status as the independent variable shows we gain nothing in predictive ability. More importantly, however, we do not know from these data whether the subjects of these incidents are mentally ill because we do not know the actual diagnosis. Officers simply indicated their perception that the subject had a mental illness. Officers did indicate the diagnosis (if known) of a subject. However, it is unclear how the officer knows this information. It may be that the officer received the diagnostic information from a family member or the subject themselves. It may be that the officer utilized the knowledge gained (such as symptoms or prescribed medications) from CIT training or other various officer trainings to list the "known" diagnosis. Thus, because

we do not have the psychiatric or medical records to confirm officers' perceptions of known mental illness, it is impossible to determine with certainty that CIT training affects officers' ability to recognize mental illness. Examining this methodological issue in the study raises a methodological question about this and previous research. This study included, we do not have the ability to say that officers, regardless of CIT training status, can recognize mental illness, nor can it be determined whether the label of mental illness affects officers' responses to mental health crisis calls. Reconceptualization of how research measures officers' recognition of mental illness in the field and the effects of such recognition on call dispositions is sorely needed.

3.5 Summary and Limitations

This analysis addressed three main questions: (1) does CIT training affect the frequency with which officers report persons as having a mental illness?, (2) how do officers respond to and resolve incidents involving persons in mental health crisis, and (3) are there significant differences between CIT and non-CIT trained officers? It appears that CIT training had little effect on the frequency of reporting subjects as mentally ill and a small effect on officers' responses and resolutions to mental health crisis calls. However, these results are complicated by various methodological concerns.

With regard to the frequency with which officers report persons as having a mental illness, it is interesting to note that officers believe they had repeated contacts with the same subjects. However, the results directly contradict this perception. The analysis indicates that subjects require police intervention fairly rarely, with most requiring one police intervention over the three year period of this analysis. Thus, it appears that officers may have repeated informal contacts with the same subject, but rarely initiate official intervention (i.e. immediate detention or arrest). This assertion is limited as there is some difficulty in collecting data on *all*

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incidents involving persons with mental illness. Officers indicated that they did not complete a data collection form unless the incident was directly related to a mental health crisis. Thus, data on *all* calls involving persons with mental illness was limited; thereby, estimating the frequency for *all* calls involving persons with mental illness was not possible.

The second and third questions addressed by this analysis were how did officers respond to and resolve incidents involving persons in mental health crisis and was there a significant difference between CIT and non-CIT trained officers. Results indicate there was a difference in how CIT officers respond to and resolve mental health crisis calls; however, this difference was relatively small.

One goal of the CIT program is to decrease the arrests of persons with mental illness. The results of this study indicate that arrest of subjects with mental illness is a rare event. However, of the few arrests that did occur, there was a significant difference between CIT and non-CIT officers. CIT officers arrested less often than did the non-CIT officers. These results cannot be generalized as the sample size of subjects arrested was extremely small. In addition, because baseline arrest data for persons with mental illness is not available, it is not possible to say whether have a CIT program reduced arrests of persons with mental illness overall.

Chapter 4: Discussion

This dissertation research had several goals. One goal was to design a study that shifted away from vignette and survey methodology toward examining actual officer encounter outcomes and comparisons between CIT and non-CIT trained officers. Prior research on CIT lacks significant use of control or comparison groups and primarily focuses on officers' attitudes and perceptions of persons with mental illness. Due to the lack of rigorous methodological design, prior research in this area is limited in its generalizability. In addition, the lack of comparisons between CIT and non-CIT trained officers and mental health crisis call outcomes makes it difficult to evaluate some of the most pressing questions about the effectiveness of CIT programs, including questions related to (1) arrest rates, (2) the use of immediate detention in hospitals, and (3) the community context in which the program is implemented.

Utilizing comparisons between CIT and non-CIT trained officers, this research examined officers' reactions to and resolutions of mental health crisis calls. Three main questions were addressed: (1) does CIT training affect the frequency with which officers report persons as having a mental illness?, (2) how do officers respond to incidents involving persons in mental health crisis?, and (3) is there a difference in how CIT trained and non-CIT trained officers respond to incidents involving mental health crisis?

An important question in the literature regarding CIT training has been whether the training increases officers' ability to recognize mental illness and to differentiate among symptoms of mental illness. The comparison of CIT and non-CIT trained officers in this study revealed CIT officers appear to recognize mental illness differently than do non-CIT officers. Unfortunately, methodological questions arise as to whether officers' perceptions of mental illness truly correlate with diagnoses that may be medically

confirmed. The varied nature of crisis calls and how these calls are identified as involving persons with mental illness provide complex methodological limitations to the conclusions that may be drawn from self-selected, officer completed data collection forms.

