

Veterans in Crisis: A Law Enforcement Response

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Veterans in Crisis: A Law Enforcement Response

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ABSTRACT

Purpose of Research

The purpose of this study is to call attention to the lack of crisis intervention training law enforcement officers receive. In doing so, this study will target to the lack of training targeting veteran related experiences such as post-traumatic stress disorder and substance abuse. The study argues that the lack of adequate training regarding a veteran crisis response may contribute to disastrous consequences for everyone involved.

Through a review of different mental health programs and crisis response models, this study focuses on similarities between these different programs and highlights strengths of these programs and models. By comparing different mental health programs and crisis response models, the hope is to recommend effective components of an ideal crisis response training program for law enforcement officers and other front line mental health professionals.

Methods

Information for this study comes from a qualitative review of the similarities and differences in different mental health and crisis response programs. The data used in this study was taken from accredited journals, law enforcement training programs, law enforcement policies and law enforcement manuals, textbooks, governmental reports, and relevant news articles from reputable sources. Ultimately from the comparisons of data, an outline for an effective law enforcement crisis training program for veterans was developed.

Key Findings

This paper calls attention to the weaknesses associated in mental health crisis response and mental health related resources in the United States among law enforcement personnel.

Some crisis intervention methodologies including: Crisis Intervention Teams (Memphis Model), Mental Health First Aid, Mobile Crisis Teams, and the Wisconsin Department of Justice Crisis Management curriculum were analyzed. From these models a recommendation for training and a three phase program regarding crisis intervention was developed. This three-phased response consisting of: initial law enforcement response, mental health specialist response, and the final phase consisting of follow up services. The development of these phases is geared to provide efficient and effective mental health crisis interventions, and provides an avenue for sustainment mental health services.

The general strain theory and the theory of psychoanalysis are used to target elements of PTSD and substance abuse related to military service. Crisis response members and other stakeholders within this model, should target these areas in an attempt to mitigate and prevent future crisis.

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VETERANS IN CRISIS: A LAW ENFORCEMENT RESPONSE

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Under the Supervision of Dr. Amy J. Nemmetz

Section I: INTRODUCTION

Statement of Problem

Out of every profession, law enforcement officers are the most likely to encounter people who are experiencing mental health crisis (Engel & Silver, 2001; Lamb, Weinberger, & DeCuir, 2002; Markowitz & Watson, 2015). The topic of law enforcement officers being trained in mental health crisis response resulted from a shooting of a man with a history of mental illness and substance abuse in Memphis, Tennessee in 1988 (Watson & Fulambarker, 2012; Palmer, 2014). Because of the shooting, a task force was created and the guideline developed by the task force was referred to as the Memphis CIT (Crisis Intervention Team) Model. The task force consisted of law enforcement officers, mental health and addiction professionals and mental health advocates (Watson & Fulambarker, 2012; Palmer, 2014).

According to Ifill (2014), approximately 2.5 million US military personnel have served in the Iraq and Afghanistan wars. As a result of these conflicts, veterans have a high risk of suffering from post-traumatic stress disorder (PTSD) and substance abuse (Hoge, Auchterlonie, & Milliken, 2006). According to the DSM-IV, PTSD is defined as:

...the development of characteristic symptoms following exposure to extreme traumatic stress or involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity to another person; or learning about

unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (p. 424).

The high risk of veterans suffering from PTSD is due in part to the advances in medical and protective technologies (Franklin, 2009). According to Franklin (2009), in previous armed conflicts warfighters who experienced trauma typically did not survive long after exposure; therefore they did not experience the repercussions of the trauma. Studies have shown PTSD coupled with substance abuse, increases the risk for veterans to be involved in the criminal justice system (White, Mulvey, Fox, & Choate, 2012).

Across the country, mental health budgets are being reduced. Self-report surveys from law enforcement officers show they do not feel as if their training in mental health crisis response is adequate (Watson & Fulambarker, 2012; Palmer, 2014). According to Weaver, Joseph, Dongon, Fairweather, and Ruzek, (2013) law enforcement officers with inadequate training in mental health response could be disastrous when confronting a veteran with combat training and experience.

Purpose of Research

The purpose of this study was to call attention to the lack of crisis intervention training law enforcement officers receive. In doing so, this study targeted the lack of training targeting veteran related experiences such as post-traumatic stress disorder and substance abuse. The study suggests that the lack of adequate training regarding a veteran crisis response could correlate with disastrous consequences for everyone involved.

Through a review of different mental health programs and crisis response models, this study focuses on similarities between these different programs, and highlights strengths of these programs and models. By comparing different mental health programs and crisis response models, the hope is to recommend effective components of an ideal crisis response training program for law enforcement officers and other front line mental health professionals.

