Reconciling Law Enforcement's Responsibilities with a Community's Expectations & Needs: A Community Oriented Policing Analysis of Crisis Intervention Teams (CIT)

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For the Men & Women of Law Enforcement, especially the Green Bay Police Department, for their commitment to honor and service.

And for those officers who took time to assist me in this endeavor: Lt. Jeremy Muraski, Lt. Paul Lewis, Sgt. John Wallschlaeger, Capt. Randy Schultz, Deputy Matt Wilson, Officer Barbara Gerarden, Officer Patrick Childs, Officer Luke Lansbach, & Officer Tracy Liska.

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Abstract

In recent years law enforcement departments nationwide have adopted community-oriented policing strategies and policies in order to best serve their jurisdiction. During this same time frame, there has been a substantial increase in the amount of Crisis Intervention Teams (CIT) formed, in an attempt to better train and educate law enforcement officers on mental illnesses and crisis intervention techniques. Literature research shows there has not yet been a focus on how CIT training falls into the spectrum of community-oriented policing methodologies, or on any current attempts to integrate the two, even though both theoretical models suffer from similar challenges, including lack of standardized definition or differences in training and expectation. There will also be a focus on what law enforcement's real responsibilities are in current American culture compared to the expectations of the community from their police department, and how deinstitutionalization changed policing.

Keywords: Crisis Intervention Teams, CIT, community-oriented policing, deinstitutionalization, law enforcement.

Reconciling Law Enforcement's Responsibilities with a Community's Expectations & Needs: A Community-Oriented Policing Analysis of Crisis Intervention Teams (CIT)

Criminal justice professionals in America suggest that American policing, since its inception, has evolved through 3 eras: the political era, the reform era, and the community era. (Oliver, 2004) In most regards, the community era revolves around the advent and implementation of community-oriented policing, a theory that seemingly has no standardized definition, but is a popular buzzword within the law enforcement arena. Even without a standard definition, community oriented policing services exist, in one form or another, in over 95% of larger municipal police departments and 88% of larger sheriff's departments. (Oliver, 2004).

Before approaching the definition (or lack thereof) of community-oriented policing, however, there must be an analysis of what policing itself is defined as, and what it consists of. Police work in American society is a complicated subject, made more so by the differences in types of law enforcement agencies that exist, and perhaps to best determine a definition one must understand the responsibilities of the police. The American Bar Association (1980) published a list of identified major responsibilities of police agencies, which included: identification of criminal offenders and activity and apprehension, reducing the opportunity for crimes to be committed through patrol, aiding individuals who are in danger of physical harm, protecting constitutional guarantees, facilitating the movement of people and vehicles, assisting those who cannot care for themselves, resolving conflict, creating and maintaining a feeling of security in the

community, promoting and preserving order, and providing other services on an emergency basis.

So if policing itself cannot be deftly summed up by a simple definition, it seems unlikely that community-oriented policing could. Significant literature has been devoted to exploring the costs, benefits, and disadvantages of community-oriented policing, but there appears to be a shortage of literature relating to one specific policing function and its role within community-oriented policing initiatives: Crisis Intervention Teams (CIT) and CIT training.

Crisis Intervention Teams (CIT) are generally defined as pre-booking jail diversion programs designed to improve the outcomes of police interactions with people with mental illnesses. (National Alliance on Mental Illness, 2010). The idea for CIT was first established in 1988 in Memphis, Tennessee, and since then the CIT model is often referred to as the Memphis Model, consisting of a 40 hour training program for law enforcement officers, and the collaboration of the police, mental health providers, and consumer advocates. (National Alliance on Mental Illness, 2010).

CIT programs exist in response to the knowledge that police officers are often the frontline response system to any and all community concerns, issues, problems, challenges, and difficulties: uniquely mobile, uniquely responsive, and the embodiment of an unique authority. This paper is an attempt to analyze the use of the CIT model through the lens of a community-oriented policing perspective, as well as analyzing current perspectives on law enforcement and what their responsibilities are and what expectations are placed upon them by the communities they serve. Ultimately the question is not if CIT "works" in the traditional sense of policing initiatives that are

considered successful or unsuccessful, but rather how CIT pertains to the current era of American policing and its community oriented focus.