As to whether CIT training affects how officers respond to persons with mental illness, the results are mixed. Most notably, CIT officers were as likely to use handcuffs as were non-CIT officers. It is possible that officers, regardless of CIT training status, use higher measures of force, such as handcuffs, as a last resort. This is consistent with Morabito's (2008) argument that characteristics of the case may dominate officers' responses to mental health crisis calls. Further research should look at whether the use of higher measures of force correlate with the type of call or type of crime.

One of the most pressing questions about CIT is whether this program reduces the arrest of mentally ill subjects and increases the use of immediate detention. Consistent with previous research, the rate of arrest for mental health crisis calls was extremely low in this study. Although it appears that CIT trained officers might be slightly less likely to arrest, the small number of cases in which there were arrests precludes more formal analysis. As a result, no conclusions about CIT's effects on arrest can be drawn.

Although this study is one of the first to provide comparisons of CIT and non-CIT trained officers' responses in the field, there are limits to the conclusions that can be drawn. First, the relative rarity of arrest makes it difficult to address crucial questions about the arrest of mentally ill persons. This study includes 668 cases, a large sample by many standards, but it was still too small to examine the rare event of arrest in any detail. The data is further limited because information was collected via officers self selecting

when to complete a CIT Statistics Sheet. In the focus groups, officers indicated that they did not complete a form for all cases involving subjects with mental illness. Thus, I do not know how many cases went unreported, nor do I know if CIT officers were more likely to fill out the forms.

Second, there are concerns about the generalizability of these results. This study was conducted in a relatively small city and thus may not be representative of all cities or cities with large populations. More importantly, the CIT program studied was an adaption of the Memphis Model. As the study brought to light, there is no standard of CIT training; both the content of and methods of training CIT officers may vary considerably from community to community making generalizations difficult. On the other hand, the BPD did retain the core elements of the Memphis Model of CIT. The differences implemented by BPD were small and are in the direction one would expect given the size of the community and the resources available. In addition, while the Memphis Model was designed for a large city, most cities in the U.S. are not large and have varying community resources for the treatment of the mentally ill. As the CIT program has been broadly and rapidly adopted across the U.S., one would expect that many smaller communities have implemented or are considering a CIT program. Thus, the representativeness of city size was not a main concern of this study.

Another goal of this research was to explore the community context in which the CIT program was implemented. When a community decides to implement a new program, the first question is why they decided to do so. In the case of CIT programs, the assumption is that a problem exists with how police handle mental health crisis calls. As this study shows, the problem may be defined differently by different actors.

In the case of Bloomington, the police department faced political and community pressure to implement a CIT program. Police administrators and some mental health advocates believed that police were doing a good job handling crisis calls prior to CIT, but saw the value of such a program for political purposes. Hearing about the anecdotal successes of CIT in Fort Wayne prompted political and community pressure for BPD to implement a CIT program. In addition, police administrators justified the CIT program saying that additional training of officers is always a good idea. The model of CIT adopted, however, was an issue of contention for some mental health advocates. As BPD adapted the Memphis Model of CIT to fit the police departments and communities needs, some advocates believed that BPD did not have a true CIT program. However, the majority of those interviewed disagree with the small number of advocates who believe in the strict adoption of the Memphis Model. While there were a small number of advocates who wanted a strict adoption, it is unclear what the Memphis Model of training actually consists of; it appears that even for cities adopting the Memphis Model, there are contextual adaptations in many programs. After three years of the BPD CIT program operating, most interviewees agreed that the contention over the adaptations was no longer an issue of concern.

An additional challenge of implementing the CIT program in Bloomington was the lack of linkages between the police department and the hospital. The Memphis Model of CIT was intended to reduce the adversarial nature between police and hospital institutions and required the cooperation of all parties to successfully function. In the beginning, Bloomington police administrators attempting to implement the CIT program had difficulty getting the hospitals cooperation. However, as the program progressed and

police administrators continued to push for hospital cooperation, the hospital eventually acceded; they eventually worked with police administrators to reduce long officer waiting periods in the emergency room and formalized procedures for immediate detentions. As time passed, the CIT program facilitated a stronger and more effective linkage between the police department and the hospital.