Significance or Implications of the Study

Up to 10% of all law enforcement contacts involve people with mental illnesses (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Palmer, 2014). As previously noted by White et. al, (2012) studies have shown PTSD coupled with substance abuse, increases the risk for veterans to be involved in the criminal justice system.

Through analysis of mental health programs and crisis intervention methodologies, this study could be used as model to develop a crisis intervention/mental health program which ultimately recognizes the symptomologies of veterans suffering from PTSD and substance abuse and diverts them into treatment programs or other community based resources and away from the criminal justice system.

Methods

Information for this study comes from a qualitative review of the similarities and differences in different mental health and crisis response programs. The data used in this study was taken from accredited journals, law enforcement training programs, law enforcement policies and law enforcement manuals, textbooks, governmental reports, and relevant news

articles from reputable sources. Ultimately from the comparisons of data, an outline for an effective law enforcement crisis training program for veterans was developed.

Contribution to the Criminal Justice Field

This study provides an outline for an effective veteran crisis response program for law enforcement and frontline mental health/crisis response personnel. This outline delivers the foundation to develop a successful curriculum for not only veterans experiencing crisis and substance abuse, but also other community members experiencing similar difficulties.

Having a successful intervention program for veterans who are experiencing substance abuse coupled with PTSD could potentially divert them from the criminal justice system (where there may not be adequate resources) and into appropriate treatment (with adequate resources).

SECTION II. REVIEW OF LITERATURE

Brief History of Mental Health Treatment in the United States

To understand the current issues facing veterans regarding crisis intervention, and crisis response, it is important to first examine the history of mental health treatment in the United States. According to Bloom (2010) for most of the history of the United States the federal government failed to assume the responsibility of a public mental health system. Throughout the history of the United States the burden of mental health care has solely rested on the states themselves. Prior to the 1950's, those suffering from mental illnesses were typically warehoused in large institutions called asylums (Chaimowitz, 2012). Because of the states having the sole responsibility to aid the mentally ill, problems began to develop within these state-run asylums. Some of these asylums had reputations of rampant abuse and neglect of their patients (Chaimowitz, 2012).

With the introduction of psychotropic medications in the 1950's and 1960's, and with the attention of the poor living conditions and lack of resources highlighted by President John F. Kennedy, a philosophy of community based treatment options was developed (Bloom, 2010; Chaimowitz, 2012). This philosophy was based on the premise that those suffering from mental illnesses, could live out their lives within a community and not in large hospitals and their mental illnesses could be controlled resulting in a somewhat "normal" life" (Chaimowitz, 2012). As a result, large mental health institutions began to release their patients and the hospitals began to close. This became known as deinstitutionalization (Chaimowitz, 2012).

Unfortunately, comprehensive community based mental health treatment never materialized (Bloom, 2010; Chaimowitz, 2012). Community treatment centers were not properly funded, and of those which were supported by matching federal funds began to see decreasing financial matches by the federal government (Bloom, 2010). To further put the failure of community based mental health treatment options into perspective, from 1955 to 1994 the number of beds for the mentally ill went from 339 to 29 for every 100,000 people (Chaimowitz, 2012).

There has also been a dramatic increase in the inmate population as a result of the lack of mental health services (Chaimowitz, 2012). From 1980 to 1995 there was a 216 % increase in the amount of incarcerations (Chaimowitz, 2012). A study by the Department of Justice in 1999 found that 16% of all inmates in the United States suffer from severe mental illnesses such as depression, schizophrenia, bipolar disorder, and others (Chaimowitz, 2012). It is estimated that over 25 % of adult Americans suffer from a diagnosable mental disorder, and of those affected 4.5 % suffer from serious mental illness (Majette, 2011).

Veterans, Delinquency, and Mental Health

Veterans returning from Iraq and Afghanistan have brought renewed interest in the psychological trauma experienced by service members. In 2008, The New York Times brought to the country's attention their discovery of 121 cases involving Iraq and Afghanistan veterans whom at the time, had killed or were facing charges of killing others within the United States (Alvarez, 2008). In many of these murder cases the stressors of combat, psychological trauma, alcohol and substance abuse, and relationship strains were said to be contributing factors

(Alvarez, 2008). Some believe because of the violence experienced in combat, veterans are re-socialized to behaviors which make them more accepting of violence and other behaviors which would otherwise be illegal in peacetime (Archer & Gartner, 1976).

Studies conducted on veterans returning from Iraq and Afghanistan have shown approximately 11 % to 19 % of the veterans suffer from mental health, substance abuse and relationship problems (as cited in Cigrang, Talcott, Tatum, Baker, Cassidy, Sonnek, Snyder, Balderrama-Durbin, Heyman, Smith-Slep, 2014). Combat exposure is one of the leading contributors to the symptoms attributed to PTSD (Cigrang et. al, 2014). Those suffering from PTSD have an increased risk of alcohol and substance abuse issues and relationship strain (Cigrang et. al, 2014). Substance abuse coupled with PTSD increases the probability of law enforcement contact (Cigrang et. al, 2014).