Community-Oriented Policing: Lack of Definition

To analyze CIT through the theoretical perspective of community-oriented policing, community-oriented policing must be described. Although an overwhelming percentage (as remarked earlier) of police departments currently have some form of community-oriented policing (COPS) initiatives, there are as many different COPS formats as there are police departments. Cordner (2006) states that community-oriented policing can be defined as a policing philosophy that "promotes and supports organizational strategies to address the causes and reduce the fear of crime and social disorder through problem-solving tactics and police-community partnerships." Oliver (2004) states that no shared definition of community-oriented policing exists among either theorists or law enforcement, and that he believes it is an intangible concept based on intangible ideas. Moore (1994) states that community-oriented policing is a model that emphasizes order maintenance and other non-emergency services more than the professional model of policing does, while White (2007) states that community policing "seeks to build upon the theoretical foundation of broken windows by expanding the police mandate and including the community as a partner in crime prevention…the best way for police to address disorder is to build a collaborative relationship with the residents of the community."

It quickly becomes clear that this lack of a formal definition translates to a lack of formal or standard implementation in regards to community policing initiatives within separate police agencies. It seems that while politicians and community members agree

that community policing is an innovative way for the police to deliver services, the agreement only has enough depth to cover the broad term of community policing, with the underlying theoretical foundation often left untouched. (Eck & Rosenbaum, 1994).

As stated by Gianakis & Davis (1998), research confirms the ambiguity and elasticity of the community policing concept, and approaches the fact that many researchers and theorists present this elasticity as a strength of the concept, and the lack of a standardized definition, while anathema to much of social science, is the essence of community policing. It allows for each specific police agency to work with its community to determine what method of community policing should exist within the jurisdiction. This paper and its focus on CIT supports that view of community policing initiatives. CIT, at its heart, is a community collaboration of law enforcement and mental health providers to best serve community members who are consumers of mental health services, and the ambiguity within the concept allows for CIT models to be specific to each separate police agency, as each community will have different providers, different populations, and different challenges to face.

In analyzing the differences in standards or definitions, there must also be mention of the similarities that exist. Gianakis & Davis (1998) state that almost every agency in Florida adopting some form of community policing added specialized patrol units to the traditional patrol function to serve specifically in a community policing role. Oliver (2004) states that in 1999, almost 113,000 sworn officers in America were working in a full-time community policing role, based upon their department's definition of community policing. This adoption of specialized officers can be reflected in almost every major police department adopting a COPS philosophy, and in turn reflects a high

percentage of departments reporting that their most radical change from traditional policing to a community focus was on training programs for officers (Gianakis & Davis, 1998) with over 92% of current American police officers estimated to have completed some form of in-service training relating specifically to community policing initiatives, programs, or goals. (Oliver, 2004).

So while there may not be a standard definition of community policing, defaulting to the individual departments implementing the programs could foster a sense of jurisdictionally relevant and specific training programs. This is very important when analyzing CIT through the lens of community policing, regardless of the lack of a standard definition.

Defining CIT

Significant literature exists substantiating the short-term effects of CIT training and use in police departments, but the research is limited in scope, with much of it focusing strictly on the training and characteristics of the officers who are involved in CIT programs. (Watson et al., 2008).

So what is CIT? What is a Crisis Intervention Team, what is the training that officers go through, and what are the expectations of them once they complete the training? And more importantly-why are law enforcement departments the public agencies stepping forward to become more involved in mental health?

When reviewing literature focusing on police interaction with the mentally ill, nearly every author mentions the importance of deinstitutionalization, but for many there may be some confusion over what deinstitutionalization actually is and what it entails. And to understand CIT, one must first understand deinstitutionalization, which requires

an understanding or introduction to the legal doctrine of parens patriae. Parens patriae refers to the legal doctrine that establishes the belief the state has the ultimate authority and power to care for those unable to care for themselves, specifically children and adults with disabilities and mental illnesses. (Hill & Hill, 2005). Because the American court system determined the state had a responsibility to care for those unable to care for themselves, every state in the nation opened up hospitals specific to assist individuals with severe or chronic mental illnesses, creating a tradition that existed from the 1800s until the mid 1950s of psychiatric patients being treated in state psychiatric facilities. (Talbott, 2004). In 1955, the census of inpatient psychiatric patients in state hospitals reached its peak of 560,000 people, only to find in 50 years time that the number has decreased more than 60%. (Talbott, 2004).