Overall, one of the most important findings of this study is that the CIT program strengthens linkages between criminal justice and mental health agencies, and addresses political and community concerns about how the police handle mental health crisis calls. The Bloomington CIT program increased communication between stakeholders, addressed mental health advocates concerns about police treatment of mentally ill persons, and streamlined procedural processes, including processes for police initiated immediate detentions and hospital processes that reduced the length of time police officers spent babysitting subjects awaiting evaluation. Thus, while CIT did not appear to have a large affect on how police officers respond to and resolve mental health crisis calls, the program did positively affect the community by, as one police administrator put it, "getting everyone on the same page and moving together toward the same goal of helping people that suffer from mental illness."

Although this study addresses gaps in the research literature, there is continued need for methodologically rigorous research designs that might establish whether CIT training causes change in officers' perceptions and responses to mental health crisis calls. There is also continued need for short, intermediate and long-term analysis of police responses to and resolutions of mental health crisis calls. Finally, there are two areas of research that are sorely lacking. First, while this study included interviews with hospital

stakeholders to place the implementation of CIT in context, questions remain about

hospital internal processes and how emergency staff respond to and resolve cases

initiated by police intervention. Second, research should examine the perspectives of

mentally ill subjects and the long term affects of immediate detention policies for

subjects.

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Appendix A – Data Collection Instrument

CIT Statistics Sheet

Crisis Intervention Statistics Sheet

☐ CIT Officer _____ ☐ Non-CIT Officer _____ CFS # _____

Officer Name: _____ Law Enforcement Agency: _____

Officer Age: _____ Sex: __M / F__ Race: ☐ Asian, ☐ Black, ☐ Caucasian, ☐ Hispanic, ☐ Other _____

In military time:
Date: _____ Time of Call: _____ Time arrived at scene _____ Time finished call: _____

Scene Location: _____

Subject Name: _____ Age: _____ Sex: M / F Race: ☐ Asian
☐ Black
Subjects Address: _____ ☐ Caucasian
☐ Hispanic
Diagnosis (if known): _____ ☐ Other _____

Nature of Incident: (check all that apply)	**Threats/Violence/Weapons**	**Prior Contacts**
☐ Disorderly/disruptive behavior	Did subject use/brandish a weapon during police intervention?	Known person (from prior police contacts)
☐ Drug-related offense	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
☐ Judge ordered detention		
☐ Neglect of self care	If Yes…	Repeat call (within 24 hours)
☐ Nuisance (loitering, panhandling, trespassing, etc)	Type of weapon (check all that apply)	☐ Yes ☐ No ☐ Don't know
☐ Public Intoxication	☐ Knife ☐ Gun	
☐ Suicide threat or attempt	☐ Other/ Specify:	**Drug Alcohol Involvement**
☐ Subject complaint		Evidence of drug/alcohol intoxication?
☐ Subject requesting intervention	Did subject threaten violence toward another person?	☐ Yes ☐ No ☐ Don't know
☐ Theft/other property crime	☐ Yes ☐ No ☐ Don't know	If Yes…
☐ Threats of violence to others		☐ Alcohol
☐ Welfare check	If yes, to whom (partner, officer, stranger etc)	☐ Other drug/specify:
☐ Other/ specify below		☐ Don't know
☐ No information		
	Did subject injure or attempt to injure self?	Medication compliance
	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
		Specify medications if known:

Complainant Relationship	**Behaviors evident at time of incident** (check all that apply)	**Incident Injuries**
☐ Self	☐ Disorientation/confusion	Were there any injuries during police intervention?
☐ Partner/spouse	☐ Delusions (specify below if known)	☐ Yes ☐ No ☐ Don't know
☐ Boyfriend/girlfriend	☐ Hallucinations (specify below if known)	
☐ Parent	☐ Disorganized speech	If yes, specify:
☐ Sibling	☐ Manic (elevated/expansive mood, inflated self esteem, pressured speech, flight of ideas, distractible)	Who was injured?
☐ Friend/acquaintance	☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)	
☐ Business Owner	☐ Unusually scared or frightened	Nature of injury?
☐ Other family member	☐ Belligerent or uncooperative (angry or hostile)	
☐ Police observation	☐ No information ☐ Other: specify on back	
☐ Other stranger		
☐ Don't know		

Disposition (check all that apply)	**Equipment/Technique** (Check all that apply)
☐ Immediate Detention in hospital ☐ Charges pending/Specify:	☐ Handcuffs (excluding for mandatory transport)
☐ Transported to Jail	☐ Verbalization
☐ Transported to medical/treatment facility, no further police involvement required	☐ OC Spray
☐ Patient stabilized on scene requiring no further police/medical intervention	☐ Baton
☐ Provided referral to mental health professional	☐ Other/specify:
☐ Other: explain in narrative section	

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Do not write in blank space above

Narrative Information

1. Officer believes subject above suffers from:

☐ a psychiatric disorder (mental illness)
☐ a developmental disability (retardation, epilepsy, etc)
☐ alcohol addiction
☐ drug addiction
☐ other/specify

2. Describe in detail harmful acts or threats of harmful acts which indicate the person is dangerous to
☐ self or ☐ others.