According to Najavitis, Norman, Kivlahan and Kosten (2010) mental health issues coupled with alcohol or drug abuse were involved in over 30% of army suicides from 2003 to 2009 (as cited in Butler and Taylor, 2015). Further Tull (2013), found those who suffer from PTSD suffer from higher rates of alcoholism and drug abuse. The journal *Military Medicine* published a study of 120 service members who had returned from Iraq and Afghanistan and highlighted the following: 6 % had PTSD, 27 % were classified as having dangerous alcohol abuse, and 6 % had problems with both PTSD and alcohol abuse issues (Tull, 2017). Veterans suffering from PTSD have also been shown to have reported higher rates of physical aggression as compared to veterans showing no PTSD symptoms (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Teten, Miller, et al., 2010).

A cross-sectional study conducted by Riviere, Merrill, Thomas, Wilk and Bliese (2012) noted the quality of a service members marriage is connected to the presence of PTSD, substance abuse, and other mental health related issues. Cigrang et al. (2014) specifically targeted relationships of 164 service members (both marriages and others committed relationships) prior to, and after combat and other high risk deployments in a longitudinal study. Their study showed over 70 % of participants had personally witnessed someone killed or seriously injured, or were exposed to high risk situations (i.e. removal of unexploded ordinance). Because of this exposure post-deployment assessments showed statistically significant increases in PTSD symptoms, depression, relationship distress and alcoholism (Cigrang et. al, 2014).

Further research conducted by Maguen, Lucenko, Reger, Gahm, Litz, Seal, Knight, and Marmar, (2010) analyzed the post combat deployment screenings of 2,797 Operation Iraqi Freedom veterans. This analysis showed 22% of soldiers had PTSD symptoms, 32% were suffering from depression, and 25% were experiencing alcohol abuse (Maguen et. al, 2010). It should also be noted that over 77% had reported seeing dead bodies, 56% of respondents had witnessed the killing of others, and 40% of respondents had reported to have killed others in combat (Muguen et. al, 2010).

Studies had shown service members who had shown resiliency in PTSD and mental health issues had strong social support networks (Cigrang et. al, 2014). Those showing resiliency were less likely to report having mental health issues (15.9%) (Cigrang et. al, 2014). Those who had limited social support networks, were at an increased risk of mental health deterioration (37.5%) (Cigrang et. al, 2014).

Shortcomings of Veteran Mental Health Related Resources

Among those who serve in the military there is an associated stigma associated with mental illness (Pols & Oak, 2007). Because of this related stigma, those experiencing substance abuse and mental health issues may not take advantage of the programs or treatments available to them (Pols & Oak, 2007). Typically, post-deployment screenings are self-reported surveys. Because of this method of data collection, the service member may not truthfully or accurately respond to the questionnaires due in part to the associated stigma. Hoge et. al (2006) describes another potential flaw in the mental health screening programs for returning veterans. These screening programs only accounted for approximately 10% of all veterans referred to mental health treatment (Hoge et. al, 2006). Service members may fear rejection from their peers, the appearance of being weak, or the potential impact these services may on their career (Pols & Oak, 2007). As a result, Pols and Oak (2007) describe these services may inherently be obstructed from those who need them the most due in part to the stigma associated with the services themselves.

Some veterans and former service members may not be eligible to receive benefits from the Department of Veterans Affairs (VA) due to their military service or discharge type (i.e. dishonorably discharged). This combination of not able to receive care, coupled with other factors such as: financial hardship, homelessness, substance abuse, PTSD, and other mental health related issues, could result in significant hardships and stress. The Affordable Health Care Act does not currently provide assistance relating to mental health (Hester, 2017). Often, the costs associated for comprehensive mental health treatments are increased (for the employee)

and the services are reduced (Hester, 2017). To make matters worse, according to Hester (2017) the VA lacks the mental health personnel to adequately support veterans who are experiencing mental health related crises. This shortcoming results in veterans not being dependent on VA mental health services for mental health care, and also allows for diminished access to crisis-intervention services during potentially catastrophic situations such as suicidal attempts or other crises (Hester, 2017). As previously highlighted, there is a significant lack of mental health related resources available to the general public, as well as military veterans. Also (as previously mentioned), law enforcement personnel are typically the first to arrive in response to these crises.

Surveys regarding crisis response found most law enforcement officers do not feel as if they have had enough training, and do not feel as if there is a cohesive system in place after responding to these types of calls (Watson & Fulambarker, 2012). For example, mental health crisis responses are often time consuming and as a result remove officers from other law enforcement duties (Watson & Fulambarker, 2012).

