Identifying Effective Components of Crisis Intervention Training Models

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ABSTRACT

Identifying the Characteristics of Effective Components of Crisis Intervention Training Models

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The problem is that many mentally ill people are being arrested and there is overrepresentation of PWMDs in prisons throughout the United States. Previous research studies focused primarily on the effects of crisis intervention training on an officer's ability to identify persons with mental illness and their confidence in responding to individuals in a crisis. However, there has not been enough research to sufficiently take a critical look at the elements of intervention and their effectiveness on decreasing arrest rates of PWMDs by directing them to effective medical mental health treatment. Specialized crisis intervention based techniques could serve to reduce the criminalization of PWMDs in the criminal justice system ensuring they are diverted to medical health facilities for treatment. Thus, this study seeks to show that continuous implementation of effective components of the CIT model will mitigate the arrests of mentally ill

people specifically in Montgomery County, Maryland and Cook County, Illinois. Despite the success of CIT in policing agencies and promising empirical support, the literature has yet to clarify CIT's critical elements. Preliminary studies of CIT programs yielded promising results regarding officer perceptions of CIT, this study will show the rate of arrests have not been conducive to the components of the existing CIT models.

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1 Introduction

Individuals with mental health problems who are incarcerated in state, federal and local jail systems remain a growing concern in the United States (U.S.). “According to the Bureau of Justice Statistics, individuals with mental health needs make up a large proportion of the U.S. correctional population. An estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates have a mental health problem” (Kim, Becker-Cohen, & Serakos, 2015, p. 5). These individuals often receive inadequate care, with only one in three state prisoners and one in six jail inmates having received mental health treatment since their admission (James & Glaze 2006).

1.1 Definition of Mental Health Illness

According to natural psychologist Eric R. Maisel**,** the most recent Diagnostic and Statistical Manual of Mental Disorders, DSM-5 fifth edition states that:

"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society

are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (Maisel, 2013)".

The National Alliance on Mental Illness (NAMI) states that “mental illness is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis” (NAMI, 2015, p.1). DSM is the APA standard, however, different states use different terminology when referencing the meaning of mental disorder. In any case, a range of mental disorders are rampant among inmates. The mentally ill have been criminalized the mentally ill and local jails are used as de facto mental health institutions, (Varney, 2014) said Alex Briscoe, the health director for Alameda County in northern California. Jails and prisons remain the places where those with severe psychosis are housed (Varney, 2014).

Thus, the two terms – mental disorders and mental illnesses - may be used interchangeably as they address the same concepts” (DifferenceBetween.net, 2011). Nearly 60 million people have some form of mental disorder in a given year. Persons with mental disorders (PWMDs) can suffer from emotional, mental and social difficulties that manifest as a manic crisis. Crisis behaviors such as angry outbursts, suicidal thoughts, or delusions can be triggered when individuals experience a breakdown in coping skills resulting in limited perception (National Alliance on Mental Health, 2015). PWMDs can experience a mental crisis from various circumstances and situations that they encounter in their daily lives. Some examples of the circumstances PWMDs might come across are homelessness, victimization, lack of medical treatment, substance abuse, and deterioration of their mental condition (Hill, Quill, & Ellis, 2004).

According to the Bureau of Justice Statistics, individuals with mental disorders make up a large proportion of the U.S. correctional population. As depicted in Figure 1.1, an estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates had a mental disorder. In this thesis, jails are defined as city or county facilities housing inmates who were awaiting trial or sentencing on a short-term basis generally for less than a year. In contrast, prisons were operated at the state or federal levels. PWMDs often received inadequate care. Only one in three state prisoners and one in six jail inmates having received mental health treatment since their admission (James & Glaze 2006).

Percentage of Inmates with Mental Health Problems

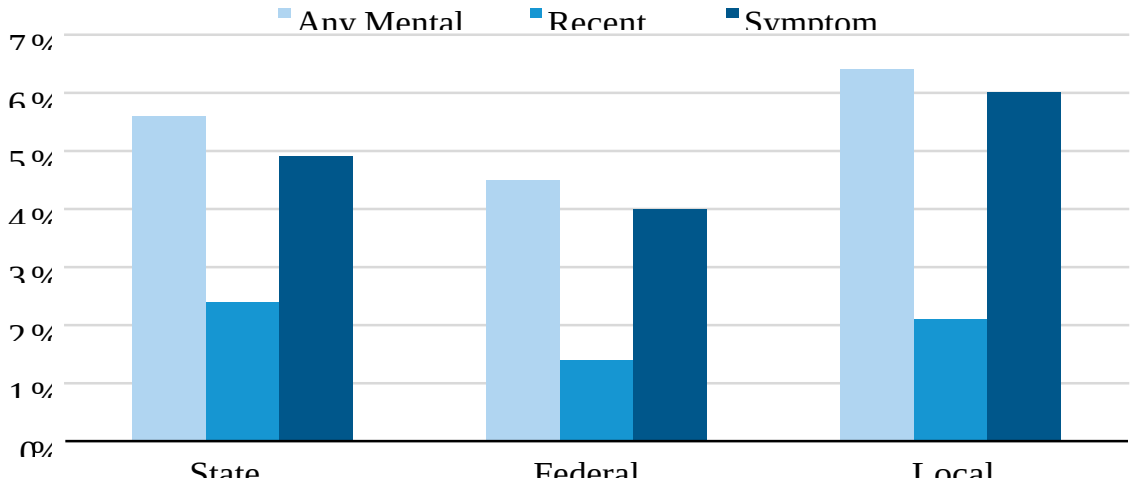

Figure 1.1

Source: James and Glaze 2006.

1.2 Statistics

The United Stated Department of Justice data (see Figure 1.2) showed that 21% suffered from DD; 12% suffered from manic-depression, bipolar, and mania; 5% suffered from schizophrenia; 7% suffered from post-traumatic stress disorder; 8% suffered from another anxiety disorder, and 6% suffered from personality disorder.

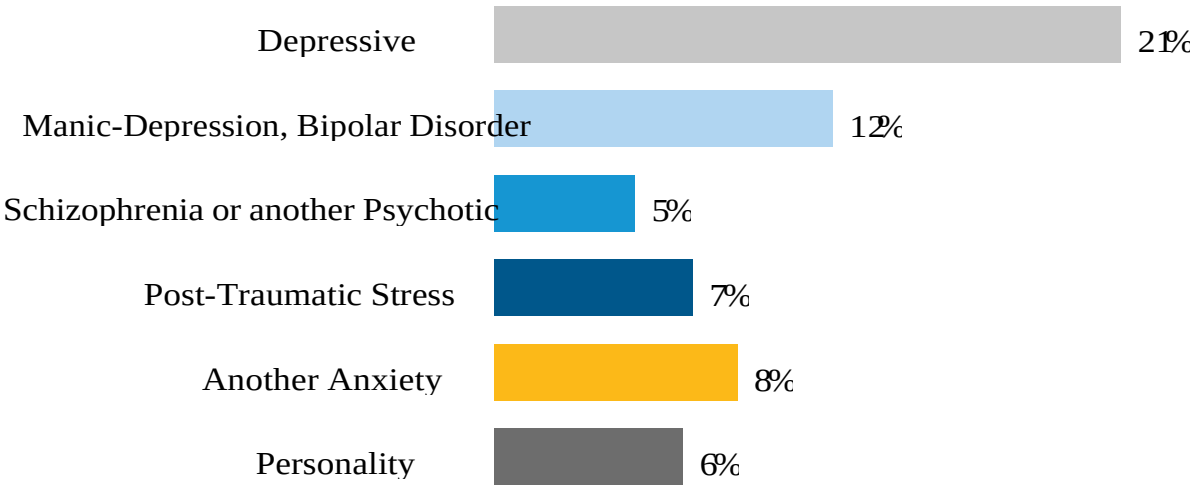

Figure 1.2

Source: US Department of Justice, Bureau of Justice Statistics 2007.

In addition, that among the total number of state prisoners "who reported a mental health problem, 49 percent had a violent offense as their most serious offense, followed by property

crimes (20 percent) and drug offenses (19 percent)" (Kim et al., 2015, p. 9). Alarmingly, mental illness affected a greater percentage of incarcerated women than men.

Within this framework, during a 12 month period at least one mental health problem was found in 73 percent of women and 55 of men in state prisons; 61 percent of women and 44 percent of men in federal prisons; and 75 percent of women and 63 percent of men in local jails (Varney, 2014).

Table 1

	STATE PRISON %	FEDERAL PRISON %	LOCAL JAILS %
Men	55	44	63
Women	73	61	75

1.3 Characteristics of Individuals with Mental Disorders

A break down in coping mechanisms can trigger an onset of a manic crisis behavior in PWMDs (Hill, Quill, & Ellis, 2004). For instance, an individual with bipolar disorder or schizophrenia may exhibit manic symptoms of their psychotic disorder and have trouble coping with reality. Their manic symptoms during a crisis can range from experiencing delusions which are inclusive of false beliefs, hallucinations, difficulty concentrating, agitated behavior, and coupled with being preoccupied, withdrawn, or argumentative (Hill, Quill, & Ellis, 2004). Prisoners suffering from mental illness are more likely to have experienced homelessness, prior incarceration, and substance abuse than those without mental illness (Cloyes et al. 2010), and, cyclically, these factors common among offenders also predispose them to mental illness (Chiu

2010). Previous research shows that police officers are often the first ones on the scene (Lamb, Weinberger, & DeCuir Jr, 2014a) when PWMDs become pose harm to themselves or others in the community during a mental crisis. “The police often fulfill the role of gatekeepers of social work in deciding whether a person with mental illness who has come to their attention should enter the mental health system or the criminal justice system” (Lamb, Weinberger, & DeCuir Jr, 2014, p. 1).

1.4 Overview of Crisis Intervention Team (CIT) Model

“The Crisis Intervention Team (CIT) model is a specialized police-based program intended to enhance officers' interactions with individuals with mental illnesses and improve the safety of all parties involved in mental health crisis (Compton, Bahora, Watson, & Oliva, 2008)”. CIT officers are trained to use de-escalation skills and specialized crisis intervention training to deal with PWMDs to ensure both parties’ safety by using safe police discretion. The evidence shows that police liability, injury, and the need for using physical force are reduced when police officers utilize crisis intervention tools on PWMDs during a crisis. CIT gives police the ability to use discretion by making decisions on whether to de-escalate a crisis, detain PWMDs safely, or take them to a mental health emergency treatment center (Oliver, Morgan, & Compton, 2010). With the implementation of effective CIT, a police officer can make a quick and safe decision on how to resolve dangerous interventions while restoring social order. “CIT is considered by many to be the most rapidly expanding and promising partnership between law enforcement and mental health professionals (Compton et al., 2008)”.

The CIT model used by police departments depends heavily on components and factors that shape effective responses on the part of the officer during an encounter with PWMDs

(Watson & Fulambarker, 2012). CIT involves three core components: intense training, partnership with community resources, and the adoption of the new role that CIT-trained officers must play within their department (Reuland, 2004; Watson, 2010). CIT models and research have focused primarily on the effects of training during the officer's encounters and the ability to identify PWMDs, but not all CIT models have that same emphasis or the same level of effectiveness on jail diversion of PWDs.

1.5 Origin of the CIT Model in Memphis, Tennessee

In 1988, the Crisis Intervention Team (CIT) model was developed and implemented by the Memphis Police Department in partnership with the Memphis chapter of the National Alliance for the Mentally Ill, the University of Memphis, and the University of Tennessee (Teller, Munetz, Gil, & Ritter, 2014; Compton, Michael et al., 2006). "This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events. This community effort was the genesis of the Memphis Police Department's Crisis Intervention Team" (City of Memphis, 2016, p.1).

The overall purpose of the CIT models was to increase safety during police encounters with PWMDs and divert PWMDs from the criminal justice system into mental health treatment (Watson & Fulambarker, 2012). The Memphis CIT is a collaboration of police officers and mental health experts. The mayor of Memphis, Tennessee (TN), enlisted the assistance of psychology departments, medical centers at local universities and the National Alliance for the Mentally Ill (NAMI) to establish building blocks for the CIT model (Thoits, 2005).