_____

_____

_____

_____

3. Please indicate any further details of the incident that you feel are important:

_____

_____

_____

_____

4. Where and by whom was the patient transported?   5. |

☐ Hospital: specify:_____   ☐ PD unit
☐ Home/group home   ☐ Ambulance
☐ Homeless shelter   ☐ Other/specify
☐ Jail
☐ Other/specify

> Amount of time spent at facility to complete the
> transfer of the subject (please specify hrs:min):

CIT V3 1007

Appendix B – Study Information Sheet

IRB Study #07-12601

INDIANA UNIVERSITY BLOOMINGTON

STUDY INFORMATION STATEMENT

Police Intervention in Mental Health Crisis: A Case Study of the Bloomington

Crisis Intervention Team (CIT) Program

You are invited to participate in a research study of the Bloomington Crisis Intervention Program. You were selected as a possible subject because study because you have been identified as a police officer employed by the Bloomington Police Department. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by the principal investigator Cindy Stewart, Indiana University, Criminal Justice Department.

STUDY PURPOSE

Your police department is participating in a research study of police officers perceptions of and responses to calls involving persons in mental health crisis. The objective of this study is to examine differences in police response to persons with mental illness and whether police officers that have taken the crisis intervention training course respond differently than those officers who have not taken the training course. The goal is to provide the police department with evidence based information about police based crisis intervention.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

You will be one of 128 police officers employed by the Bloomington Police Department who will be participating in this research.

PROCEDURES FOR THE STUDY:

You are asked to do the following things:

You will be asked to complete a Crisis Intervention Statistics Sheet at the end of each call that involves a mental health crisis. A mental health crisis call might include situations where a person suffers from a psychiatric disorder, developmental disability, alcohol or drug addiction, or other mental health related issue. The Crisis Intervention Statistics Sheet will ask you about the call, your perceptions of the call, and what actions you took to solve or complete the call. At the end of each shift, you are asked to turn in any Crisis Intervention Statistics Sheets you've completed to the designated CIT Coordinator, who will then give all of the completed Sheets to the principal researcher.

You will be asked to continue to complete these Sheets for inclusion in this study until June 30, 2009.

RISKS OF TAKING PART IN THE STUDY:

While on the study, the risks are:

The Crisis Intervention Statistics Sheet gathers personal information, including your name, age, race and gender. There is a small risk of loss of confidentiality. However, the principal investigator will make every attempt to protect your confidentiality (please see Confidentiality below). At the end of the study (approximately October 30, 2009), all identifying information will be removed from the Sheet and from the study entirely to protect your confidentiality.

BENEFITS OF TAKING PART IN THE STUDY:

The benefits to participation that are reasonable to expect are:

The information you provide in this study will help us to know more about how police officers respond to calls involving persons in mental health crisis. This information may aid police departments and other agencies in developing crisis intervention training programs or other programs designed to aid police officers and/or persons in mental health crisis.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. Data gathered will be kept in locked filing cabinets and secured computer databases and only reported as aggregate data. The computers will be kept in locked rooms and will also be protected by password. Only the Principal Investigator will have access to these passwords. At the end of the study (approximately October 30, 2009), all identifying information will be permanently deleted from the Crisis Intervention Statistics Sheets and computer databases.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the IUB Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP).

COSTS

There are no added costs to participate in this study.

PAYMENT

You will not receive payment for taking part in this study.

COMPENSATION FOR INJURY

Since you are completing this form on duty, you will follow office policy on compensation for injury, it will not be provided via this study.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study or a research-related injury, contact the researcher Cindy Stewart at 812-855-9325 or cmcnair@indiana.edu.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IUB Human Subjects office, 530 E Kirkwood Ave, Carmichael Center, L03, Bloomington IN 47408, 812-855-3067 or by email at iub_hsc@indiana.edu

Appendix B – Interview Schedule

Interview Schedule

The principal investigator will utilize the follow set of questions as a guide in this semi-structured interview. The interviewee is encouraged to elaborate upon areas of interest to him/her. The principal investigator will ask the following questions in the order that seems appropriate for the conversation to continue in the most unobstructed manner. Questions not included in the following set may arise during the interview. Responses to these unanticipated questions will be included in the final analysis.