One of the key areas mentioned by Smydo and Lord (2016) as to the lack of police officers being trained in crisis response is the shortages of available officers to attend training. Some law enforcement agencies simply do not have the staff available to send officers to training. Of the limited officers who may be trained in crisis response, they may not even be dispatched to calls requiring their skills due to being already dispatched to an unrelated call, or dispatcher's not properly assigning calls (Smydo & Lord, 2016).

Brief Examples of Commonly Used Mental Health and Crisis Response Methodologies

Crisis Intervention Teams (Memphis Model)

One of the most commonly practiced crisis response models is: Crisis Intervention Teams or otherwise known as: “CIT.” Crisis Intervention teams derived from an incident which had occurred in Memphis, Tennessee in 1988, in which law enforcement officers fatally shot a man who had a history of suffering from mental illness (Watson & Fulambarker, 2012). After the tragedy, members of the community, law enforcement and others with experience working with the mentally ill and substance abusers developed a training program to respond to crisis, which is commonly referred to as the “Memphis Model.”

The Memphis CIT model consists of a 40 hour course which is given to law enforcement officers related to crisis response, which is led by mental health professionals, mental health advocates and law enforcement instructors (Watson & Fulambarker, 2012). Officers receiving this training are typically volunteers and are taught how to recognize the signs and symptoms of mental illness, treatment options, legal concerns, as well as de-escalation techniques and scenarios (Watson & Fulambarker, 2012). The goal of the CIT model is to reduce the amount of arrests for those suffering from mental illness by diverting them into treatment-based community interventions (Canada, Angell, & Watson, 2010). Other goals of the CIT model are to promote officer and citizen safety as well as promoting positive interactions between law enforcement and those suffering from mental illness.

Mental Health First Aid (MHFA) Model

Mental Health First Aid (MHFA) was developed in Australia as way to educate people about mental illnesses (Mohatt, Boeckmann, Winkel, Mohatt, & Shore, 2017). The goals of the program is for those who have taken the training to be able to identify the signs and symptoms of mental illness, to reduce stigma, and to provide effective assistance for those experiencing crises (Mohatt et. al, 2017).

Mohatt et. al (2017) along with a panel of medical and mental health professionals developed Military MHFA (M-MHFA). The M-MHFA program consists of an 8 hour seminar, and was developed so those with limited mental health training and experience (i.e. first responders) would be able to provide assistance and direct support efforts to those experiencing mental health crises or stressors (Mohatt et. al, 2017). A study conducted by Mohatt et. al (2017) showed those who had received the training showed a decrease in the stigma associated with mental health crisis, as well as a positive increase in their perception of their ability to assist others in crisis (Mohatt et. al, 2017). Further, knowledge of mental health resources also increased (Mohatt et. al, 2017).

Mobile Crisis Teams

Various forms of mobile mental health crisis teams have been implemented across the country. Mobile crisis teams typically consist of law enforcement and mental health professionals who “co-respond” to incidents (Rosenbaum, 2010). The premise of this co-response concept is that law enforcement and mental health professionals can work together to

provide the resources available to the person experiencing the crisis as well as providing resources to each other (Rosenbaum, 2010).

One model of a mobile crisis response model is the Crisis Outreach and Support Team (COAST) developed in Albuquerque, New Mexico. The COAST team is designed to assist non-violent crisis situations and to also offer assistance to those who are suffering from mental illnesses and homeless populations (Rosenbaum, 2010). It is important to note the COAST team is a supplement of the Albuquerque Police Department (APD) CIT program, which handles high-risk crisis situations (Rosenbaum, 2010).

The COAST team consists of five crisis specialists who are non-law enforcement personnel but are employed by the APD. The crisis specialists are led by a police sergeant and also have access to a psychiatrist (Rosenbaum, 2010). COAST provides services to those who may have otherwise gone without services (Rosenbaum, 2010). Examples of these services include: crisis intervention, conflict resolution, identification of housing, family services, and substance abuse related resources (Rosenbaum, 2010). Rosenbaum (2010), describes how a benefit to this model is the allowance of non-law enforcement personnel to deal with non-law enforcement/non-criminal issues. This allows law enforcement personnel to conduct their law enforcement duties.

Wisconsin Basic Law Enforcement Crisis Management Training

The Wisconsin Department of Justice (WIDJ) provides for its basic law enforcement academy students a somewhat comprehensive training block in crisis management. This block of instruction covers 20 hours of how to recognize the signs and the symptoms associated with

mental illnesses such as dementia, bipolar disorder, schizophrenia, drug and alcohol problems, and mental disabilities (WIDAJ, 2007). Basic academy students also learn the legal context for placing people who are experiencing a mental health crisis on an emergency detention if the person who is experiencing the crisis is a danger to themselves or others (WIDAJ, 2007).