Before the CIT program was introduced, the standard protocol for officers responding to encounters with PWMDs was to take them to jail or use lethal physical force to detain PWMDs

in crisis. However, the key to CIT intervention is the use of social service providers and jail diversion alternatives between officers and the mentally ill population (McGuire & Bond, 2011). Thus, the intent of CIT was two-fold: 1) to improve the safety of officers and the public during potentially dangerous situations, and 2) to decrease the number of arrests of persons with mental illness (Teller et al., 2014). Seemingly, the goals of the CIT were to provide immediate response to situations where PWMDs experiencing a state of crisis are to be directed to an establishment that offers mental health treatment. Also, to reduce injury to the responding police officer while destabilizing PWMDs in a state of crisis (Martinez, 2010).

1.6 Statement of the Problem

The problem is that many PWMDs are being arrested, which results in overrepresentation of PWMDs in prisons throughout the United States (Ritter et al., 2010). At the same time, there are safety concerns for police officers and the public in regards to the treatment on handling incidents with PWMDs. Previous research studies focused primarily on the effects of training on officer ability to identify PWMDs and their confidence responding to PWMDs in crisis. However, there has not been enough research to sufficiently take a critical look at the effectiveness of CIT elements on crisis intervention as a jail diversion. Specialized crisis intervention based techniques could serve to reduce the criminalization of PWMDs in the criminal justice system ensuring they received medical attention for their mental condition (Oliva & Compton, 2008). This requires a diversion of PWMDs to mental health services in lieu of arrest for those individuals whose deviant behavior is thought to be caused by mental illness. In addition, more effective CIT training procedures, along with implementation strategies, should take place to redirect PWMDs into the mental health care system where PWMDs will get support

services for their mental health (Munetz & Griffin, 2006). Specialized components from the crisis intervention models used by officers have the potential to redirect PWMDs in the criminal justice system to mental health treatment as appropriate. This would positively affect the use of scarce community resources; improve community relations, officer safety, and public safety (Ritter et al., 2010).

1.7 Purpose of the Study

The purpose of this study is to examine the effectiveness of the CIT Model components for those who are afflicted with mental disorders during a state of manic crisis when responded by a CIT trained officer. This is important because the previous research disclosed that an overwhelming number of PWMDs are overrepresented in the criminal justice system. "It is estimated that 1 million PWMDs are booked into U.S. jails each year, and are incarcerated 1.5 times as often as they are hospitalized for their psychiatric disorders (Fisher & Grudzinskas, 2010)". Training in manic crisis incidents given to officers, with access to effective mental health services, can improve the management of mental crisis in a community. Officers are spending more time on arresting PWMDs or managing crisis related incidents rather than responding to other police incidents (Cordner, 2006). Arresting PWMDs for misdemeanors such as disorderly conduct or loitering due to their mental disorder criminalizes mentally disordered behavior (Fisher & Grudzinskas, 2010). Thus, this study seeks to show that continuous implementation of effective components of the CIT model will mitigate the arrests of mentally ill people specifically in Montgomery County, Maryland and Cook County, Illinois.

For this thesis, Cook County, Illinois was chosen because an article deemed Cook County Jail as the largest mental health facility and the Chicago police department is the largest

department in the nation. The article asserts that one-third of the prisoners there have psychological disorders. According to the data, at Cook County Jail, about one in three inmates has some form of mental illness (or disorder). "At least 400,000 inmates currently behind bars in the United States suffer from some type of mental illness—a population larger than the cities of Cleveland, New Orleans, or St. Louis—according to the National Alliance on Mental Illness" (Ford, 2015, p. 1). The majority of the inmates were arrested for crimes of survival such as breaking or entering to find a place to sleep due to homelessness or retail theft to find something to eat. Some PWMDs are incarcerated due to drug related charges from substance abuse. NAMI approximates that nearly 25 to 40 percent of all mentally ill Americans face the possibility of jail or incarceration at some point in their lives (Ford, 2015). I chose Montgomery County because within the Montgomery County and Baltimore, Maryland vicinity, the number of mentally ill individuals have grown within jail facilities at an estimate of 20 percent of the jail population. Also, there have been many cases of offenders with mental health issues being processed through the Department of Corrections. They included one case in 2011 in the community of Olney in which a man named Rohan Goodlett believed he was getting instructions from his TV to kill or be killed, according to authorities "For more than three decades, beginning with Estelle v. Gamble in 1976, the courts have protected the constitutional right of prisoners to health care" (Rold, 2008). Hence, American prisoners are the sole group with a constitutional right to health care (Ford, 2015).

1.8 Significance of the Study

This study seeks to examine the effectiveness of the procedural components of the CIT model as a jail diversion alternative. In other words, does the training of police officers in CIT

mitigate the arrests of PWMDs? Are PWMDs redirected to the mental health care system for adequate support services? This is important because it will address the major concerns of why the CIT model was initially developed as previously mentioned. Additionally, this research study seeks to inform current and existing literature, current CIT training models, and crisis intervention policies in police departments on police responses to PWMDs in communities by incorporating effective educational references on crisis intervention tactics. With effective use of crisis intervention tools from police departments with PWMDs, higher rates of placement in effective mental health facilities and lower rates of incarceration will show the effectiveness of the CIT training positively (McKenna, 2011).

1.9 Overview of Theoretical Framework

The theoretical framework for this study is "labeling theory". Research sociologist, Thoits (2005) asserts that labeling theory is based on behaviors that are considered deviant or inappropriate when society labels them as deviant or not in conformity with social norms. Members of society interpret those behaviors as deviant and attach a label to individuals who they consider deviant as a distinction. Individuals who are labeled negatively due to current social norms may be considered a drug addict, a criminal, juvenile delinquent, sex offender, and or mentally ill. The labelling theory approach emphasizes "the negative effects of psychiatric labelling. According to this theory, through labelling the negative stereotype of the mentally ill, which is still prevalent among the general public, will be triggered. This in turn will lead to increased discrimination against those suffering from mental disorder" (Angermeyer & Matschinger, 2003, p. 304).

PWMDs are stigmatized in our society due to false perception of the type of mental disorder a mentally ill person may exhibit. Negative connotations connected with mental illness may be as harmful, in which negative societal stigmatizations limits social opportunities that is available for PWMDs (Overton & Medina, 2008). Negative stigma affects PWMDs by evoking barriers a mentally ill individual may face in obtaining treatment for a mental condition. Barriers that PWMDs may face ranges from financial challenges regarding medical treatment, and negative attitudes from mental health professionals' lack of resources and budget cuts that affect social services (Overton & Medina, 2008).

On the other hand, "sociological role theory points to the positive effect of labelling" (Angermeyer & Matschinger, 2003, p. 304). Hence, if the mental condition is perceived "as an illness, the privileges of the patient role are granted and patients are not held responsible for their illness resulting in a more accepting attitude towards those suffering from mental disorder" (Angermeyer & Matschinger, 2003, p. 304). Overall, officers completing CIT training reported increased confidence on how to view mental illness as a brain disorder rather than misconduct. This resulted in less criminalization of the mental illness, reduced stereotyping and negative stigmas of PWMDs (Thoits, 2005).

Many studies examined whether or not police confrontations with PWMDs found that behavioral signs of mental impairment influenced the use of force by police, or if those who appeared mentally ill were more likely to be injured by police due to stigmatization of mental illness in society (Kesic, Thomas, & Ogloff, 2013). Officers' attitudes can influence interactions with PWMDs affecting police discretion on how to respond to calls. An attitude or belief towards a PWMDs illness that is perceived as dangerous by police can come in the form of avoidance

and withholding help. Educating officers to recognize mental illness symptoms and recognize the risk of danger involved when subduing a dangerous individual will equip them with the de-escalation techniques. This results in more positive interactions with PWMDs during police encounters (Ritter, Teller, Munetz, & Bonfine, 2010).

1.10 Research Questions

Based on previous studies, the research questions for this study are:

1) Did the CIT training strategies decrease the number of arrests for PWMDs?
2) Was there an increase in the number of PWMDs redirected to the mental healthcare system using the CIT model?

2 Literature Review

This section will address the component of the CIT model specifically in Montgomery County, Maryland and Cook County, Illinois. In addition, this paper will address CIT policies and procedures in addition to the social and environmental factors of the CIT components. This study seeks to determine the effectiveness of the components in the CIT model in its efforts to decrease the number of arrests and increase the number of redirected PWMDs to mental health facilities. Early research findings provide preliminary support for the effectiveness of CIT in enhanced self-efficacy and reduced social distance stigma among CIT-trained officers. Such changes in in police attitudes are an important foundation of effectiveness in CIT training. The use of force by officers and the lack of confidence when handling interactions with PWMDs may lead to irrational responses by both parties escalating a non-violent situation to a dangerous situation (Compton et al., 2011).

2.1 Overrepresentation of PWMDs in Jails

There are an overwhelming number of mentally ill persons in the prison and jail systems. The U.S. prison population has quadrupled over the past 25 years, and correctional institutions are now responsible for meeting the health care needs of approximately 2.3 million US inmates (Wilper et al., 2009). In terms of the mental health of prison and jail populations in the United States, the Bureau of Justice Statistics (BJS) indicates that more than 700,000 inmates reported symptoms or a history of a mental health disorder at midyear 2005 (James & Glaze, 2006). These

numbers represent a substantial need for mental health treatment in the criminal justice system. "However, given that many prisons and jails are not equipped to handle this growing population with special needs, these numbers raise concerns about the well-being of PWMDs involved in the criminal justice system, as well as the safety in correctional facilities and communities in general" (Kim et al., 2015).

As previously mentioned in Chapter 1, PWMDs are overrepresented in jails, and some of their charges can stem from officers' misinterpretation of their related behaviors by their mental disorder. During patrol duties, law enforcement officers, who often take on a mental health triage role, encounter many PWMDs in addition to those with alcohol and drug problems along with developmental disabilities. Most officers are unaware of the signs and symptoms of mental illnesses or available resources for PWMDs (Compton et al., 2011). Therefore, they might arrest subjects rather than refer them to psychiatric services, which criminalize PWMDs for having a mental disorder (Compton et al., 2014). Offenders with severe mental illness place even more strain on the criminal justice system as a whole, in terms of their unique case-processing requirements, treatment needs and their increased risk of recidivism (Baillargeon et al., 2009; Cloyes et al., 2010; Feder, 1991). In addition, housing mentally ill offenders in the criminal justice system is costly. In addition to high health care costs, mentally ill inmates tend to have higher rates of prison misconduct and recidivism (Fellner, 2006; Toch & Adams, 2002).

2.2 Components of CIT Model

"The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the

'Memphis Model'." (Dupont, Cochran, & Pillsbury, 2007, p. 3). Overall, the CIT model provides officer intervention-based services to assist PWMDs for the purpose of reducing stigmas and entry into the prison system while increasing mental health care services. Thus, this allows for more effective interaction between the criminal justice system and the mental health care system (Dupont et al., 2007).

As depicted in Table 2-1, the three primary core elements with specific components for the CIT model are: ongoing, operational, and sustaining.

Table 2-1: Elements of a CIT Model

ELEMENTS	COMPONENTS
1) Ongoing	**a.** Partnerships: Law Enforcement, Advocacy, Mental Health **b.** Community Ownership: Planning, Implementation & Networking **c.** Policies and Procedure
2) Operational	a. CIT: Officer, Dispatcher, Coordinator b. Curriculum: CIT Training c. Mental Health Receiving Facility: Emergency Services
3) Sustaining	a. Evaluation and Research b. In-Service Training c. Recognition and Honors d. Outreach: Developing CIT in Other Communities

Source: The University of Memphis School of Urban Affairs and Public Policy Department of Criminology and Criminal Justice CIT Center (September 2007)

For the purposes of this paper, I will focus on two different elements and one related component for that particular element as follows: 1) Ongoing Element (Partnerships: Law Enforcement, Advocacy, Mental Health), and 2) Operational (Curriculum: CIT Training) (Dupont et al., 2007).