This is deinstitutionalization: the removal of individuals from inpatient settings in state run psychiatric hospitals and the placement of these same individuals back into their communities. Talbott (2004) states that the reasons for this are numerous, not the least of which was significant advocacy from family members of mentally ill individuals during this time period that it would be best if these patients were back home receiving treatment, close to family members and social support systems. This advocacy corroborated with pharmaceutical advances and newer psychopharmacological agents that were extremely powerful, and this all was during a time of stretched state budgets and financial funding shifts in federal health care programs such as Medicaid, Medicare and Supplemental Security Income. (Talbott, 2004).

Around this same time, American court systems were also taking a closer look at the requirements and standards in place that allowed for involuntary commitment of

individuals to these state hospitals and the lack of constitutional benefits for committed patients. As such, almost every state set stringent standards for involuntary civil commitments, thereby reducing the number of new admissions to state hospitals while the hospitals began to seemingly empty out. (Cornwell, 1998).

While some tenets of deinstitutionalization were beneficial and treated patients in a more humane manner, communities and mental health service providers were not prepared for the influx of individuals returning to their communities in need of long term mental health services, and as such the idea fell apart. Large numbers of "obviously mentally ill people on city streets, people who were dirty…who hallucinated and talked to themselves or shouted to others…In many places, huge ghettos of discharged patients were created in areas of low-cost housing, proprietary homes, or deteriorating neighborhoods." (Talbott, 2004).

It is argued that what actually happened was not a form of deinstitutionalization of the mentally ill, but rather a transfer or transinstitutionalization, as police departments now became the front line for assisting the mentally ill individuals placed back in the community with failing support systems. (Talbott, 2004).

For years, police departments struggled with this added expectation of them-responding to calls relating to individuals with mental illnesses, calls in which officers had little education and even less training. A literature review shows the overwhelming consensus listing police officers as the first responders for individuals in mental illness crises. (Teller et al., 2006, Borum et al., 1998, Laing et al., 2009, Steadman et al., 2000). It is perhaps interesting to note that in 1955, 0.3% of the American population was mentally ill and residing in a state psychiatric facility, while in 1999, 0.3% of the

American population was mentally ill and residing in the custody of the criminal justice system. (Borum, 2000). In true bureaucratic form, 40 years after deinstitutionalization began, law enforcement departments finally began implementing formalized training procedures and specialized units relating to mental illness, with the general term given to these programs as Crisis Intervention Team models, or CIT.

The CIT model, established in Memphis, provides police officers with 40 hours of classroom and experiential de-escalation training in handling crises, allowing those officers to serve as specialized frontline responders, in the hopes of these officers redirecting people to treatment services rather than the judicial system. (Compton et al., 2008). It has already been established that law enforcement officers are the first responders to individuals with mental illnesses, so the CIT model is an attempt to train and educate officers on some basics of mental illness in order to better equip them to respond to calls of this nature.

Since its introduction in 1988, the CIT model is now the most rapidly expanding program relating to mental illness response in police departments around the nation, with over 400 CIT-related programs currently in existence. (Compton et al., 2008).

The Criminalization of Mental Illness

The United States has the highest incarceration rate of any industrialized country in the world, with 1 in 32 adults under some form of correctional supervision. (Bartol & Bartol, 2004). Of this population of individuals under correctional supervision, nearly 66% were under community supervision, such as probation or similar variants, 22% were residing in prisons, and 11% were being held in jails. (Bartol & Bartol, 2004). With a current American population estimated at 309 million people (U.S. Census Bureau,

2010), that would place the estimate at approximately 9.6 million people under some form of supervision in the United States.

The prior numbers should be analyzed in conjunction with the estimate that 26% of adults, or nearly 80 million people, in America suffer from a diagnosable mental disorder. (National Institute of Mental Health, 2010). So if 1 in 4 adults is suffering from a diagnosable mental illness, and 1 in 32 adults is under community supervision, estimates place those mentally ill individuals involved in the criminal justice system at almost 2.4 million people.

Laing et al., (2009) states that approximately 10% of calls for service that police respond to involve an individual who has mental health problems, while White (2007) estimates that 7%-10% of police-citizen encounters involve a mentally ill individual, and Cordner (2006) places the number at 7%. In analyzing the existing literature, the number does seem to center around the conservative estimate of 10%.

To determine perceptions of both police officers and the general public in how often police respond to calls involving individuals with mental illnesses, a survey was handed out, and respondents were asked to estimate, percentage-wise, the amount of calls police officers in their jurisdiction responded to involving an individual with a mental illness. The average estimate by current police officers was 15% (n=50), and the average estimate by civilians was 35% (n=42). Sellers et al., (2005) state that in a nationwide survey, the figure was determined to be more around 7% of police calls, and attributable to deinstitutionalization, restrictive laws regarding civil commitments, and reductions in funding and budgets for community-based mental health programs.