Academy students are also taught a basic format as to resolving crisis. This format consists of the following steps: getting the person's attention, checking the person sense of reality, attempting to establish rapport, officer expressing their perception of reality, and finally working towards a resolution to the crises (WIDAJ, 2007). Other guidelines are provided for interactions with people who are suicidal as well as guidelines for people who are under the influence of alcohol or drugs.

SECTION III. THEORETICAL FRAMEWORK

Introduction

Many different theories could be applied to those who are experiencing crises. Crisis intervention is an important role for not only law enforcement, but for other community stakeholders. Veterans and others within the community at any given point could potentially experience a crisis situation due to an undiagnosed mental health issue such as PTSD, or arise out of alcohol or substance abuse. Applying the proper theoretical framework when working to resolve these volatile situations, could prove to be a rewarding experience. Consequently, not applying the proper framework, in an effort to resolve these issues could have catastrophic outcomes.

General Strain Theory

The general strain theory was introduced by Robert Agnew in 1992. Agnew (1992) identified three types of strain within the general strain theory. The first type of strain is: strain is the actual or anticipated failure to achieve positively valued goals. The second type of strain is: strain is the actual or anticipated removal of positively valued stimuli. The final type of strain is described as: Strain is the actual or anticipated presentation of negatively valued stimuli.

Agnew (1992) describes how the first type of strain (actual or anticipated failure to achieve positively valued goals) is what most people generally strive for: “monetary success and/or middle class status” (p. 51). It is important to note there are other positively valued goals other than money, such as career aspirations, housing, etcetera. Agnew (1992) identified three subcategories of strain within this first type of strain (Strain is the actual or anticipated failure to achieve positively valued goals). The first subcategory is: strain as the disjunction between aspirations and expectations/actual achievements. The second subcategory is: expectation and actual achievements. The final subcategory is: fair/just outcomes and actual outcomes. When people perceive they are prevented from achieving positively valued goals through legitimate channels, they may attempt to achieve these goals through illegitimate means (Agnew, 1992). Or, if people feel as if they have been wronged, or expect to succeed and fail, they will inherently experience some degree of strain.

The second type of strain (actual or anticipated removal of positively valued stimuli) occurs when something which is regarded as a “good thing” in a person’s life vanishes or the person strongly believes the “good thing” will disappear (Agnew, 1992). Examples of this could

include: the ending of a relationship, the death of a close friend or relative, loss of employment, housing etc. (Agnew, 1992). Agnew (1992) describes how delinquent behavior could potentially occur when a person is facing this second type of strain: attempting to prevent the loss of the positive stimuli, trying to get the positive thing back once it's lost, seeking a substitute for the positive stimuli, or directing resentment and anger towards the cause of the loss.

The third and final type of strain proposed by Agnew (1992) (presentation of negative stimuli), occurs when something toxic impacts, or threatens to impact a person's life. This type of strain could be influenced like the second type, as the person experiencing the strain tries to reduce the impact the negative strain has on their lives (Agnew, 1992). This could occur by the person (who is experiencing the negative stimuli) taking anti-social behaviors in an attempt to: lessen the impact of the negative stimuli, to stop or prevent the stimuli, or similar to the second type of strain, direct anger and resentment to the source of the noxious stimuli (Agnew, 1992).

A study conducted by Vayalapalli, Fareed, Byrd-Sellers, Stout, Casarella, and Drexler, (2013) could be linked to the general strain theory. They found that veterans who had substance abuse issues were more likely to complete intensive outpatient programs if they had stable housing (Vayalapalli et. al, 2013). Vayalapalli et. al (2013), found those who are homeless have higher rates of substance abuse, and have issues with their physical and mental health.

Issues such as homelessness and substance abuse are relevant to many of the elements which relate to the general strain theory. For example, each of the three sources of strain can easily be identified regarding the topic of homelessness. First, there is a clear disjunction between aspirations and expectations/actual achievements. Most people as children do not desire

to grow up to be homeless and struggle to survive. Secondly, the removal of positively valued stimuli may have occurred when the person lost their flow of income, ultimately resulting in the loss of their home. Third, the presentation of noxious stimuli could have occurred in the events leading up to homelessness such as drug use, alcoholism, mental illnesses etc. These aspects may have led to homelessness, and also increase the chances of a perpetual cycle of noxious stimuli. This perpetual cycle of noxious stimuli could include things such as: victimization, exposure to the elements, hunger, lack of medical care, etc.

Military Strain

The culture of the military itself can present different sources of strain. For example, the military is bureaucratic in nature which creates goal blockage due to the competitive nature of promotions, transfers, assignment placements, and awards (Bucher, 2011). This could potentially become a disjunction between aspirations and expectations/actual achievements as described previously by Agnew (1992). According to Bucher (2012), some service members may even turn to steroid use in order to gain a competitive advantage over their peers. Steroid use could potentially lead to increased aggression, paranoia, and delusions (Bucher, 2012).