2.3 The Cook County CIT Model

Chicago, Illinois has the second largest police department in the United States. The Chicago Police Department is comprised of 25 police districts and serves approximately 2.9 million residents. Officers are required to adhere to specific laws concerning PWMDs even if they are not CIT trained. The Chicago CIT model recognizes many factors such as officer characteristics, organizational factors, treatment facilities and the interaction between the treatment centers and the CIT officers, and community characteristics. The Chicago Police Department (CPD) has been using their CIT model since 2008. The Chicago Police Department is comprised of 25 police districts and serves approximately 2.9 million residents. All Chicago police officers receive nine hours of training on mental health issues during their pre-service academy training (Canada et al., 2010). CIT was adopted as a result of recommendations set forth by a Mental Health Task Force, initiated by then Chicago Police Department's Superintendent Cline. The Mental Health Task Force consisted of mental health and criminal justice stakeholders. They were asked to assess current policies and programs regarding Chicago's law enforcement response to individuals with mental disorders (or illness). The task

force recommended CIT as an initiative to enhance knowledge regarding mental disorders and skills when responding to calls involving PWMDs (Canada, Angell, & Watson, 2010).

Under the Chicago Police Department CIT model, police officers must complete 40 hours of state certified training. Since the fall of 2004, NAMI Chicago has been working with the Chicago Police Department to assist in the implementation of the 40-hour Crisis Intervention Team (CIT) training for Chicago police officers. This makes Chicago the largest urban area with CIT training in place for its officers (Canada et al., 2010). In 2005, the Chicago Police Department began piloting testing CIT in two demographically different districts with the launch of two 40-hour CIT trainings. Officers in these districts were encouraged to apply to the program (Canada et al., 2010). In each district 40 officers and supervisors were trained. In July 2006, the Chicago Police Department began program expansion, training approximately 30 officers from across the city each month (Watson et al., 2009) (Canada et al., 2010).

Numerous CIT-trained officers based in Chicago public schools asked for additional training specific to mental health issues for the juvenile population. An Advanced Juvenile 40-hour CIT Training for officers who previously completed the Basic CIT training was implemented in April of 2010 (Campbell, 2012). This made Chicago the first city in the nation to address the prevalence of mental illness among delinquent youth (Campbell, 2012). The goals were to advance officer knowledge of youth mental illness, decrease violent interactions, decrease the number of mentally ill youth in the juvenile justice system and teach officers with the skills to safely interact with youth in crisis (Campbell, 2012). The Chicago police department CIT model consists of learning crisis intervention skills, identifying mental disorders, substance abuse, geriatric issues, and psychotropic medications (Martinez, 2010).

A key component of the Memphis CIT model is the use of a psychiatric emergency drop-off with a no refusal policy. In Chicago, emergency drop-off centers might not be designated in all police districts. These centers can assist individuals who are in need of other medical assistance. Due to the size of the city, a single point of access and/or no refusal crisis drop-off point were not feasible (Watson, Ottati, Draine, & Morabito, 2011).Thus, Chicago's CIT program relies on memorandums of understanding (MOUs) with designated hospitals throughout the city that establish no-refusal policies and give police transports priority to reduce the time that officers spend waiting in emergency rooms. These MOU arrangements and corresponding departmental Special Orders directing officers to transport persons in need of psychiatric evaluation and care to the designated facilities (Watson et al., 2011). Previous research studies revealed that Chicago's CIT program has CIT officers using less force than non-CIT-trained officers. No correlation was found between CIT implementation and less police injuries in comparison to the Memphis CIT program (Martinez, 2010). Under the Chicago, IL CIT model used by the Chicago Police Department there was no difference in arrest rates between CIT and non-CIT trained officers during patrols. However, CIT officers were more likely to direct PWMDs to mental health services and less likely to resolve calls with contact only than their non-CIT colleagues (Watson et al., 2011).

2.4 Montgomery County, Maryland CIT Model

In 1999, the Montgomery County, Maryland (MD) police department established the Montgomery County Police Crisis Intervention Team. The model used by Montgomery County, MD police officers focuses on providing the necessary training and skills regarding how to safely de-escalate dangerous encounters with PWMDs who are in crisis when the police encounter

them. The Montgomery County police department CIT program was modeled after the Memphis CIT program (Hill, Quill & Ellis, 2004). According to Hill et al. (2004), the CIT program has three complementary components that have made it a success: the training component, the CIT officer component, and the CIT coordinator component. The training component of the model consists of lethal and non-lethal training maintaining control of the situation to avoid the possibility of it escalating further (Hill et al., 2004).

The police department formed an Immediate Action Team, which incorporates the department's less-than-lethal weapons into a standardized protocol. The CIT Officer component consists of basic training that comprises a 40-hour block of instruction wherein officers receive both classroom and hands-on instruction. Professionals from the partnering mental health organizations teach various blocks of instruction, which cover the different types of mental illness, interview techniques, de-escalation strategies, and other relevant topics (Hill et al., 2004). Upon completion of the 40-hour course of instruction, CIT trained personnel receive a badge indicating their CIT certification. This helps the public to identify officers wearing the badge are specialized in CIT training (Hill et al., 2004). There is an assigned officer per policing district who is a voluntary CIT coordinator. The full time CIT coordinator establishes relationships with the partner agencies, manage the CIT training courses, attend meetings with police management, meet with other CIT coordinators within their districts and meet with mental health community professionals (Hill et al., 2004).

2.5 Differences & Similarities of CIT Models

In this section, the similarities and differences of the components of CIT training models in Chicago, Cook County, Illinois and Montgomery County, Montgomery, Maryland. Although

there are several components and key factors, in this paper. The similarities and differences are discussed for the following elements as illustrated in Table 2.5: Ongoing Element #1 (drop off units and collaboration) and Operational Element #2 (CIT personnel and mental health services).

Ongoing Element #1:

- Drop off units
- Collaboration

Operational Element #2:

- CTI personnel
- Mental health services

Elements	Composition	Similarities (Cook and Maryland)	Differences
Ongoing	Partnerships, community ownership, drop off policies	▪ Drop off units ▪ Collaboration with other sites	Cook: uses CIT MD: uses MCT
Operational	CIT personnel, CIT training, mental health services	▪ Volunteer Police Officers ▪ Specialized Training for Dispatchers ▪ Training from	Cook: use MOU's MD: uses EEP and crisis intervention centers

		NAMI & mental health consultants	

Table 2.5: Ongoing Element #1 (drop off units and collaboration) and Operational Element #2 (CIT personnel and mental health services).

2.6 Memphis, Tennessee CIT Model

2.6.1 Stakeholder elements. The core stakeholder elements of the CIT Memphis model require partnerships, community ownership, and policies for effective implementation. Within this framework, ongoing collaboration, support mechanisms, networks and sustainability are critical components. Ongoing collaboration between law enforcement and mental health organizations pave the way for a coordinated effort in CIT. Additionally, the community must have support mechanisms and networks in place for PWMDs between police and mental health professionals. It is essential to have trained operational personnel such as officers, dispatchers, and coordinators in place to facilitate the CIT training. Sustaining elements such as evaluation and research develop ongoing outreach in communities (Dupont, Cochran, & Pillsbury, 2007).

In order to facilitate efforts for the Memphis CIT model, officers receive specialized training for law enforcement. In addition, strong partnerships between mental health and law enforcement are enacted along with enhanced emergency psychiatric services are available to assist PWMDS. This particular model provides self-selected officers with 40 hour of classroom training in de-escalation and managing mental crisis. The model trains officers on how to identify various mental illnesses, addictive diseases, site visits to local emergency mental

treatment facilities, and mastering de-escalation crisis intervention skills (Oliva et al., 2010). For instance, police officers learn how to interact directly with PWMDs, crisis teams, and treatment centers (Lord, Bjerregaard, Belvins, & Whisman, 2011). In addition, emergency dispatchers are also trained with the ability to recognize a CIT call and how to dispatch a CIT officer. CIT training involves police officers interacting directly with PWMDs, crisis teams, and treatment centers (Lord, Bjerregaard, Belvins, & Whisman, 2011). There are challenges in the implementation of CIT when adequate training is not provided for dispatch personnel. Furthermore, the CIT models does not address the limited availability of psychiatric emergency facilities, a design for all community settings, and other varying social factors (Compton et al., 2010). This is significant because the core elements of the CIT model require an ongoing coordinated effort

2.6.2 Mental health consultants. Another strategy used by police departments is the use of mental health consultants who are hired by the police department to provide on-site and telephone consultations to officers in the field (Lamb et al., 2002). These collaborative teams are deemed effective in resolving emergency situations and diverting PWMDs to the mental health system rather than to jail (Lamb et al., 2002). The major goals of these specialized mobile crisis teams are to resolve the crisis and to reduce criminalization. Studies that have evaluated such teams found that they had arrest rates of up to 13 percent, in contrast to an arrest rate of 21 percent. The findings in the statistics show that effective mental health consultants on the field lower the incidence of inappropriate arrests (Lamb et al., 2002). Mental health agencies have clinicians and officers that interact when police assistance is needed to address safety issues. Clinicians may ask police to conduct well-being checks or call them for assistance with a client

in crisis. Clinicians participate and conduct the modules of the CIT curriculum (Watson et al., 2012).

2.6.3 Response models. Police departments may utilize one of three popular alternative response models that include the Mobile Crisis Team (MCT), the Community Service Officer (CSO) model, or the Crisis Intervention Team (CIT) model (Martinez, 2010). The Crisis Intervention Team (CIT) is trained officers who can identify symptoms of mental illness, referring PWMDs to mental health services (Martinez, 2010). The Mobile Crisis Team (MCT) involves partnerships between officers and mental health professionals who come up with an action plan on how to manage PWMDs experiencing a mental crisis. The Community Service Officer (CSO) model uses candidates who have social work background and crisis intervention training. These three models serve as alternatives to traditional responses in managing PWMDs having a mental crisis.

The Montgomery CIT model and the Chicago CIT model are similar because the main goal is to provide effective response to PWMDs. On the other hand, they are different because the Montgomery County CIT model uses an onsite mental health mobile crisis team onsite with the police officer responding to crisis calls. The Chicago Cook County CIT model uses the CIT trained officer only to stabilize PWMDs in crisis. The Mobile Crisis Team (MCT) model is used by the Knoxville, Tennessee police department, while the Chicago, IL police departments use the traditional CIT model (Martinez, 2010). The Montgomery County Department of Health and Human Services in Montgomery, Maryland has formed a Mobile Crisis Team (MCT) that incorporates mental health professionals who are available from 8 a.m. to midnight, 7 days a week (Hill et al., 2004). According to Kimball & McDowell (2001), the MCT is a mobile

outreach service that provides emergency mental health services to the community. The MCT assists the Montgomery County Police Department, family members, friends, neighbors, and school personnel who observe an individual with disturbing behavior. Among the calls that the MCT receives, 50 % of MCT assistance are due to police requests for assistance during CIT responses (Kimball & McDowell, 2001). There are up to two MCT therapists who assist the police officers during a CIT response. The role of the therapists is to stabilize the individual, evaluate behavior, and assist the officers with the PWMDs mental health problem (Kimball & McDowell, 2001). If the PWMDs does not exhibit any severe symptoms of mental illness the CIT officer will request an emergency evaluation petition (EEP) from the MCT. As a concerted effort, an EEP provides the MCT or officer permission to transport an individual against their will to a hospital emergency room for a mental health evaluation. With police officers and MCT units working together the crisis centers are more likely to get an increase in referrals of PWMDs clients who are brought in (Kimball & McDowell, 2001).