The interviewee will be asked to sign an informed consent form and will receive a copy of the form for their records.

The interview will be audio taped. The length of the interview will depend upon the length of the interviewee's responses. However, it is expected that the interview will last approximately 1 hour.

Questions for principal investigator to pose to initiate and continue conversation:

1. What do you see as the main problem the police department faces with respect to officers responding to mental health crisis calls?
2. How well prepared do you think police officers are to handle persons in mental health crisis?
3. How helpful are the linkages between the police department and medical institutions in providing officers assistance with mental health crisis calls?
4. How effective is the CIT Program?
5. Has the implementation of this program been a positive experience for you? for your agency?
6. What problems or complications have you or your agency experienced since the implementation of the CIT program?
7. Are there areas of training that you'd like to see incorporated into the CIT training?
8. Are you concerned about any aspect of the CIT training and/or its deviation from the Memphis Model? In what ways do you think the BPD CIT program has deviated from the Memphis Model?
9. What positive outcomes do you see from the implementation of the CIT Program?
10. What disadvantages do you see from the implementation of the CIT program?
11. Do you think your attitude toward the CIT program changed from its implementation to now? How? Why?
12. Do you think your agencies attitude toward the CIT program has changed from its implementation to now? How? Why?

With respect to the linkages between the police department and other medical or mental health services:

13. Do you believe the linkages were established primarily due to the implementation of the CIT program?
14. Describe the strength of these linkages.
15. During the implementation process, were there obstacles to establishing these linkages?
16. Do you think these obstacles have been overcome? How?

Appendix B – Interview Consent Form

IRB Study #07-12601

INDIANA UNIVERSITY BLOOMINGTON

INFORMED CONSENT STATEMENT
Interview

Police Intervention in Mental Health Crisis: A Case Study of the Bloomington

Crisis Intervention Team (CIT) Program

You are invited to participate in a research study of the Bloomington Crisis Intervention Program. You were selected as a possible subject because study because you have been identified as stakeholder in the Bloomington CIT Program. A stakeholder is defined as persons involved in the design, implementation and/or management of the CIT Program. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by the principal investigator Cindy Stewart, Indiana University, Criminal Justice Department.

STUDY PURPOSE

The purpose of this study is to examine stakeholder's perceptions of (1) the implementation of the Bloomington CIT Program, (2) the community linkages created through the CIT Program, and (3) the perceived effectiveness of the program.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of 10 subjects who will be participating in this interview research.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will do the following things:

This interview will inquire about your opinions related to the Bloomington CIT Program, including your perceptions of the implementation process, the community linkages established by the implementation of this program, and your opinions about the effectiveness of the program.

The interview will be audio taped and transcribed by the principal investigator, Cindy Stewart.

The interview will last approximately 1 hour

If you decide to participate in this interview, the researcher will ask you a series of questions about your perceptions of the Bloomington CIT Program. Your taped interview will be transcribed and utilized for analysis. If you agree, quotations from this interview may be used. You may be identified as belonging to a specific group of stakeholders, such as medical professional, police personnel, or mental health advocate; however, your name and agency affiliation will be kept confidential

RISKS OF TAKING PART IN THE STUDY:

While on the study, the risks are:

There is the potential for social risk (embarrassment) if your responses were to be disclosed. However, you will be identified as a police officer and the principal investigator will take steps to reduce the likelihood of responses or potential quotes from divulging your identity.

Your responses will not be linked to you personally. However, it may be possible, due to the nature of your response, or level of specificity in your response to a certain question that your identity may be determined by others.

There also may be other risks that we cannot predict.

BENEFITS OF TAKING PART IN THE STUDY:

The benefits to participation that are reasonable to expect are:

The information you provide in this interview will help us to know more the CIT implementation process and its perceived effectiveness. This information may aid police departments and other agencies in developing crisis intervention training programs or other programs designed to aid police officers and/or persons in mental health crisis.

ALTERNATIVES TO TAKING PART IN THE STUDY:

Instead of being in the study, you have these options:

An alternative to participating in this study is to choose not to participate.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. The principal investigator will maintain the audiotapes in a secure location. Audio tapes will be destroyed by the principal investigator at the end of the study (approximately October 30, 2009). Prior to their destruction, the audio tapes will be transcribed by the principal investigator; your personal information (your name, age, race, affiliation) will not be included in this transcription.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the IUB Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP).