In viewing the statistics from another perspective, 20% of individuals with severe mental illness report being arrested at least once in a 4 month period before a hospitalization, most commonly for drug offenses or public disorder crimes. (Borum et al., 1998). Borum (2000) states that of family members surveyed by an Oregon chapter of the National Alliance on Mental Illness (NAMI), more than 50% reported their mentally ill family member had been arrested at least once, with an average of 3 times. According to Bartol & Bartol (2008), 16% of all state prison and local jail inmates reported they suffered from a diagnosed mental illness. Teplin (1990) found that 9.5% of males incarcerated at Cook County Jail in Chicago, Illinois had experienced a severe mental disorder, characterized as either schizophrenia or bipolar disorder, as compared to 4.4% of males in the general population.

Territo, Halsted & Bromley (2004) state that the Los Angeles County Jail System, by default, has become the nation's largest mental health institution, with an average of 1,700 inmates being treated for severe mental illnesses. The Dallas County Juvenile Department has a budget of $6.6 million specifically for treatment and psychiatric hospitalization for juveniles incarcerated-the same amount of money Dallas County's Mental Health Institution has for its entire program. (Territo, Halsted, & Bromley, 2004). It has become increasingly clear that the taxpayers, and subsequently, the government, have decided to increase budgets and responsibilities of correctional agencies in responding to mentally ill individuals, while no clear increases or substantial benefits have been allotted to state psychiatric hospitals or facilities, or to the creation of new community-based mental health facilities.

By default, then, the deinstitutionalization of state psychiatric hospitals has resulted in the treatment of mentally ill individuals shifted from mental health professionals to the criminal justice system: a system woefully incapable of providing treatment. Dr. Richard Lamb, an instrumental supporter of deinstitutionalization, admits that the purpose was driven because of the advent of powerful antipsychotic medications, but that the goal was for the money being spent to traditionally house the mentally ill would then be funneled into establishing community-based treatment centers, an idea of which only the first half came to fruition. (Territo, Halsted & Bromley, 2004). Steverman & Lubin (2007) highlight that while community based mental health care programs can be seen as costly, at approximately $26 a day, it is far costlier to have those same individuals incarcerated, with the average approximate cost of $65 a day.

In the American criminal justice system, the initial gatekeepers are the police officers, so for such a staggering number of individuals with mental illness to be involved in the correctional system, it naturally follows then that the initial entrance into the system was through some form of contact with the police. Laing et al., (2009) state that the police have become the most important role in the management of mental health crises in the community, and are often the first and only service to respond to a mental health crisis. Reuland, Schwarzfeld & Draper (2009) remark that all too often, inadequately treated individuals with mental illnesses now manifest their symptoms in ways that nearly guarantee contact with law enforcement, often through public disorder or nuisance crimes, such as trespassing, disorderly conduct, or creating disturbances in public. (Abram & Teplin, 1991).

Enter the Police

The expectation that law enforcement officers can address every concern in each situation is daunting and unrealistic. (Young & Brumley, 2009). And yet, police officers are expected to effectively resolve problems that have been created over a period of years in a matter of minutes, with little training and even less cooperation. It is important to recognize that mental illness is not, in and of itself, a police concern. (Cordner, 2006). Police officers receive training in enforcing the law, not necessarily in interacting with people with mental illness or in crisis intervention, and Wellborn (1999) states that not only is this a significant concern, but that for too long police departments have had to shoulder the burden of mental illness in their communities with little assistance or cooperation from mental health providers. As Draine, Wilson & Pogorzelski (2007) state, the discourse around mental illness has moved from deinstitutionalization to decriminalization, as lack of treatment causes an individual to engage in unusual or symptomatic behavior that results in them coming to the attention of law enforcement.

Cordner (2006) states that 92% of police officers have had at least one encounter with a mentally ill individual in the previous month, with an average of 6 such encounters per month. Because of the wide variety of duties police officers are expected to conduct during the course of patrol, Cordner (2006) listed the 5 most frequent types of contact scenarios: a family member calls the police for help during a psychiatric emergency, a suicidal individual calls the police for help, police officers encounter an individual with mental illness behaving inappropriately in public, citizens call the police because they feel threatened by or are concerned for an individual with mental illness, and a person with mental illness calls the police for help because of real or imagined threats. As stated by Heinecke (2005), when an individual with mental illness loses control-by

nonadherence to medication, self-medication through substance abuse, or through another trigger, they are said to be “in crisis”, and anybody who is in crisis is out of control and is desperately trying to find a way or means to become back in control.