In Memphis, Tennessee when PWMDs are in crisis or arrested exhibiting signs of mental illness or substance abuse, CIT officers are dispatched. The triage center is a one-stop centralized crisis service for officers. The center has a no-refusal policy for police referrals and officers are able to transport individuals either voluntarily or in custody. This allows the officers the flexibility of returning to duty within in 30 minutes. The no-refusal policy addresses barriers in the traditional emergency room model by eliminating unnecessary arrests (Steadman et al., 2001). A key component of the Memphis CIT program is a psychiatric emergency drop-off with a no refusal policy that gives police transports priority allowing officers to resume their patrol duties. Under the CIT program that the Chicago Police Department utilizes, there is no central

drop-off in the vicinity of Chicago in the Cook County region (Compton et al., 2011). The Chicago Police Department uses the traditional methods of officers interacting with PWMDs in crisis. The Chicago Police Department maintains memorandums of understanding (MOUs) with designated emergency facilities in each police district in Chicago, IL (Watson, Ottati, Draine, & Morabito, 2011). The local NAMI affiliates provide the police departments with contact resource cards that list information about mental health service resources (Watson et al., 2011). A designated Emergency Mental Health Receiving Facility is a critical aspect of the Memphis CIT Model as it provides a resource of emergency entry for PWMDs. To ensure CIT's success, the Emergency Mental Health Receiving Facility must provide CIT Officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status. "The Emergency Mental Health Receiving Facility is part of the operational component of the Memphis CIT Model that provides feedback and engages in problem solving with the other community partners, such as Law Enforcement and Advocacy Communities (Dupont et al., 2007)".

CIT is predicated on effective admission policies into mental health facilities. According to Wysinger (2014), in a report to the United States Senate Committee on the Judiciary, Illinois has more than 700,000 adults struggling with severe mental illnesses at an annual cost to the state of more than $2.6 billion in costs. According to the National Alliance on Mental Illness (MIllinois (NAMI), in the last four years spending on mental health in Illinois has been cut by 32%. In Chicago, 50% of its community mental health centers closed in 2012. This created a huge impact on public access for PWMDs to mental health services. While the closure of community mental health centers may contribute to the increase in the number of mental health-

related police calls for service, it is not the only contributing factor. In Chicago, for instance, the majority of PWMDs brought to hospitals by Chicago Police Department (CPD) officers are of low income, uninsured or on Medicaid, and unable on their own to access National Alliance on Mental Illness (NAMI) needed services. The unfortunate reality is that currently the largest providers of mental health services are jails (Wysinger, 2014).

The Illinois Department of Public Health (IDPH) supports PWMDs who require long-term care services. In 2011, there were 114,375 admissions to beds for acute mental illnesses and 887,220 inpatient days. Illinois Department of Corrections (IDOC) health care staff estimates 16 percent of 48,000 individuals in the total IDOC population have a mental health disorder. An estimated 14 percent in Illinois county jails have mental illnesses and 526,000 adults in Illinois had a serious mental illness in 2012. A number of inpatient admissions were referred by the criminal justice system for mental health treatment. In 2012, PWMDs with misdemeanors made up 36 percent of the forensic referrals statewide and 50 percent were in the Chicago metro area (Illinois Department of Human Services, n.d.)

According to (Kimball, 2001), the Montgomery Police Department initiates formal and informal pre-booking diversion from jails to the community mental health services. Officers formally divert PWMDs through an EEP and transport the PWMDs to a hospital emergency room, contact the MCT team or transport the PWMDs to the Crisis Center. To qualify for an EEP the PWMDs must be a threat to themselves or others who are unable to access mental health treatment. With an EEP the officers transport the PWMDs to the closest emergency room and return to their patrol duties. Hospitals have up to 6 hours to complete a mental health evaluation on PWMDs and decide if the person is stable enough to be released or committed into a Mental

Hospital (Kimball, 2001). The Department of Health & Human Services Crisis Center provides 24/7 walk in crisis stabilization services to PWMDs. The Crisis Center provides short term mental health services and a 72 hour stay at the intervention center. While it is estimated that 15,000 arrestees are brought to Central Processing Unit before appearing in court. The Montgomery County Department of Corrections (DOCR) refer 141 inmates per month for mental health screening with an annual number of referrals at 1,695 in the year 2000 (Kimball, 2001).

2.7 CIT Operational Elements

2.7.1 Volunteer officers. Another key component of the Memphis, TN CIT model is that officers volunteer to become CIT officers, in which a small number of officers are trained in the CIT program (McGuire & Bond, 2011). Within the CIT Memphis program only 25% of the police force is CIT trained to ensure 24/7 availability (Dupont, Cochran, & Pillsbury, 2007). The CIT is made up of volunteer officers from each Uniform Patrol Precinct. CIT officers are called upon to respond to crisis calls that present officers with complex issues relating to PWMDs. CIT officers also perform their regular duty assignment as patrol officers. The Memphis Police Department has 225 CIT officers who participate in CIT training under the instructional supervision of mental health providers, family advocates, and mental health consumer groups. The training affords CIT officers with a more confident, offer a more humane, and calm approach. These officers maintain coverage 24 hours seven days per week. These officers maintain a 24 hour, seven day a week coverage. Other departments are now having 100% of their patrol officer's complete CIT training so there is consistency across patrol officers (Reuland, Draper, & Norton, 2010). The Montgomery County Police Department CIT model, has an officer

who serves full time as the department's CIT coordinator. The CIT coordinator's duties focus on establishing relationships with partner liaisons; organizing the basic CIT training bimonthly; attending quarterly meetings with the police chief; meeting monthly with the district CIT coordinators; and participating in meetings with the mental health community. The coordinator also tracks all incidents involving CIT officers and collects data on CIT incidents (Hill et al, 2004). For statistical purposes, all CIT members must complete a brief report after they resolve an incident involving PWMDs. Each of the six police district stations has an officer assigned as a district CIT coordinator, a voluntary position that is performed along with regular patrol responsibilities. The district coordinators assist the department coordinator by recruiting officers to become CIT certified, tracking various CIT related incidents, briefings on critical incidents, assisting CIT members with their cases, and participating in monthly meetings with the department CIT coordinator (Hill et al, 2004).

In Chicago, CIT research was conducted on the CIT program that began in 2000. Officers volunteer for the training program and receive no monetary incentives to participate. Upon volunteering for the program, the officers are assessed by the CIT coordinator on motivation, motives, and job performance before participation in the training. According Watson (2009) all Chicago police officers receive 9 hours of training on mental health issues during their preservice academy training (Watson, Ottati et al., 2009).

2.7.2 Training of personnel. Training led by both law enforcement and mental health professionals is the most effective teaching process for CIT trainees. Training for the police officers should include classification of mental disorders, learning skills in interacting with PWMDs, conducting crisis intervention and learning local laws pertaining to PWMDs. Emphasis

should be placed on de-escalating situations that might lead to the use of deadly force on PWMDs by police officer (Lamb, R., Weinberger, L., & DeCuir, W., 2002). Training of dispatch personnel to identify mental health crisis related calls to CIT officers is an important component of the Memphis, TN CIT model. Many police departments have not included dispatch personnel or protocols into the CIT training programs (Compton et al., 2011). Training of dispatch personnel to identify and appropriately assign mental health related calls to CIT officers is an important component of the model that many CIT programs struggle to include (Compton et al., 2011). Emergency communications such as 9/11 dispatch is generally a separate department that the police department does not run. Thus, some CIT programs have not fully implemented dispatch protocols and training of dispatch personnel.

Within the Montgomery County Police Department Basic training comprises a 40-hour block of instruction wherein officers receive both classroom and hands-on instruction. Professionals from the partnering mental health organizations teach various blocks of instruction, which cover the different types of mental illness, interview techniques, de-escalation strategies, and other relevant topics. The officers participate in a live "hearing distressing voices" exercise (Hill et al, 2004). This role-playing scenario provides them with a glimpse of what it is like to hear voices in their heads. Each officer wears a set of headphones and listens to the distressing voices for one hour while performing various tasks to get police familiar with real life events (Hill et al, 2004). Afterwards, police officers visit a nearby Maryland hospital for PWMDs where they meet the hospital staff and engage in a group discussion with mentally ill patients who have had experiences with law enforcement when they were in a crisis (Hill et al, 2004). The group discussions offers police a great insight into understanding how a person experiencing mental

crisis behavior reacts to police presence. The role players are mental health professionals from the Montgomery County Department of Health and Human Services (Hill et al, 2004). The scenarios are videotaped, and each student receives a critique at the end of the session. The advanced CIT training component provides CIT members with continuous information and knowledge to enhance their skills (Hill et al, 2004). The less-than-lethal portion of the CIT program involves a patrol tactical plan for dealing with individuals in crisis called the Immediate Action Team. The plan incorporates the department's less-than-lethal weapons into a standardized protocol for the usage of less lethal weapons. The less-than-lethal arsenal consists of Tasers, beanbag shotguns, pepper spray, expandable batons, and ballistic shields. Only CIT members are issued Tasers, while specific individual officers carry beanbag shotguns (Hill et al, 2004).

The Chicago Police Department requires their police officers to take a 40 hour course taught by mental health clinicians from the community, police academy trainers, representatives from the prosecutor's office, advocates, consumers and family members. The Chicago CIT Program has trained over 2,200 police officers, 1,800 of which are still active CPD members. This training utilizes a unique specialized subject matter approach, which relies upon the instructional expertise of mental health professionals and PWMDs. The curriculum includes lectures, role-play, and panel's discussions with mental health community, family members, and mental health service providers (Watson et al., 2011). Topics that police are taught in is how to recognize the symptoms of mental illnesses, and legal procedures regarding on how to respond to PWMDs. Majority of the training time is focused on realistic role-play exercises in which officers use de-escalation skills. The officer's role playing is recorded and reviewed by mental

health professionals who provide feedback on their interaction with PWMDs. The key components of the CIT course taught are: officers are exposed to common types of mental illness, officers are exposed to the experiences of PWMDs, and officers receive instruction in listening and responding skills with crisis intervention strategies (Watson, 2011).

According to Wysinger (2014), Chicago Police Department data shows that Chicago police responded to over 2.2 million calls for service in 2012. In addition, while only 20% of patrol officers are CIT-trained, less than a majority of mental health related calls were responded to by a CIT-trained officer. Thus, the outcomes of many mental health related calls were not benefited by interaction with an appropriately trained officer due to missed opportunities to divert people from unnecessary jail; and reducing needed access to mental health services (Wysinger, 2014). Thus, just over 25% of these calls over a three-year period were handled by CIT trained personnel. Of interest, approximately 56.5% of the 5,392 CIT-trained responses in 2012 resulted in diversions to mental health facilities (Wysinger, 2014).

3 Theoretical Framework

3.1 Labeling Theory

In 1960, the National Institute of Mental Health (NIMH) estimated that 563,000 beds were available in U.S. state and county psychiatric hospitals. By 1990, the number of beds declined to about 98,800 (Markowitz, 2006). Several factors contributed to declining numbers such as new medications that controlled developing manic symptoms being developed, ideological views on confinement in states adopting stricter legal standards for involuntary commitment and the shifting of costs for mental health care (Markowitz, 2006). These elements contributed to the policies surrounding deinstitutionalization of the mentally ill. Advocates for change in the mental health system have noted that the capacity for treating America's mentally ill has substantially diminished. With de-institutionalization on the rise, mental health patients are more likely to be discharged from state hospitals into the community. With stricter standards in place regarding involuntary commitment PWMDs were not being admitted into mental health hospitals. Currently patients are often temporarily stabilized and frequently released back into the community, without adequate follow-up treatment creating a "revolving door" (Markowitz, 2006). A revolving door occurs when a PWMDs becomes better from short term treatment. Yet, when they stop their medical treatment, PWMDs end right back in the mental health system again (Markowitz, 2006) and the cycle continues. Limited medical treatment options of PWMDs, can influence police criminalization. Even when police may recognize symptoms from mental illness, some officers use "mercy bookings". Mercy bookings take place when a police officer arrests PWMDs for protection so the individual can get mental health treatment through the

prison system. This can create another situation for criminalization of PWMDs (Markowitz, 2006).