COSTS

There are no added costs to participate in this study.

PAYMENT

You will not receive payment for taking part in this study.

COMPENSATION FOR INJURY

In the event of physical injury resulting from your participation in this research, necessary medical treatment will be provided to you and billed as part of your medical expenses. Costs not covered by your health care insurer will be your responsibility. Also, it is your responsibility to determine the extent of your health care coverage. There is no program in place for other monetary compensation for such injuries. However, you are not giving up any legal rights or benefits to which you are otherwise entitled.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study or a research-related injury, contact the researcher Cindy Stewart at 812-855-9325 or cmcnair@indiana.edu.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IUB Human Subjects office, 530 E Kirkwood Ave, Carmichael Center, L03, Bloomington IN 47408, 812-855-3067 or by email at iub_hsc@indiana.edu

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with the investigator(s).

SUBJECT'S CONSENT

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

Subject's Signature:_____**Date**:_____

Signature of Person Obtaining Consent:_____**Date**:_____

Appendix B – Focus Group Consent

IRB Study #07-12601

INDIANA UNIVERSITY BLOOMINGTON

INFORMED CONSENT STATEMENT
Focus Group

Police Intervention in Mental Health Crisis: A Case Study of the Bloomington

Crisis Intervention Team (CIT) Program

You are invited to participate in a research study of the Bloomington Crisis Intervention Program. You were selected as a possible subject because study because you have been identified as a police officer participating in the Bloomington CIT Program. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by the principal investigator Cindy Stewart, Indiana University, Criminal Justice Department.

STUDY PURPOSE

The purpose of this study is to examine officers' perceptions of (1) the implementation of the Bloomington CIT Program, (2) the community linkages created through the CIT Program, and (3) the perceived effectiveness of the program.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of 16 subjects who will be participating in this focus group research.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will do the following things:

The approach of the research is exploratory focus groups. A focus group is a small group of people (about 8) who meet together and provide opinions to some questions asked by a group leader and participate in conversation with others involved in the group. You will be asked some questions about your opinions related to the Bloomington CIT Program, including your perceptions of the implementation process, the community linkages established by the implementation of this program, and your opinions about the effectiveness of the program.

The focus group will be audio taped and transcribed by the principal investigator, Cindy Stewart.

The focus group will last approximately 1-1 ½ hours.

Comments you make during this focus group may be quoted. In conjunction with that quotation, you may be identified as police personnel or as a police officer; however, your name any other identifying information will be kept confidential

RISKS OF TAKING PART IN THE STUDY:

While on the study, the risks are:

There is the potential for social risk (embarrassment) if your responses were to be disclosed. However, you will be identified as a police officer and the principal investigator will take steps to reduce the likelihood of responses or potential quotes from divulging your identity.

Your responses will not be linked to you personally. However, it may be possible, due to the nature of your response, or level of specificity in your response to a certain question that your identity may be determined by others.

There also may be other side effects that we cannot predict.

BENEFITS OF TAKING PART IN THE STUDY:

The benefits to participation that are reasonable to expect are:

The information you provide in this focus group will help us to know more the CIT implementation process and its perceived effectiveness. This information may aid police departments and other agencies in developing crisis intervention training programs or other programs designed to aid police officers and/or persons in mental health crisis.

ALTERNATIVES TO TAKING PART IN THE STUDY:

Instead of being in the study, you have these options:

An alternative to participating in this study is to choose not to participate.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. The principal investigator will maintain the audiotapes in a secure location. Audio tapes will be destroyed by the principal investigator at the end of the study (approximately October 30, 2009). Prior to their destruction, the audio tapes will be transcribed by the principal investigator; your personal information (your name, age, race, and rank) will not be included in this transcription.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the IUB Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP).

COSTS

There are no added costs to participate in this study.

PAYMENT

You will not receive payment for taking part in this study.

COMPENSATION FOR INJURY

In the event of physical injury resulting from your participation in this research, necessary medical treatment will be provided to you and billed as part of your medical expenses. Costs not covered by your health care insurer will be your responsibility. Also, it is your responsibility to determine the extent of your health care coverage. There is no program in place for other monetary compensation for such injuries. However, you are not giving up any legal rights or benefits to which you are otherwise entitled.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study or a research-related injury, contact the researcher Cindy Stewart at 812-855-9325 or cmcnair@indiana.edu.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IUB Human Subjects office, 530 E Kirkwood Ave, Carmichael Center, L03, Bloomington IN 47408, 812-855-3067 or by email at iub_hsc@indiana.edu

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with the investigator(s).