An example of the actual or anticipated removal of positively valued stimuli in the military could also include the separation of the service member from their homes and families for an extended period of time during a deployment (Bucher, 2011). The presentation of noxious stimuli could include the numerous facets of combat including: the direct threat of losing one's life, witnessing death and destruction (Bucher, 2011). Other sources of noxious stimuli could

include: stressors associated with training (i.e. yelling, lack of sleep), pain, injuries, and loneliness (Bucher, 2011).

Some research has suggested a potential link between substance abuse and strain among members of the military. For example, Hallam (2008) suggests some service members use substances to dull their emotions in order to manage the stress of their employment. A study conducted by Bucher (2011) found service members used illegal substances (while deployed) as a way to cope with stress due in part to the lack of positive or legitimate coping mechanisms. Bucher (2011) also found survey participants who had reported physically attacking their partners did so because of the inability to properly control stress.

Psychoanalytic Theory

It is important while discussing mental health, crisis, and substance abuse to also discuss a theory relating to personality. The psychoanalytic theory is based on the writings Sigmund Freud which discuss the unconscious mental processes which influence the behaviors and the actions of a person (Funder, 2016).

There are four main components relating to psychoanalysis. The first component is psychic determinism. Psychic determinism is the belief that everything which happens is because something caused it to happen (Funder, 2016). According to Funder (2016), there are no accidents and every behavior demonstrated by a person could be fixed given the proper framework to identify, explain and rectify the behavior. Every thought, and every reason a person forgets a detail of a particular subject or person, is due to the unconscious part of the mind (Funder, 2016).

The second component of psychoanalysis is the internal structure (not a physical structure) of the mind itself. According to psychoanalysis theory, the internal structure of the mind consists of three parts: id, ego, and superego (Funder, 2016). The id is described as the primitive drives and emotions housed in the unconscious part of the mind where every desire is wanted to be fulfilled immediately (Funder, 2016). The second internal structure of the mind the ego, is considered the rational portion of the mind which stabilizes the desires of the id and superego and reality (Funder, 2016). The final internal structure of the mind the superego, is considered the conscious of a person which a person bases their morality and behaviors around (Funder, 2016).

The third component of psychoanalysis is the psychic conflict and compromise within the internal structure of the mind. As mentioned previously, the role of the ego is to be rational and to stabilize desires. When the ego makes the compromise, this is what the person actually thinks and does (Funder, 2016).

According to Funder (2016), the final component of psychoanalysis is the mental energy of a person known as libido. This energy is what is used in order to make the mind function. When the mind is using energy to do one thing, it is unavailable to do another (Funder, 2016).

Anxiety, Defense, and the Role of Ego in Psychoanalysis

Funder (2016) describes how anxiety can be caused by the mind itself as well as other external influences. The degree of anxiety a person experiences can have a wide range. A person can have a minimal degree (being upset in a traffic jam) of anxiety to a severe case in which the person could be terrified to the point of pure panic (Funder, 2016).

It is the role of the ego to prevent people from experiencing a high degree of anxiety. The ego creates defense mechanisms in order to diminish or alleviate the impact of anxiety of a person (Funder, 2016). Some of defense mechanisms include: denial, repression, reaction formation, projection, rationalization, intellectualization, displacement and sublimation (Funder, 2016).

Crises arising from PTSD and substance abuse could potentially occur if the person does not have adequate defense mechanisms or if a defense mechanism is not safely/properly used. For example, if a person violently projects their anger upon others, is not considered properly utilizing defense mechanisms. Another example could include the attempted repression of feelings with alcohol, drugs, or other antisocial behaviors, as a way to alleviate anxiety experienced by PTSD symptoms.

SECTION IV. RECOMMENDATIONS

A Recommendation for an Efficient and Effective Crisis Response Model

Introduction

A reoccurring theme throughout the many sources of data used in the course of research was how law enforcement officers feel as if they are inadequately trained for mental health related calls (Watson & Fulambarker, 2012; Weaver et.al 2013; Palmer, 2014). Watson and Fulambarker (2012) further describe common frustrations among law enforcement officers in their response to a mental health related call including: these types of calls are often time

consuming, mental health providers not being responsive, and as mentioned previously, these types of calls divert officer from other law enforcement activities.

It is important to have a basic foundation of mental health and crisis response training for law enforcement officers, including training on veteran-centric issues such as PTSD and substance abuse. A proposed crisis response model consists of three phases: initial response, secondary response, and follow-up services.

Training

It is important for law enforcement officers to feel confident in their training, as they are often the first to arrive during mental health and crisis response situations. When discussing veterans specifically, Weaver et. al (2013) highlights how veterans are trained in combat, policing tactics, and are usually trained on the same level, or have more advanced training than responding officers. If law enforcement officers do not feel confident in their training this could lead to severe issues. Police are often seen as the proverbial “gatekeepers” of the criminal justice system. The proper management of a mental health crisis could determine the difference between criminal charges and the proper mental health interventions (Weaver et. al, 2013).