Additionally, negative stereotypes and fear of PWMDs among the public cause people frequently call the police for assistance in addressing mental health crisis in their communities. The public will call ask police officers to respond to PWMDs who might experience a crisis or need emergency assistance. The public expects police officers to serve as social workers in addition to their regular police duties (Lurigio & Watson, 2010). According to the labeling theory, negative stereotypes of the mentally ill play an important role in the cause of mental disorders (Socall & Holtgraves, 1992). PWMDs who are stigmatized negatively internalize their mental disorder as a negative label. The negative labeling and negative societal reaction creates the mental disorder (Scheff, 1984). Other studies done on modified labeling theory in, Link (1987) & Link et al., (1989) suggesting that negative societal reactions create self-devaluation of devaluation by others (Socall & Holtgraves, 1992). Many experimental and quasi-experimental studies find that negative attitudes toward the mentally ill largely result from their behavior and the label of "mentally ill" has no effect (Kroska & Harkness, 2008). According to the modified labeling theory of mental illness in Link (1989), the negative consequences of psychiatric labeling come from two social psychological processes. First, when a PWMDs is diagnosed with a mental illness, cultural ideas associated with the mentally ill such as being incompetent foster negative internalization. Second, the cultural meanings are transformed into that society will reject the individual triggering defensive behaviors. The defensive behaviors can result in harmful outcomes from having reduced social networks or feelings of demoralization (Link et al. 1989; Kroska & Harkness, 2008). Many experimental and quasi-experimental studies find also

found that negative attitudes toward the mentally ill largely resulted from their behavior and the labelling of "mentally ill" had no effect (Kroska & Harkness, 2008).

Furthermore, stigma and discrimination increase the burden of living with a mental illness. The deinstitutionalization of mental health services and the development of community-based services have not made basic changes to mitigate the situation. Negative attitudes, stereotypes and discrimination are still prevalent. In fact there is evidence that public attitudes have not changed during the last two decades, or even turned worse in the case of people with schizophrenia. Stigmas affect PWMDs in a negative way contributing to low self-esteem, a lack of financial and social resources. It is also a major barrier to PWMDs seeking medical treatment causing non-adherence (Hansson & Markstrom, 2014).

The deinstitutionalization of PWMDs in the community has led to the development of a variety of mental health services that include treatment in community mental health centers (Hansson & Markstrom, 2014). Also, police departments have been included as gatekeepers to the criminal justice and mental health service system. According to Hansson & Markstrom (2014), 5% of all police encounters involved persons with mental illness, 30% have had the police involved in accessing mental health treatment centers, and 15% were referred to emergency inpatient services by police (Hansson & Markstrom, 2014). In Kesic et al. (2013), studies examined whether police encounters with PWMDs found that behavioral indications of mental impairment influence the use of force by police, or whether those who appear mentally ill are more likely to be injured by police due to stigmatization of their mental condition. Officers' attitudes influence interactions with PWMDs affecting police discretion on how to respond to crisis calls. An attitude or belief towards a PWMDs illness that is perceived as dangerous by

police can come in the form of avoidance and withholding help. Preliminary findings further suggest CIT also has the potential to alter beliefs about mental illness and to reduce stigma toward individuals with mental illness (Compton et al., 2006). CIT training results in improvement in attitudes and knowledge about mental illness, and improvement in confidence in identifying and responding to persons with mental illness (Hansson & Markstrom, 2014).

In Watson et al. (2010) research was conducted to investigate the impact of CIT on Chicago police officers 'response to calls involving PWMDs. Differences were examined between CIT and non-CIT officers describing their response to mental health calls. Watson et al. (2010) began data collection on the impact of CIT in police encounters with PWMDs in four Chicago police districts in February 2008. According to the data 532 officers had completed CIT training and all of Chicago's 25 police districts had CIT trained officers (Watson et al., 2010). The Chicago CIT study sampled 216 officers across the four districts using surveys conducted in person and follow-up phone interviews (Watson et al., 2010). The researchers analyzed by comparing and contrasting references made by CIT trained and non-CIT officers regarding response to calls involving a subject with a mental illness. The findings from the study indicated that officers perceived that CIT training modified the manner in which they respond to mental illness-related calls relative to their non-CIT trained counterparts (Watson et al., 2010; Canada et al., 2012).

Previous data was compiled and assessed in a study from Compton (2006), during nine CIT trainings conducted in the metropolitan Atlanta area between December 2004 and July 2005. Each training class included approximately 18 to 20 officers from local jurisdictions. Although only one hour of the training specifically focused on schizophrenia, many of the other lectures,

presentations, and de-escalation experiences (Compton et al., 2006). The pretest survey in Compton et al. (2006), on the 159 Atlanta police officers included sociodemographic variables and six questions to determine level of familiarity with and exposure to mental illnesses. It was hypothesized that after CIT training, officers would report improved attitudes regarding aggressiveness and violence among individuals with schizophrenia, become more supportive of local treatment programs, have enhanced knowledge about schizophrenia, and report lower levels of social distance (Compton et al., 2006). Thus the study supports the hypothesis that an educational program for police officers may reduce stigmatizing attitudes toward persons with schizophrenia. Educating officers to recognize mental illness symptoms and to recognize the risk of danger involved will equip them with the de-escalation techniques. This results in more positive interactions with PWMDs during police encounters (Ritter, Teller, Munetz, & Bonfine, 2010).

4 Methodology & Analysis

4.1 Research Method

For this research study, meta-analysis and quantitative methods will be used. There is an overall lack of research in examining placement outcomes used to assess the models effectiveness on PWMDs being referred to long term mental health treatment rather than incarceration. The research will determine whether CIT training strategies decrease the numbers of arrests for PWMDs, or is there an increase in the number of PWMDs referred to mental healthcare systems. The null hypothesis will show that CIT is not effective. In contrast, the alternative hypothesis will show that CIT is effective. The instrumentation used for data analysis is:

1. NIMH, gov't database systems
2. Excel software
3. SPSS
4. Utilize peer review journals, government reports, textbooks, statistics, program evaluation websites and articles on which CIT training models that will show effective model components.
5. County databases
6. Police records

According to James & Glaze (2006), jail inmates had the highest rate of symptoms of a mental health disorder at the State level by 49%, and Federal level at 40%. State prisoners who are PWMDs were likely as those without a mental disorder to have been homeless in the year before their arrest at 13%. Jail inmates who had a mental health problem 24% were three times as likely to report being physically or sexually abused in the past. Over 1 in 3 State prisoners who had a mental health problem had received mental health treatment after admission (James & Glaze, 2006).

State prisoners 18%, Federal prisoners 10%, and jail inmates 14% reported that they had most commonly used prescribed medication for a mental problem in the year before arrest and reported an overnight stay in a hospital for a mental health treatment. James & Glaze (2006) also asserted that female inmates and local jails had higher rates of mental health problems than male inmates at an estimated 73%. Male's inmates had mental health problems at 55% (James & Glaze, 2006). Over a third 37% of State prisoners who had a mental health problem said they had used drugs at the time of the offense. Out of the total percentage of offenses reported among state prisoners who had a mental health problem, 49% had violent offenses as their most serious offense, property 20%, and drug offenses 19%. In addition, robbery was the most common offense 14%, drug trafficking 13%, and homicide 12% (James & Glaze, 2006). Among jail inmates who had a mental health problem, an estimated 23% had received treatment during the year before their arrest: 17% had used medication, 12% had received professional therapy, and 7% had stayed overnight in a hospital because of a mental or emotional problem (James &

Glaze, 2006). Among inmates who had a mental problem, about 5% of those in State prisons, 3% in Federal prisons, and 2% in local jails had stayed overnight in a hospital for a mental problem. The findings in this report are based on data in the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails (James & Glaze, 2006).

According to Schaefer (2003), Baltimore city, Maryland began expansion of their diversion programs in 1995.County officials were trying to implement a system that would identify PWMDs before being incarcerated as a pre-booking jail diversion initiative. PWMDs charged with misdemeanor crimes such as petty theft, loitering, or disorderly conduct would be paired with a social worker who would closely develop an alternative treatment plan such as psychiatric treatment. Also, the social worker would identify incarcerated PWMDs and provide counseling in jail while developing a treatment plan for these individuals after discharge. An alternative to prison programs are considered diversion programs have that are trying to reduce recidivism, treat mentally ill offenders and implement sufficient follow-up care for PWMDs. Due to the lack of treatment and poor quality of available mental health treatment, PWMDs will keep returning to the criminal justice system creating a revolving door phenomenon. Jail diversion programs are solely created for PWMDs to keep them away from criminal incarceration and redirecting them towards treatment services (Schaefer, 2003). According to Torrey et al. (2014), the largest state mental hospital, Spring Grove Hospital Center holds less than PWMDs who are incarcerated than the Baltimore County Jail, which has 2,200 inmates. Studies in 2002 reported that 16 percent of male and 33 percent of female jail inmates had severe mental illness in Montgomery County. Recent estimates show that there are serious mental illness among all jail inmates at

25% in Montgomery and Howard Counties. Involuntary treatment of PWMDs is challenging in Maryland due to no laws that allow for assisted outpatient treatment (AOT). This lack of assistance to treat PWMDs carries over to the prisons, where a failure to treat PWMDs has negative outcomes (Torrey et al., 2014).

Torrey et al. (2014), explained that the Cook County Jail in Cook County, IL, with 9,700 inmates, is the largest mental institution in Illinois and United States. Assuming 2,068 PWMDs are in the jails, more than the number of PWMDs in all five remaining state psychiatric hospitals combined, are held in Cook County Jail. In the Illinois state prison at Dixon and Pontiac Correctional Institutions, there are 45,470 inmates who receive care for a mental disorder (Torrey et al., 2014). In Maryland, the largest public institution for individuals with psychiatric illnesses is Patuxent Institution in Jessup, a correctional facility for prisoners with severe mental illness and substance abuse.

4.2 The Effectiveness of CIT on Arrest Rates

Previous research was conducted to determine if there was a correlation between CIT and arrest rates. A study in Steadman et al., (2001) was conducted to examine three pre-booking jail diversion models for PWMDs in order to determine the difference in arrest rates between the programs. The three pre-booking models were Memphis, Tennessee; Montgomery County, Pennsylvania; and Multnomah County, Oregon. All three of the jail diversion programs participated in the current Substance Abuse and Mental Health Services Administration (SAMHSA) jail diversion development application initiative. Although all three jail diversion programs are different from each other they share a common approach in response to PWMDs

having a crisis and jail diversion alternatives. The Montgomery County program is a pre-booking and post-booking diversion program that includes a freestanding psychiatric hospital with crisis intervention, crisis hotline, mobile crisis outreach, and referral to treatment. The crisis triage center is part of the University of Tennessee psychiatric services and has a no-refusal policy with a 30-minute turnaround time for police. The service receives 500 referrals a month and 70 percent of the referrals come from law enforcement agencies. The Multnomah County pre-booking jail diversion program, has a crisis triage center and a police crisis intervention team program that is modeled after the Memphis crisis intervention team. The triage center is the crisis system for Multnomah County (Steadman et al., 2001). Among the services at the triage center are a 24-hour crisis line; crisis intervention and stabilization; mobile outreach; voluntary subacute treatment; detoxification; mental health treatment; referral to outpatient community providers; and medication management clinics. Each of the three programs has established legal policies in place so that specialized crisis response sites can accept and detain PWMDs who may or may not have pending criminal charges. The programs in Multnomah County and Montgomery County have use misdemeanor arrest diversion and the Memphis program uses police based mental health crisis referral (Steadman et al., 2001). It appears that 24-hour specialized crisis response sites with no-refusal policies, appropriate legal foundations, and real linkages to community-based services are a key element in successful pre-booking jail diversion programs for individuals with serious mental illness and substance abuse problems. Overall the data revealed that the proportion of crisis calls was higher in the CIT program even though the three programs had low arrest rates at 2 percent (Steadman et al., 2001).

Borum & Franz (2011), dispositions of encounters between CIT officers and PWMDs are examined to estimate the proportion of arrests occurring on CIT calls and the decrease of arrests due to using CIT by officers. The sample included CIT calls from nine policing agencies in Florida from 2001 to 2005. Data on the number of arrests and total number of CIT calls prior to CIT were compiled from the Mental Health Association of Central Florida (MHACF) (Steadman et al., 2000). A total of 52 arrests occurred out of 1539 total CIT calls and a total of 290 arrests were prevented yielding a 19% prevented arrest rate. The present results suggest that PWMDs are rarely arrested when CIT officers respond to behavioral health crisis calls. According to the study, the low arrest rate among CIT calls in Central Florida is consistent with prior estimates from other CIT programs in other regions (Steadman et al., 2000).

When studying the effects of implementing CIT in Akron, OH. Researchers found that the proportion of mental disturbance calls increased after implementing CIT. The proportion of arrests for these calls were unchanged after the program, but many more CIT officers transported people to treatment facilities on voluntary referrals (Teller et al., 2006).