SUBJECT'S CONSENT

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

Subject's Signature:_____**Date**:_____

(must be dated by the subject)

Signature of Person Obtaining Consent:_____**Date**:_____

Appendix B – Focus Group Schedule

Focus Group Schedule

Focus group methodology uses group interaction to explore participants' knowledge, experiences and opinions about a particular topic. A group leader (in this study the principal investigator) encourages participants to explore areas that are important to them and encourages participants to pose and respond to their own and other participants' questions or comments. Thus, the following set of questions is designed to initiate conversation between participants of the focus group. However, the conversation will not be limited by these questions or the principal investigator. The principal investigator will attempt to limit interjections into the conversation, except where prompting to initiate or continue conversation is warranted.

Focus group participants will be asked to sign an informed consent form and will receive a copy of the form for their records.

The focus groups will be audio taped. The focus group will last 1-1/2 hours.

Potential questions for principal investigator to pose to initiate conversation:

1. What do you see as the main problem this department faces with respect to officers responding to mental health crisis calls?

2. How well prepared are you to handle persons in mental health crisis?

3. How helpful are the linkages between the police department and medical institutions in providing you assistance with mental health crisis calls?

4. How effective is the CIT Program?

5. Has the implementation of this program been a positive experience?

6. What problems or complications have you experienced since the implementation of this program?

7. Are there areas of training that you'd like to see incorporated into CIT training?

8. Would you voluntarily participate in a follow-up CIT training session?

Appendix C: Variables

 Variables and Attributes

Variable	Attributes
Officer Characteristics	
Officer number	Number assigned by primary instructor
Law enforcement agency	Bloomington, Fort Wayne, Indianapolis, Largo, Portland
Officer training status	CIT, non-CIT
Officer Age	Numerical age
Officer gender	Male, Female
Officer race	Asian, Black, Caucasian, Hispanic, Other (list)
Subject Characteristics	
Subject ID#	Number assigned by primary investigator
Subjects Age	Numerical age
Subject Gender	Male, Female
Subject Race	Asian, Black, Caucasian, Hispanic, Other (specify)
Diagnosis	Diagnosis given by medical professional (if known)
Call Characteristics	
Date of call	Month/day/year
Officer response time	Time call received
	Time arrived at scene
	Time finished with call
Scene location	Location of subject at time of officer response
Nature of Incident	Disorderly/disruptive behavior, drug-related offense, judge ordered detention, neglect of self care, nuisance, public intoxication, suicide threat/attempt/completion, subject complaint, subject requesting intervention, theft/other property crime, threats of violence to others, welfare check, Other (specify), no information available
Threats/Violence/Weapons	
Subject brandished weapon	
-during intervention	Yes, no, don't know
- type of weapon	Knife, gun, other (specify)
Subject threaten other	Yes, no, don't know
-to whom	Write in who was threatened: i.e. partner, officer, stranger etc)
Subject injury (prior to police intervention)	Yes, no, don't know
Prior contacts	
Subject known person	Yes, no, don't know
Repeat call (within 24 hours)	Yes, no, don't know
Drug/alcohol involvement	
Evidence of drug/alcohol intoxication	Yes, no, don't know
-if yes…	Alcohol, other drug (specify), don't know
Medication compliance	Yes, no, don't know
-specify medications if known	Write in medication name

Complainant relationship	Partner/spouse, boyfriend/girlfriend, parent, sibling, friend/acquaintance, business owner, other family member, police observation, other stranger
Behaviors evident at time of incident	Disorientation/confusion, delusions, hallucinations, disorganized speech, manic, depressed, unusually scared/frightened, belligerent or uncooperative no information available, other (specify)

Incident injuries
  during police intervention   Yes, no, don't know
    -if yes, who was injured   Write in, i.e. subject, officer, bystander, etc.
    -nature of injury   Write in nature of injury

Disposition of case	Immediate detention, transport to jail, transport to medical/treatment facility, subject stabilized on scene, referral to mental health professional, other (specify)
Charges pending	Write in pending charges
Equipment/technique	Handcuffs, verbalization, OC spray, baton, other (specify)

Subject Transported   Hospital, home/group home, homeless shelter, jail, other (specify)
    -by whom   officer, ambulance, other (specify)