At a minimum, law enforcement officers should receive mental health crisis management training in their basic academy training. Using the Wisconsin Department of Justice (WIDJ) curriculum as a guideline, (due to its broad coverage of related topics) basic crisis training should be somewhat comprehensive. This training should cover a wide variety of topics including: mental disorders, personality disorders, assisting people with mental disorders, suicidal people, people under the influence of alcohol or drugs, people exhibiting medically significant behavior,

developmental disabilities, and Alzheimer's/dementia (WIDAJ, 2007). Basic law enforcement training related to veteran mental health issues should also be provided. For example, the WIDAJ curriculum discusses how veterans with PTSD may react violently if they hear a loud noise, because the noise may trigger a previous traumatic combat experience.

Once officers begin working in their profession, training in MHFA and/or the Memphis CIT Model is recommended to further hone crisis response skills. These courses are designed to reduce the stigma associated with mental health and provide in depth guidance for the utilization of community resources to appropriately divert those who have mental health related issues into appropriate treatment options. These courses also expand skills such as de-escalation and have been shown to increase the confidence of those who have attended the training in their ability to appropriately manage a crisis situation. Additionally, law enforcement officers should receive continuing education related to crisis response throughout their careers to maintain their proficiency.

Crisis: A Recommendation for a Three Phase Response

A three phased progressive response is recommended to alleviate some current issues facing law enforcement officers in their response to crisis. This response model could aid in the alleviation of frustrations, direct the appropriate personnel to a crisis response, increase the chances the proper utilization of resources, and finally provide an appropriate outcome. The first phase would be the initial response in which law enforcement would arrive and assess the overall scene to ensure the safety of the secondary response personnel. Officers responding during this first phase should be trained in either the MHFA or Memphis CIT model in order to attempt to

develop rapport and utilize de-escalation techniques. However due to staffing abilities, officers without this in-depth training would have been provided an overview of techniques in their basic academy in which to utilize, until more advanced trained personnel arrive.

Once the first phase has been implemented, the second phase personnel arrive shortly thereafter. This second phase comprises of a mobile crisis team consisting of mental health crisis specialists who have direct contact with a psychiatrist and is modeled after the COAST program as previously described. This second phase mobile crisis team has the ability to take control of the scene, and relieve law enforcement officers so they can continue with their law enforcement function (if it is determined no crime has been committed and the situation has deescalated). The crisis team works with law enforcement and other stakeholders within the community to divert the person experiencing crisis into the appropriate treatment option or program.

The third phase consists of follow-up. This phase serves as an outlet for the person who had experienced crisis, as well as serves as a vehicle to rapidly connect to the resources and treatment should they encounter similar situations which may lead them to the path of another crisis. It is the goal of this phase to assist the person in the aspects of their lives in which they may be experiencing difficulty, and provide the sustaining interventions to prevent further crisis episodes. Some of these sustaining interventions and resources provided in this phase could include: steady employment, housing, anger management, alcohol and drug abuse treatment, and others.

Applying the General Strain Theory to Veterans Experiencing Crisis

During the three recommended phases of crisis response, the three key areas of the general strain theory should be targeted by the responding crisis personnel in order to appropriately manage the crisis, and provide sustainment options after the resolution of the crisis for the veteran. If sources of strain are identified, response personnel should attempt to effectively manage or alleviate these stressors. Targeting the sources of strain, helps to ensure the goal of preventing or mitigating the impact of future crisis occurs.

Some of the key target areas involving veteran-related strain would include topics which have been discussed previously such as: the status of personal/intimate relationships, the various examples of the presentation of noxious stimuli (i.e. alcohol and drugs to cope with stress, PTSD, injuries, and loneliness), and the disjunction between aspirations and expectations/actual achievements (i.e. failure to promote, homelessness, etc.). Often, one source of strain produces strain in other areas as well. This could lead to a perpetual cycle of strain, resulting (in extreme cases) in a mental health crisis or other destructive behaviors.

Take for example a veteran or service member who has to leave the military due to some involuntary reason (i.e. career ending injury, conduct). The person may have had the goal of retirement from the service, however now they are being forced into a life/lifestyle they may have not adequately prepared for. This would create a source of strain in anyone's life, to leave a place of employment involuntarily. This strain has the strong probability to produce strain among the members of the family which could lead to financial hardship, and in extreme cases, homelessness, or a myriad of anti-social behaviors. These areas once effectively treated could

potentially break a possible perpetuating cycle of strain. Having a crisis team interjecting itself (playing the role of positive stimuli) into this environment of negativity (or crisis) may alter the crisis state of the veteran by providing the resources necessary leading to a positive life course.