Chicago implemented CIT in 2005 in two pilot districts (Watson et al. 2009) with initial funding from the Substance Abuse and Mental Health Services Administration (SAMSA). Outcomes of the CIT training in the Chicago district have been limited in studies (Watson, 2012). Watson et al. (2010) addressed this gap with research on CIT implementation and effectiveness in Chicago by sampling CIT and non-CIT officers. Among sampled participants, 55% of their calls involving PWMDs resulted in officers directing PWMDs into mental health services. It was estimated that 31% of calls resulted in officers having contact with PWMDs not taking any action, and 10% of calls resulted in arrest (Watson, 2012). Researchers found that CIT

trained officer's report more calls per month involving individuals with a mental illness. Although CIT and non-CIT trained officers' did not significantly differ in terms of the number of calls resulting in arrest, CIT trained officers' directed significantly more individuals into mental health services compared to non-CIT trained officers. These findings suggest that CIT in Chicago might have influence on an individual's access to services (Watson et al., 2010). Overall, there was no evidence found that CIT reduces the likelihood of arrest for PWMDs.

According to Gur (2010), PWMDs are more likely to be arrested due to frequent encounters with police contributing to the increasing proportion of PWMDs being arrested than taken to a mental health facility. For example, local mental health facilities might not admit PWMDs that also have substance abuse problems and the substance abuse treatment facilities might not intake PWMDs. According to the State of Illinois Community Safety & Reentry Commission (n.d.), in Illinois, the state's prison population has grown from approximately 15,000 in 1983 to nearly 45,000 in 2005. In Chicago, IL, the Cook County Jail is one of the largest single site county jails in the United States. On December 31, 2005, the adult prison population was 44,919 while Illinois's prison population ranks third in the Midwest and eighth in the nation (State of Illinois Community Safety & Reentry Commission, n.d.). In 2004, 72 percent of Illinois Department of Corrections (IDOC) inmates were convicted of non-violent drug offenses and property crimes. Half of all parolees are re-arrested within the first 8 months after release. Approximately 14 percent of men and 40 percent of women who recently entered Illinois Department of Corrections reported a history of mental health illness. Large numbers of Illinois inmates enter the system with psychiatric or substance abuse disorders (State of Illinois Community Safety & Reentry Commission, n.d.).

According to McMillan (2015), in 2009, the joint Committee received a presentation from Dr. Fred Osher from the Council of State Governments Justice Center regarding a study on the prevalence of serious mental illness. The study found that the rate of mental illness for male inmates across all five study sites was 14.5% and for females 31 %. In the first phase of the study (2002-2003), 18% of male inmates and 28% of female inmates in Montgomery County were found to have serious mental illness. In the second phase of the study (2005-2006), 8% of male inmates and 21% of female inmates were found to have serious mental illness. The study notes that in 2012 there were 13,790 bookings in CPU. Of those booked, 8,631 were admitted to jail custody (McMillan, 2015). Approximately 50% of those booked are either released at the bail review hearing. Due to limited availability and the eligibility criteria for community-based services, in Montgomery County the CIT approach relies to a great extent on transporting people to jail. Even though police can transport people in mental health crisis instead of transporting them to a hospital or jail, this does not mean inpatient stays are guaranteed. Montgomery County Crisis Center has limited capacity and the beds are fully occupied. The Crisis Center may also be caring for displaced and homeless families, which is very different population (McMillan, 2015). This shortage of alternative beds also poses problems for DHHS CATS staff because there are limited alternatives for those who have been admitted to the Central Processing Unit. Offenders who are not released after their initial hearing with the District Court Commissioner are assessed by the Pre-Trial Assessment Unit. The Pre-Trial Assessment Unit staff estimates that about 20% of the people assessed have indications of some kind of mental health problem. Even when program resource exists that would allow someone to be diverted, not all mental health programs accept referrals from the criminal justice system. Due to a decrease in community based detox

and intermediate care beds as a barrier to diversion, making jail the default location for PWMDs (McMillan, 2015).

According to Kimball (2001), Montgomery County Police Department officers initiate pre-booking diversion from the criminal justice system to community mental health services for PWMDs who commit non-violent crimes. Law enforcement officers are transporting up to 15,000 people annually to Central Processing Unit (CPU) for booking (Kimball, 2001). CPU staff conducts a formal mental health screening for individuals who are detained by the District Court Commissioner and admitted to Montgomery County Department of Corrections. Department of Corrections (DOCR) Pre-Trial Services Unit (PTSU), staff monitor pre-trial defendants referred by the court for mental illness symptoms and suicidal attempts. The District Court Commissioner detains approximately 60% of the 15,000 individuals DOCR holds (Kimball 2001). It is estimated that 1,200 defendants are placed in pre-trial supervision during the year 2000 and 30% have a mental illness. PWMDs are also referred to substance abuse treatment along with their mental health treatment (Kimball 2001). Addiction Services Coordination (ASC) reports that approximately 50% of their clients come from the criminal justice system, including the Pre-Trial Services Unit, the Intervention Program for Substance Abusers, Community Re-Entry Services, the Pre-Release Center, and the Community Accountability, Reintegration and Treatment (CART) program. ASC screens for those who may have mental illnesses that become co-occurring disorders. Sometimes, even when mental health resource exists that would allow PWMDs to be diverted, not all mental health programs accept referrals from the criminal justice system (Kimball 2001).

4.3 CIT Shows Increase in Arrest Rates

In various states such as South Carolina, Louisiana and West Virginia, many jailed adults with mental illnesses have not been charged with any unlawful conduct who are frequently held due to no other places for them to go. It is unlawful for the state to detain an individual criminally without charge. In South Carolina, over 40 percent of mentally ill men and women incarcerated in jails had no criminal charges pending against them. In Louisiana, the same finding has been made as to nearly 30 percent of the state's severely PWMDs in jail (Pustlinik, 2005). A West Virginia jail official reported that a local psychiatric hospital released its patients purposely creating a revolving door phenomenon. The jail official reported that he would invent charges on which to detain PWMDs. With these types of actions being committed by law enforcement this increases likelihood of arrest and detention without charge for PWMDs without having committed any crimes (Pustlinik, 2005).

In a 1993 NAMI report on the criminalization of PWMDs, there were 30,700 seriously mentally ill individuals in our nation’s 3,353 jails on a given day. A recent report from the United States Department of Justice estimated that mid-year 1998 there were 283,800 PWMDs in the nation’s prisons (Munetz et al., 2001). Ohio with a good mental health system has a high rate of criminalization of the mentally ill. A report indicated that Ohio experienced a 285% increase in mentally ill inmates in their state prison population between 1990 and 1996 a total of 4977 mentally ill prisoners. The Summit County system has reduced the admission rate to the state hospital from 810 admissions in 1988 to 89 admissions in 1996. Munetz et al., (2001) did a case study where PWMDs with severe mental disorders had a greater risk of being incarcerated.

In the study, 86% of subjects had a history of substance abuse at the time of arrest. Crimes associated with substance use were non-violent and associated with symptomatic psychosis. Torrey (1994) argued that there is an increased risk of violence in a subgroup of PWMDs who are characterized by non-compliance with medication and substance abuse and previous history. Summit County is collaborating with the Akron Police Department to establish a Crisis Intervention Team for PWMDs to have diversion from the criminal justice to the mental health system (Munetz, Grande, & Chambers, 2001).

In the Teller et al., (2006) study, dispatch logs from the Akron Ohio CIT program reported that more voluntary police transports to emergency treatment facilities occurred after CIT training. They conclude that CIT can assist persons in crisis in gaining access to the treatment system, but did not change in the rate of arrest (Borum & Thompson, 2006). Akron, OH unlike Memphis, TN has a freestanding psychiatric emergency service, which means that individuals who have a comorbid no psychiatric medical condition may be referred to a general hospital emergency department. Under the Akron, Ohio CIT program, officers receive a 40-hour introduction to mental health and mental illness. The Akron Police Department provided data on the number of calls for assistance that were coded as mental disturbance calls by police department dispatchers from May 1998 through April 2004. According to the study in Teller (2006), between May 1998 and April 2004, the Akron Police Department received 1,527,281 calls for service, of which 10,004 were related to mental disturbances. The total number of calls per year increased slightly over the six years. There was an absolute increase in the number of calls identified as mental disturbance calls and in the rate of calls related to mental disturbances per 1,000 calls for assistance. Over the six-year period, almost 25 percent of the 10,004 mental

disturbance calls resulted in transportation to psychiatric emergency services and 31 percent resulted in transportation to local hospitals (Teller, 2006). Thirty-two percent of the calls involved police interaction with no need for transport and 3 percent of the calls resulted in an arrest. Since the CIT program began, there has not been an increase in the volume of all calls, but the absolute number of mental disturbance calls and the proportion of such calls have increased. The increase in the number of calls related to mental disturbances took place after the implementation of the CIT program. This could be due to the dispatchers becoming more aware to assess a call as involving PWMDs. The higher rate of arrest by CIT-trained officers was unanticipated in the study. Mental health systems support CIT programs in part because they view the programs as prearrest diversion programs and this could be possible due to dispatchers sending CIT officers to the most challenging mental disturbance calls. This would support the case of higher arrest rates by CIT-trained officers disappeared. Thus, CIT-trained officers' arrest rates were not different from those of non-CIT officers. The advantage was that CIT-trained officers transported mentally disturbed individuals to treatment facilities more often (Teller, 2006).

4.4 Diversion & Placement Outcomes

In 2010, the Agency for Healthcare Research and Quality examined Emergency Department (ED) data from 2007, found that 12.5% of all ED visits in the United States were due to mental health compared with 5.4% in 2000. The worsening of psychiatric patients coming to EDs has been due to reductions in inpatient beds that caused higher ED traffic. In San Antonio, TX, headquarters of the Bexar County Jail Diversion Program in 2009 the program’s Crisis Care Center, founded in 2005, sees approximately 800 patients per month. The Houston

Police Department, which has 1,250 crisis-trained officers has the country's largest CIT, uses a freestanding psychiatric ED. The ED took in about 4,100 persons in a mental crisis who would have gone to jail (McKenna, 2011).

According to Stewart (2012), the Multnomah County in Oregon has expanded mental health services to adults by 90% in 2004. Since 2001, suicides and welfare check calls have risen by 39%. Police officer holds are placed by the police on individuals who the officer believes are a danger to the community or themselves. Director's custody holds are placed by trained mental health professionals who are authorized by the local Mental Health Authority to order persons to be taken into custody, which includes transporting PWMDs to a medical facility for evaluation by a medical staff. In 2004, 5,292 adults were served by Multnomah County mental health providers and in 2011 there have been 10,062 persons served. Between 2009 and 2012, force was used in less than 5% of all custodial contacts with individuals who required a police officer-assisted hold in 2009, but there was no difference in the percentage persons arrested in 2009 (Stewart, 2012). (Skeem & Bibeau, 2008) conducted a study of police reports for Crisis Intervention Team officers in Memphis, Tennessee, between March 2003 and May 2005. In reviewing the 655 reports, they found that 45% involved a suicidal crisis, 26% involved a threat to others. This report found that officers used forced in 15% of the 189 events that posed extreme risks or violence. A study examined the implementation of a CIT program and SWAT callouts. According to Compton, Berivan, Oliva, & Boyce (2009), the study found that the introduction of CIT-trained officers had no significant correlation with the number of SWAT callouts in Atlanta, Georgia. Police officer-assisted holds peaked in 2000, but they dropped in 2001. This drop in officer assisted holds had to do with the closure of the Crisis Triage Center in mid-2001. The

closure of the Crisis Triage Center (CTC), a police drop-off site, impacted police services to PWMDs in a mental health crisis. Due to the changes, the creation of a Mobile Crisis Unit, which pairs a mental health professional with a police officer helps in responding to PWMDs who have ongoing mental health in frequent contact with the police. With the closure of the Crisis Triage Center in 2001, Multnomah County can no longer take in PWMDs at the psychiatric triage facility that had a "no refusal" policy for police. Police officers only option is to take PWMDs to the hospital emergency departments. While the county has opened the Multnomah County Crisis Assessment and Treatment Center (CATC), it does not provide the same service as the former Crisis Triage Center due to limited capacity to accept clients who are combative (Stewart, 2012).