A misconception that commonly exists within the general public is the expectation that the police have a grasp of the situation upon arriving to the scene of a call for service. Oftentimes, police officers are given little more information than an address and a quick summary of what is believed to be the problem. This summarization is conducted by the dispatcher or call taker, who determines what information they believe the officers need to know to respond to the call. Officers do not always have prior notice that they are responding to a crisis or call involving an individual with a mental illness. (Cordner, 2006). Furthermore, it cannot be stressed enough that police officers generally respond to the extremes on a spectrum. Mental health professionals and family members are often more aware of the passive symptoms as they develop over time within individuals with mental illness; officers are called when the situation has peaked to a crisis, with the individual in an angry, ambivalent or unstable state of mind, which calls for an alert approach. (Gentz & Goree, 2003).

There is a disconnect between what the police department and its officers actually are trained and required to do, and what the community expects from them, often an issue exacerbated by the consistent portrayal of law enforcement in the media.

Mental Illness & Law Enforcement in the Media

Mental illness is one of the most stigmatized medical conditions in our society, a problem highlighted by lack of general understanding and access to accurate and valid information, the central aspect of which can be seen reflected in the overwhelming

perception that individuals with mental illness are dangerous and unpredictable. (Stout, Villegas & Jennings, 2004).

Television, including broadcast news, is the primary source of information about mental illness for the majority of Americans. (Stout, Villegas & Jennings, 2004). Social scientists, specifically sociologists, have long been studying the effects of television and the psychology of mass media, and it has long been established that heavy exposure to consistent messages on television reiterate, confirm, and nourish perceptions individuals have about social reality. (Gerbner et al., 2002). Research on mental illness portrayals on television revealed that 72% of characters with mental illness were portrayed as violent, 47% of news items used generic terminology for mental illnesses in lieu of specific diagnoses, and dangerousness to others was the highlight of 62% of news stories relating to mental illness. (Stout, Villegas & Jennings, 2004).

In American prime time television shows, 32% contained at least one character with a mental illness, but not one comedic or situational comedy show had a character with a mental illness, leaving the portrayal of mental illness to the crime and drama shows. On American crime shows, over 50% of violent offending characters had a mental illness. (Stout, Villegas & Jennings, 2004). In 49 children's films, 24% had at least one character labeled as having a mental illness, with 43% of the films containing at least one reference to mental illness. Of the 24% that contained a character with mental illness, 67% of those characters were portrayed as adult, male, Caucasian, and violent. (Stout, Villegas & Jennings, 2004).

The media works in a similar manner when looking at the portrayal of law enforcement. Dominick's (1973) landmark study revealed that lawbreaking and crime are

common elements on prime time television, with 77% of television shows portraying at least 1 crime or illegal behavior. However, only 3% of those crimes were motivated by substance abuse or drug activity. And while the Federal Bureau of Investigation at the time indicated only 23% of crimes classified in the Uniform Crime Reports are cleared, or closed, television shows for that same period showed a clear rate of 88%, with 90% of those cleared cases shown as being successfully solved. (Dominick, 1973). On television, 60% of the crimes portrayed were violent in nature, specifically murder, which entailed 22% of the crimes shown on television. (Dominick, 1973). For that same time period, the FBI listed burglary as the most common crime, with murder listed least common.

Of the characters that portrayed the criminal justice system, 31% of the offender characters were referred to as professional criminals, 94% of the offenders had committed a premeditated crime, 29% of the crimes the offenders committed occurred in a business establishment, and 32% of the crimes were motivated by financial greed, with the next closest motivation (31%) being to avoid detection by the police. (Dominick, 1973). What is even more interesting to note is the portrayal not of the offenders, but of the law enforcement officers: 95% of the characters who were police officers were white males, and 30% of them committed a violent act in the course of duty, however this statistic could be misleading, because it was found that the leading law enforcement character almost always (92%) engaged in violence against an offending character. (Dominick, 1973).

And while Dominick's landmark study is now currently 37 years old, the numbers do not appear to have changed much. As stated by Mendoza (2005), "For network and cable TV, crime does pay."