Applying Psychoanalytic Theory to Veteran Related Crisis

When discussing PTSD and substance abuse, these are both factors which can relate to the psychoanalytic theory. Specifically within this theory, anxiety and the defense mechanisms should be targeted by personnel within the crisis response model. It is suggested that members of the crisis response team and others link the veteran who was experiencing the crisis episode to intervention options which help them cope with their anxiety. A person's defense mechanisms are supposed to provide a safety net to prevent an overreaction, but during a crisis episode this safety net has failed (Funder, 2016). When one's internal coping mechanisms fail, a crisis mental state occurs.

Conversely, defense mechanisms may be fully in place. However, these defense mechanisms may be considered destructive. Veterans (and others) may turn to alcohol and drugs as a means to cope with their psychological trauma. Further, the defense mechanisms of: denial, repression, reaction formation, projection, rationalization, intellectualization, displacement and sublimation could also be used as coping mechanisms; however they have the potential to make the person worryingly detached from the real world (Funder, 2016). This is a dangerous aspect, because once removed from reality, a person may not think of consequences which may result from their actions. The prevention of further anxiety, and the use of destructive defense

mechanisms to cope with anxiety, is the primary focus of phases two and three of the recommended crisis response model.

SECTION V. SUMMARY AND CONCLUSION

The topic of mental illness has been stigmatized throughout history. Up to the mid twentieth century, people with mental illnesses were housed in state run asylums. With the development of psychotropic drugs in the 1950's and 1960's, as well as instances of patient abuse and neglect being brought to light, a shift to a community based treatment philosophy took hold. Large mental health institutions began to close; this was the beginning what was called deinstitutionalization. Unfortunately, the funding for a comprehensive community based mental health treatment option never materialized. As a result, decades of inadequate diagnosis and treatment of those suffering from mental illness, has created a massive mental health problem in the United States.

Since the War on Terrorism began on September 11, 2001, the topic of the mental health of U.S. military veterans has brought renewed interest to the American public. This is due in part to high profile news reports of veterans committing homicide and violent assaults, and then blaming their combat and/or deployment experiences as the reasons for their actions. Studies have shown approximately 11% to 19% of veterans returning from Iraq and Afghanistan suffer from mental health, substance abuse, or relationship problems (Cigrang et. al, 2014). Veterans suffering from PTSD have an increased risk of alcohol and drug abuse, which also increases their chances of having a law enforcement contact (Cigrang et. al, 2014).

Often, veterans suffering from mental health related issues do not seek the appropriate treatment or care due to the stigma associated with mental illness (Pols & Oak, 2007). Service members may fear the diagnosis of mental illness may lead to peer rejection or have a negative impact on career goals (Pols & Oak, 2007). Also, of those veterans who have mental illnesses, some may not qualify for treatment from the Department of Veterans Affairs due to their type of discharge, or due to some other element regarding their period of service. Of those who do in fact qualify for benefits from the VA, the VA lacks the resources to provide adequate care (Hester, 2017).

Data taken from surveys of law enforcement officers have shown officers do not to feel like they have sufficient training in dealing with mental health crises (Watson & Fulambarker, 2012). Another reason noted for the lack of training in mental health crisis response is the availability of officers to attend training programs related to this topic (Smydo & Lord, 2016). Also, officers with specialized training may not even get to mental health related calls due to their caseload (Smydo & Lord, 2016).

Presently used crisis intervention methodologies including: Crisis Intervention Teams (Memphis Model), Mental Health First Aid, Mobile Crisis Teams, and the Wisconsin Department of Justice Crisis Management curriculum were studied. From these models a recommendation for training and a three phase program regarding crisis intervention was developed. This three phased response consisted of: initial law enforcement response, mental health specialist response, and the final phase consisting of follow up services. The development

of these phases was geared to provide efficient and effective mental health crisis interventions as well as providing an avenue for sustainment mental health services.

The general strain theory and the theory of psychoanalysis were selected as a way to target the associated stressors or elements of PTSD and substance abuse related to military service. It was recommended the crisis response members and other stakeholders within the recommended model, focus on these areas as a way to mitigate and prevent future crisis.

In conclusion, the topic of inadequate mental health related resources is a major area of concern in the United States. Due to the lack of resources, people suffering from mental illnesses and military veterans may inappropriately be incarcerated where a diversion program may be more appropriate. Law enforcement officers are seen as the gatekeepers of the criminal justice field. It is through their crisis response training, as well as their connection to mental health related resources to ensure, citizens and military veterans who suffer from mental illnesses, PTSD, alcohol and substance abuse, get the appropriate treatment for their illnesses. Without the appropriate training, appropriate personnel, and the additional support services (if needed), crisis intervention could be considered inadequate and ineffective.

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