4.5 CIT Does Not Affect Diversion and Placement Factors

The mental health care system can be a barrier for regarding this issue of diverting the mentally ill to mental health treatment by CIT trained police. Social service agencies and emergency hospital centers can refuse to admit intoxicated or severely dangerous PWMDs referred by police. In addition to the outcome of placement factors for PWMDs, the revolving door phenomenon of recidivism can burden the mental health emergency center and hospitals (Dupont & Cochran, 2000). There is also a lack of a systematic structure that links first responders like police officers to the mental health system. Steadman et al. (2001) address this problem and recommend the following: use of designated drop-off sites and a no refusal policy so that officers options are not limited (Tucker, Van Hasselt, & Russell, 2008).

According to Case, Steadman, Dupuis & Morris (2009) jail diversion for people with serious mental illness is a strategy by which jail time is avoided by using community-based

treatment as the diversion. As a public health strategy, jail diversion has been recommended by President George W. Bush in the Subcommittee on Criminal Justice of the President's New Freedom Commission on Mental Health (2004) for connecting PWMDs with community-based mental health treatment avoiding time spent in jails. The first federal program that expanded jail diversion programs was started in 1997 under the authority of the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS). The California the Board of Corrections has supported the Mentally Ill Offender Crime Reduction program in 1998 and in Florida grants have been awarded through the Criminal Justice, Mental Health and Substance Abuse Reinvestment program in 2007. Existing literature and studies on reviewing the effectiveness of jail diversion have found support for its role in reducing arrests, but there is little support for the diversion improving access or quality mental health services (Case, Steadman, Dupuis & Morris, 2009). Broner, Lattimore, Cowell, & Schlenger (2004), a quasi-experimental comparison group design was employed to evaluate the effectiveness of jail diversion at three months and 12 months for programs funded through the Center for Mental Health Services' Jail Diversion KDA initiative. Across eight sites included in the published analyses, diverted individuals experienced fewer jail days, although diversion had no effect on arrests. While service utilization improved at three months following diversion, service utilization was characterized by a lack of treatment. Using six sites from the same KDA study, Steadman and Naples (2005) compared 12-month outcomes for diverted and non-diverted PWMDs. Compared with the non-diverted group, diverted PWMDs spent more days in the community and experienced equivalent arrests. Diverted

PWMDs were more likely to visit the emergency room or to be hospitalized (Case, Steadman, Dupuis & Morris, 2009).

According to Bloom (2010), in 2008, the Treatment Advocacy Center (TAC) issued an online report that evaluated the adequacy of the number of state and county hospital beds in each state. In 2005, there were 17 public hospital beds per 100,000 in the U.S. population. The TAC panel determined that 50 beds per 100,000 was the minimum number needed to provide PWMDs with basic mental health services. South Carolina and eleven other states were facing a bed shortage in public beds, while Oregon was listed with 20 other states as having severe bed shortages as their hospital beds are full in capacity (Bloom, 2010). As in most states Oregon funds its state hospitals with fund dollars while community funding is based on state and county partnership. The state hospitals serve 24% of the state hospital population for civil commitments and 63% of the state hospital population are serving the criminal court system. The first federal lawsuit heard in the Federal District Court for the District of Oregon, in which a hearing was ruled in favor of the plaintiff s in 2002, sought to compel the State of Oregon to provide more expeditious treatment for criminal defendants who had been found incompetent to stand trial. The plaintiffs were also kept in the Oregon jails while waiting for beds at the Oregon State Hospital. The plaintiff s, presented data that showed that PWMDs were held in jails under very poor circumstances, for long periods of time. Data was recorded on 105 PWMDs who were found incompetent to stand trial and they spent an average of 32 days in jail waiting for a hospital bed for mental health treatment (Bloom, 2010).

According to Goin (2004), PWMDs who are incarcerated are more likely to be at risk increased medical health problems in prison and recidivism. The criminalization of PWMDs

reinforces stigma by equating mental health problems with criminal misconduct. Rather than reinforcing the message that mental illnesses are not character defects but an illnesses that can be effectively treated, PWMDs are subjected to being criminalized in the community. For example, at New York's Riker's Island correctional facility the average stay for all prisoners is 42 days, while the average stay for prisoners with serious mental illness is longer at 215 days. Treatment received in jails for PWMDs is usually directed toward suppressing symptoms rather than managing the mental illness. As noted above, inmates with mental illness are released later than other prisoners due to emerging symptoms that manifest themselves as behavior problems or aggressive conduct. People who might have benefited from the highly effective treatments for mental illnesses create a revolving door on criminal justice system's fiscal resources as well (Goin, 2004).

4.6 Studies Show that CIT Increases Diversion and Decrease Arrests of PWMDs

According to Broner et al. (2004), nearly 2000 subjects were identified in eight sites, 971 diverted subjects and 995 non-diverted subjects. There were three month follow-up interviews with 741 diverted and 756 non-diverted. Twelve month follow-up interviews were completed with 697diverted and 656 non-diverted. For pre-booking sites (e.g. Memphis, Pennsylvania, and Portland), the diversion program reported, from police records kept for this study, the charge that would have been filed if the participant had been arrested and not diverted. The mechanism for diversion varied across the sites, although less so in the pre-booking sites. In the pre-booking sites, the police made the decision to divert subjects were taken to emergency departments rather than being arrested. Jail personnel identified potential diversion subjects in the post-booking sites and participants received treatment in jail while awaiting diversion. The three pre-booking sites

were similar, with two of the three sites, Memphis and Portland, employing the Crisis Intervention Team model (Steadman et al., 2001).

4.7 Studies Show CIT Increases Placement Outcomes of PWMDs in Mental Health Facilities

According to Schafer (2003), mentally ill inmates keep returning to the criminal justice system after being released from jail or prison called the "revolving door" phenomenon (Orlando Sentinel, 2000). All inmates, including the mentally ill ones, are discharged from Riker's Island without money, medications, insurance (insurance is generally lost to those incarcerated), prescriptions or treatment plans. Many jails, such as Riker's Island in New York City, have been criticized as being the "largest mental hospital" (Heyrman, 2000) and other jails have even been described as "dumping grounds" for mentally ill individuals (Los Angeles Times, 1998). As compared to non-mentally ill inmates, mentally ill inmates are more likely to be harmful to themselves, to other inmates, and to correctional staff. It is also believed that mentally ill inmates are more likely to be victimized and abused by other inmates (Ogloff, Roesch, & Hart, 1994). Diversion programs have evolved over the decades with the purpose of leading PWMDs away from criminal incarceration and redirecting them towards mental health treatment services (Draine & Solomon, 1999, p. 57) (Schaefer, 2003). According to Schaefer (2003), Los Angeles experienced over 3,300 incarcerated PWMDs in 1993. City officials called for the creation of the Task Force of the Incarcerated Mentally Ill. The task force consisted of mentally health professionals and police officers. The program provided mental health professionals to drive in police patrol cars and assist the police in assessing the mental status of an offender (Los Angeles Times, 1993). Kings County in Washington State, in 1991 established a pre-booking diversion

program in which a police officer, who recognized PWMDs, could take them to a new crisis center instead of bringing the person to jail. The only requirement for the PWMDs was that they could only be taken to the crisis center if the crime they committed was a nonviolent misdemeanor crime (Schaefer, 2003).

In general studies researching the effectiveness of CIT on arrest rates, doesn't seem to show the decrease in arrests when officers use CIT, but do show an increase in CIT responses to crisis calls as well as referrals to mental health treatment centers. However, results from different CIT sites have been inconsistent. Memphis and Portland, the two sites previous research studies, differed in relation to various measures of mental health and placement outcomes (Broner et al., 2004). A CIT program in Akron, Ohio, showed higher arrest rates than previously examined programs (Teller, Munetz, Gil, & Ritter, 2006). The CIT programs examined in the aforementioned studies differ substantially in the elements included. For instance, one program works with emergency medical services or on-site mobile crisis units. Another utilizes a 24-hour community-based crisis center rather than a psychiatric emergency room. Due to each CIT program being different there are limitations in relation to what elements are responsible for differing results in arrest rates and referrals to mental health treatment centers for PWMDs (Dupont & Cochran, 2002; Steadman et al., 2001). In previous research studies, results were revealed that Chicago's CIT program has CIT officers using less force, but no correlation was found between CIT implementation and less police injuries in comparison to the Memphis CIT program (Martinez, 2010). Also, there was no difference in arrest rates between CIT and non-CIT trained officers during patrols in Chicago. However, CIT officers were more likely to direct PWMDs to mental health services (Watson et al., 2011). According to McKenna (2011) there is

of limited availability for community-based services for PWMDs in Montgomery County, MD. The Montgomery County CIT approach relies on transporting people to jail and receiving mental health treatment as a post booking jail diversion rather than a pre-booking jail diversion.

5 Conclusions & Recommendations

Communities need to have specialized support mechanisms and networks in place for PWMDs that are in the community, ranging supportive family members, to mental health community crisis centers and social networks. This study has also shown that these same communities would also benefit from having CIT trained police officers and mental health professionals available for responding to calls involving the mentally ill. Trained operational personnel such as officers, dispatchers, and coordinators, need also to be in place to facilitate the CIT training, which will serve as a vehicle for information-sharing and developing inter-system relationships among all of these CIT workgroup members (Borum & Thompson, 2006).

According to Gur (2010), incarcerating PWMDs absorbs a significant portion of criminal justice resources, which strains the system and places people in prison and jail settings that were not intended to address mental health problems. Prisons have been argued to fail PWMDs, which is evidenced by higher recidivism rates compared to non-PWMDs (Gur, 2010). The neglect of PWMDs reflects an essential issue in criminology wherein research is focused more on public safety than on public health. The focus on PWMDs as perpetrators (especially of violent crimes) has likely contributed to negative stereotypes about such persons (Bullock & Arrigo, 2006; Choe, Teplin, & Abram, 2008).

5.1 Placement Outcomes

Even though the effective components of CIT can be addressed, CIT is not truly effective when the factors of placement outcomes once CIT is used to detain the PWMDs present problematic circumstances for the full effectiveness yielded from CIT training and

implementation . Some of these problematic factors include complex intake policies of mental health facilities, refusal of admission to a PWMDs, and disruptive behavior during police transport, to name a few (Lamb, Gross, & Weinberger, 2004). Much of the existing literature on police outcomes with regard to PWMDs have focused on the use of police discretion and the ability of officers to effectively utilized training provided to them, and this training commonly involves the implementation of tactics learned in the crisis intervention training programs. This crisis intervention training is deemed to be effective if it results in lower placements of PWMDs in jail detention facilities and higher placements in specialized mental health facilities in the community. However, these placement outcomes are heavily dependent on characteristics of mental health facilities the community and the individual with the mental disorder, and these important factors have been often overlooked in the existing literature. Characteristics of those facilities that have shown to be relevant to the placement of PWMDs are policy on refusal, the types of mental disorders treated, number of beds available, and location of the facility with regard to city center areas of cities. According to research by Honberg & Gruttadaro (2005), mental health services for most PWMDs are unavailable or inaccessible. In the 1999 Bureau of Justice Statistics report, the U.S. Department of Justice, 16 percent adult inmates in U.S. jails suffer from serious mental illness. Half of the American population has severe mental illness such as schizophrenia, bipolar disorder, major depression, panic disorder and obsessive-compulsive disorder (Honberg & Gruttadaro, 2005). Psychosis can be found in mental disorders such as schizophrenia, delusional disorders, bipolar and mood disorder. Symptoms can range from disturbances in perception, and behavior. The disturbances include delusions, hallucinations, de-realization and impaired communication (Douglas, Hart & Guy, 2009). There