Officer Beliefs
  Officer believes subject suffers from: Psychiatric disorder, developmental disability, alcohol addiction, drug addiction, other (specify)

Officer believes subject is: Danger to self, danger to others

Narrative Questions
  Describe in detail harmful acts or threats of harmful acts which indicate the person is dangerous to self or others
  Indicate any further details of the incident that you feel are important

VITA
Cindy Stewart

Education

PhD. 2009 Indiana University, Bloomington Criminal Justice
Tracks: Law and Society and Cross-Cultural Studies, Minor in African Studies

B.A. 2004 Indiana University, Bloomington
Major: Criminal Justice, Minors: Psychology, Classical Civilizations
Honors: Criminal Justice Departmental Honors and General Honors Notation
Graduated with Distinction

Areas of Teaching and Research Interest

Mental Illness and the Criminal Justice System, Methodology, Statistics, Police &
Society, Law & Society, African Justice, Social Conflict

Teaching Record

Assistant Professor (2009-current)-The College of Mount St. Joseph:
- Introduction to Criminal Justice
- Mental Illness in the Justice System
- Corrections

Instructor (2008-2009)-Indiana University:
- The Nature of Inquiry (Methodology)
- Techniques of Data Analysis (Statistics)
- Undergraduate seminar titled "Policing the Mentally Ill"
- Introduction to Criminal Justice- Online Study Course

Associate Instructor (2004-2008)-Indiana University:
- The Nature of Inquiry
- Introduction to Criminal Justice
- The Mad and the Bad

Professional Service

- Research Assistant for Jeanine Bell, JD. Topic: Move-in Violence-Hate crime in
  neighborhood context
- 2005-2006 Graduate Faculty Representative for Criminal Justice Department Graduate
  Program
- 2005 1st African Symposium on Negotiation and Conflict in Cape Town, South Africa
  through the IIMCR (The Institute for International Mediation and Conflict Resolution.
- 2003-2004 Member of Honors College Extracurricular Program Committee
- 2003 Member of IU Martin Luther King Jr. Day Committee

- 2002-2003 Internship with Honors College Extracurricular Program. Planned and hosted programs including: Crime and Punishment in America; Privacy, Piracy, Pornography, and the USA Patriot Act: Are There Things You Should Not Know?; Deaf Culture: Living in a World Without Sound; Art and Taboo (IU Art Museum)
- 2002-2003 Advisors Assistant for Honors College Welcoming and Advising Committee

Academic Honors

- 2004 Honors Degree in Criminal Justice for Undergraduate Thesis titled "South African Mental Health Laws: A Historical Review"
- 2002 Edward L Hutton International Experience Scholar
- 2001 Culbertson Essay Prize for Best Freshman Essay

Publications

- Stewart, Cindy (manuscript under review). *A Cultural Profile of Policing in South Africa: A Framing and content Analysis of Media Representations during the Transition from Apartheid to Democracy.*

- Stewart, Cindy. (2009) *Introduction to Corrections Learning Guide.* Bloomington: Indiana University School of Continuing Studies Independent Study Program.

- McNair, Cindy. (2008). *Criminal Justice P100 Introduction to Criminal Justice Learning Guide.* Bloomington: Indiana University School of Continuing Studies Independent Study Program.

- McNair, Cindy. (2006) "Malawi". World Policing Encyclopedia (Vol. 2, pp 523-527). New York: Routledge.

Presentations

- Stewart, Cindy. *Social Disorganization and Crisis Intervention: A Spatial Analysis.* American Society of Criminology. Philadelphia, PA. Nov. 2009.
- Sundt, Jody, McNair, Cindy & Snowden, Alexandra. *Academic Achievement and Student Intellectual Development: Implications for Teaching Research Methods to Criminal Justice Undergraduates.* American Society of Criminology. St. Louis, MO. Nov. 2008
- McNair, Cindy. *Police-Citizen Interaction: A Narrative Analysis of the effects of Gender and CIT.* American Society of Criminology. Atlanta, GA. Nov. 2007.
- McNair, Cindy. *An Investigation of Police Response to Situations Involving Persons in Mental Health Crisis.* Annual CIT Conference. Memphis, TN. Aug. 2007.
- McNair, Cindy. *Crisis Intervention: An investigation of police response.* American Society of Criminology. Ontario, Canada. Nov. 2005.
- McNair, Cindy. *Crisis Intervention: An investigation of police response.* Indiana University, Department of Criminal Justice Colloquium Series. Oct. 2005.