has been a decrease in inpatient psychiatric treatment beds for people requiring acute care services as many of which do not have sufficient beds or staff. There is a continued lack of adequate mental health benefits in private health insurance and human resources shortages in the mental health field (Honberg & Gruttadaro, 2005). The decrease in inpatient psychiatric treatment beds and the burden of providing psychiatric treatment has fallen on community hospitals, which cannot always meet the need to treat PWMDs. Many factors have contributed to the decrease in available beds and treatment range from lack of adequate mental health benefits, restrictive managed-care practices limiting, and critical resources shortages in the mental health field. For youths, the families of young people experiencing psychiatric crises sometimes have no place to get necessary treatment (Honberg & Gruttadaro, 2005). PWMDs who exhibit violence to others disrupt treatment efforts, by creating psychiatric deterioration. This causes the risk for self-harm, self-neglect, and victimization from family support groups (Douglas, Hart & Guy, 2009). PWMDs that have a psychiatric diagnosis are often stigmatized and experience diminished self-esteem (Douglas, Hart & Guy, 2009). Dangerousness is also heavily dependent upon the state that PWMDs are in when police arrive on scene**.** Violence to others poses a salient public health concern for police, mental health professionals and PWMDs. If psychosis is a cause of violence, then the behavior along with psychotic symptoms can play a factor in violence. The psychosis that the PWMDs are experiencing may play a role in destabilizing decisions, interference in managing interpersonal conflicts. Disturbance in PWMDs behavior in the form of psychosis behavior can increase the likelihood of them becoming angry or impulsively acting out violently (Douglas, Hart & Guy, 2009). By clearly outlining what characteristics of individuals with mental disorders and situational factors are additionally relevant to this placement outcome,

law enforcement can be trained in these CIT programs to implement the most appropriate outcome for the situation and for the individual. While the existing literature determines the effectiveness of these CIT models on the basis of placement outcomes, these outcomes are heavily dependent on the characteristics of the individual and the mental health facility, and these characteristics are often overlooked in current research. By bridging the gap between the two areas of study by identifying these characteristics in order to be able to more effectively train officers in crisis intervention strategies, can be used in conjunction with knowledge of local community mental health characteristics and situational factors that are simultaneously relevant to the ability to engage in the use of dispositional attribution's in individual behavior.

5.2 Recommendations for Communities and Agencies

Training officers on jail diversion of PWMDs by way of referral to mental health emergency crisis centers will be ineffective if mental health resources in the community are not available to take PWMDs to. Although follow-up mental health services may be viewed as outside the scope of CIT, quality outpatient services may aid in decreasing criminal justice involvement and allay mental health service costs associated with CIT (Cowell, Broner, & Dupont, 2004). Policies and procedures are a necessary component of CIT because they provide a set of guidelines that direct the actions of both law enforcement and mental health officials. These guidelines provide feedback from all parties and stakeholders affected and how to sustain infrastructure through inter-agency agreements (Dupont et al., 2007). The policies in place should allow for a wide range of inpatient and outpatient referral sources in order to accommodate law enforcement agencies with a CIT program. Barriers that prevent officers from accessing immediate mental healthcare for an individual with mental illness should be eliminated

(Dupont et al., 2007). As the CIT model includes a designated psychiatric emergency receiving facility with a "no-refusal" policy as a core element (Dupont et al., 2007; Steadman et al., 2001).Unfortunately, a single psychiatric emergency receiving facility with a no-refusal policy might be absent in many jurisdictions. For example, for the Atlanta Police Department's CIT program, which has been in operation since 2004, the main emergency mental health drop-off facility is a county hospital. There is a single site but no formal agreement between the hospital and the Atlanta Police Department. In Georgia state law if a physician is absent, then a police officer needs a court order to transport PWMDs in custody for a psychiatric emergency evaluation only if the person has committed a crime (Mental Health Code–Emergency Admission, 2009). In these type of situation officers are more likely to transport PWMDs to jail (Compton, 2010).

In Compton et al., (2010), according to the 2000 U.S. Census estimates, 25% of the nation's population resides in rural areas around the U.S. (Bureau of Census, 2001). In rural areas that don't have medical resources for PWMDs can affect mental health service disparities, increase social stigma in seeking mental health treatment, and a lack of intervention services. Improving mental health access to psychiatric emergency services in rural areas for PWMDs is an obstacle for law enforcement implementing CIT. The availability of a psychiatric emergency receiving facility, which is a key element in the CIT model, is a lack thereof in rural areas (Compton et al, 2010). The transportation of PWMDs to distant emergency mental health facilities can result in law enforcement officers being out of patrol duties for a longer period of time. Long distances in rural areas are also a barrier to psychiatric mobile crisis unit responses, which may contribute to longer waiting times for responding officers in need of onsite crisis

workers. For example, according to a survey in Sullivan and Spritzer (1997), a psychiatric population in rural Mississippi, 75% of PWMDs had been held in local jails without charges at least once in their lifetime while awaiting hospital admission. For effective implementation of CIT in rural areas, there needs to be collaboration between local law enforcement and mental health facilities (Compton et al., 2010). How a community adopts a CIT program will depend on a variety of factors. According to Reuland (2004), the proposed the following steps for Planning a Police Based Specialized Response Program would include:

1. Examining Available Models
2. Adapting the Model to the Locality

a. Mental health services adaptations

b. Training adaptations

c. Response protocol adaptations

3. Educating the Community
4. Obtaining Necessary Reviews and Approvals
5. Setting Logistics and Administration

According to Borum & Thompson (2006), adapting the CIT Memphis model to some jurisdictions for police agencies can pose a challenge due to planning, implementing and sustaining the program. Based on the CIT model the following elements compose of community support such as leadership in the police department and local hospitals. Law enforcement may not operate under the same administrative policies, or mental health agencies may not be critical in a given jurisdiction. Another problem with inadequate programs among leadership is an inability to retain CIT officers. Police officers may not have specialized CIT units that focus on

the social work aspect of CIT rather than focusing on their patrol duties. Police dispatchers must also have a mechanism in their system to identify CIT officers, and have procedures allowing them to send CIT officers first to mental health crisis calls (Borum & Thompson, 2006).

Research and evaluation of the components of CIT must be conducted to ensure positive outcomes for the enhancement of future CIT program development. On the other hand, police lacking de-escalation skills necessary for working with PWMDs, officers may use unsafe police discretion by escalating an encounter to violence resulting in injuries to both parties and criminalizing mentally ill persons. Training such as the CIT curriculum influences the officer's knowledge about mental illness so they can assess situational factors regarding an encounter with a PWMDs in crisis. Numerous cities and states have implemented CIT models that provide instruction and training to prepare officers to safely respond to situations involving PWMDs in crisis. In order for the characteristics and components of the CIT models to be effectively used in crisis interventions by police on PWMDs, there needs to be more focus on how to implement and utilize effective CIT components in models during crisis interventions.

Comprehensive case management strategies, such as Assertive Community Treatment (ACT) programs have been shown to be extremely successful. ACT offers offenders with mental illness highly structured case management, with a designated professional charged with overseeing PWMDs treatment and rehabilitation plan. There needs to be more change in local, state and federal laws that can improve effective jail diversion programs for PWMDs, such as the Mentally Ill Offender Treatment and Crime Reduction Act of 2003. The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 provides funding for Mental Health Courts and diversion programs. The funding can be used for mental health programs that offer specialized

training to officers and mental health professional in identifying manic symptoms in PWMDs. The changing laws and legislation can provide incentives for the criminal justice, juvenile justice, mental health, and substance abuse treatment systems to work collaboratively to develop effective services for offenders with mental illness (Goin, 2004).

By containing PWMDs in jails rather than allowing them to benefit from effective treatments, is not an effective fiscal investment as well. The current situation for PWMDs in the criminal justice systems creates a cost shift away from the human service systems. For example, the Pennsylvania Department of Corrections estimates it costs them $140 a day to incarcerate PWMDs, while it only costs them $80 a day for an average inmate (Goin, 2004). According to Alakeson, Pande, & Ludwig (2010), the Community Mental Health Centers Act of 1963 was intended to create a mental health center in every community to serve deinstitutionalized PWMDs. With so many challenging factors to community health, those factors have created severe constraints on the capacity of community-based mental health care. Total state spending on mental health services was 30 percent less in 1997 than in 1955. A number of states that have enrolled people with disabilities in Medicaid managed care have cut back coverage for high-cost antipsychotic drugs. The Patient Protection and Affordable Care Act of 2010 addressed the problem of boarding through the creation of a $75 million demonstration project known as the Medicaid Emergency Psychiatric Demonstration (Alakeson, Pande, & Ludwig, 2010). This project will allow all hospitals to receive Medicaid reimbursement for emergency psychiatric care. Hospitals are not reimbursed for this care because Medicaid does not cover inpatient psychiatric services in institutions with more than sixteen beds. This solution does not divert PWMDs away from emergency rooms and is only a short-term fix. A longer-term solution will

require increasing the capacity of community mental health services and expanding health reform law in Medicaid eligibility. Thus, this expansion will add more demand for community mental health services, whose primary clients in most states are Medicaid recipients (Alakeson, Pande, & Ludwig, 2010). For example, Harris County, Texas, has developed an Emergency Psychiatric Program, which has been recognized as a model for comprehensive emergency services in an urban setting (Alakeson, Pande, & Ludwig, 2010). The program has six core features that include a 24/7 public help line, 24/7 psychiatric emergency services, a mobile crisis outreach team, a crisis stabilization unit with sixteen psychiatric inpatient beds, a voluntary emergency residential unit, and a crisis counseling unit. The most important features for reducing emergency room boarding is a 24 hour community based psychiatric emergency service and the mobile crisis outreach team. The psychiatric emergency service in Harris County sees approximately 11,000 patients a year, which is staffed by psychiatrists, licensed social workers, nurses, and psychiatric technicians. The Harris County mobile crisis outreach team is able to assess and resolve crises. Only 2,352 people were seen by this team in 2006 and 2007, with only 4 % of PWMDs requiring hospitalization (Alakeson, Pande, & Ludwig, 2010). New health reform laws to permit home and community based services to be offered as part of a Medicaid state plan rather than through a waiver could provide a funding mechanism for effective community based crisis services for PWMDs.

5.3 Mental Health Courts

Even though some law enforcement agencies are using CIT as a jail diversion alternative for PWMDs, not all officers have access to transport PWMDs to mental health services. A lot of time PWMDs are still incarcerated and receive mental health treatment during the post booking process in jail. To reduce the risk of reoffending, mental health courts link participants to community-based treatment and use the authority of the court to leverage compliance with that treatment. Most studies simply describe the treatment offered by the court. Mental Health Courts (MHC) essentially give offenders a choice between following a treatment plan, taking medication or going to jail. The court thus becomes the treating authority instead of the community mental health centers. According to Harrington (2013), courts in the United States are ill-equipped to handle the increasing number of mentally ill defendants entering the criminal justice system. MHCs link defendants suffering from mental illness to treatment as an alternative to incarceration, in the hopes of lowering recidivism rates. This also keeps mentally ill offenders from being caught in the revolving door where they are in jail, and back in the community, and in jail again. Many MHCs are developing different approaches such as therapeutic jurisprudence, restorative justice, and preventive law in establishing Mental Health Courts (MHCs). Following the establishment of the first MHC in Broward County, Florida and by 2007 there were over 175 courts in jurisdictions across the United States. Thus, therapeutic jurisprudence focuses on identifying and treating underlying causes of specific defendants' troubles, which may be drug abuse,

mental illness and homelessness. Criminal activity in itself is only a symptom of the underlying disorder plaguing the defendant. Treating the disorder with therapeutic jurisprudence can reduce the offender's recidivism. Diverting individuals away from the criminal justice system and toward treatment programs can also help reduce court costs (Harrington, 2013). The Thresholds Jail Program in Chicago, Illinois, a program which provides case management for mentally ill clients who have been released from jail, demonstrates how an effective program can reduce incarceration-related costs. Thirty individuals enrolled in the program spent a combined 2200 fewer days in jail and 2100 fewer days in hospitals during their participation. Gur (2010) explained the Thresholds Jail Program in Cook County, Illinois reported cost saving of $18,873 per person per year. The Thresholds Jail Program was 1 of only 3 such programs with published outcome data on program effectiveness. Like drug courts, MHCs are run by multidisciplinary teams consisting of court personnel, mental health professionals, and other community professional who provide treatment and supervision to defendants (Harrington, 2013).

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