Table 1

Current Television Shows Involving the Criminal Justice System

Network	# of Primetime Shows	# of Primetime Shows Involving Criminal Justice System	% of Primetime Shows Focusing on Criminal Justice System
ABC	45	13	29%
CBS	34	18	53%
FOX	20	7	35%
NBC	31	8	26%
TOTALS:	***130***	***46***	***35%***

(American Broadcasting Company, 2010; Columbia Broadcasting Company, 2010; Fox Broadcasting Company, 2010; National Broadcasting Company, 2010.)

What the table does not reflect is the upcoming fall season, where new prime time television shows are premiered, and how of the 13 upcoming new television shows to premiere on CBS, 10 of them involve the criminal justice system, which will bump up CBS's percentage of crime-related programming to 60% of its entire schedule. (Columbia Broadcasting System, 2010).

This suggests that the misconceptions that are promoted through the media about criminal justice, law enforcement, and mental illness are constantly being promoted, with almost 35% of all television programming on stations available to everyone for free relating specifically to crime or criminal justice. As Frederick (1973) argues, if individuals look to television as an educational source, they should be aware of the numerous distortions, omissions, and falsehoods. Without this knowledge, individuals who watch television are inundated with one-dimensional caricatures of law enforcement officers and individuals suffering from mental illnesses. It then sociologically will follow

that these caricatures quickly become examples for those within the general public who have no real world knowledge of law enforcement or mental illness. The expectations of these individuals on their law enforcement will then be shaped and their standards set by what they see on television, likewise what they believe about mental illness and what they know will be shaped by what they see on television, as defined by cultivation theory. (Stout, Villegas & Jennings, 2004).

Research on the subject also points out another interesting fact: 53% of undergraduate psychology and nursing students reported that television was their primary source of information on mental illness, and the majority of them believed individuals with mental illnesses, specifically schizophrenia, were different from them and labeled their behavior as unpredictable. (Granello & Pauley, 2000).

So what is the truth in relation to violence amongst the mentally ill? Teplin, Abram & McClelland (1994) highlight that the long-standing stereotype of mentally ill individuals with violent tendencies is reinforced by the media's portrayal of mental illness, but that the truth is mental illness is a relatively small risk factor for violence. After a landmark 6 year longitudinal study, it was discovered that while persons with a prior arrest for a violent crime were twice as likely to be arrested for a violent crime during the 6 year follow up period when compared to those with no prior violent crime arrest, there was no difference in the group suffering from mental illness when compared to those without. In other words, the best predictor of future violence or recidivism was prior violent arrests, and mental illness had no bearing and psychiatric disorder did not increase the probability of being arrested for a violent crime after release. (Teplin, Abram & McClelland, 1994).

There was evidence to support that psychotic symptoms may be more powerful predictors of violence than a diagnosis per se, but that comorbidity had the largest bearing on violent tendencies, specifically those individuals with mental illnesses who also had a substance abuse disorder. (Teplin, Abram & McClelland, 1994).

In recognizing the influence of comorbidity in relation to violent tendencies, Abram & Teplin (1991) discovered that 84% of individuals diagnosed with schizophrenia being held in the Cook County jail in Chicago, Illinois were alcohol dependent, 60% were drug dependent, 67% met criteria for antisocial personality disorder, and that only 7% had no co-disorder. The numbers remain as high for individuals diagnosed with major depression, with 81% alcohol dependent, 60% drug dependent, and 68% meeting criteria for antisocial personality disorder. (Abram & Teplin, 1991). Individuals with bipolar disorder led, however, with 87% alcohol dependent, 47% drug dependent, and 82% meeting criteria for antisocial personality disorder. (Abram & Teplin, 1991).

Evidence shows mental illness is not a very valid predictor of violent behavior, but those individuals with mental illnesses who displayed violent behavior or symptoms had comorbid disorders in high percentages. This suggests that mental illness is still a small vulnerability to violent behavior, but that substance abuse issues is a large one, a fact reflected in the percentages of non-mentally ill offenders incarcerated who also suffer from substance abuse issues.

Studies further reveal a lifetime alcohol/drug dependency rate between 5.5%-5.8%, with the highest rates among those aged 18 to 24. (Brown et al., 1989). These studies also reveal that individuals with mental illnesses are more prone to polydrug abuse or to combined alcohol and drug abuse and dependence. (Brown et al., 1989). The

use of these substances complicates diagnosis, interferes with treatment, and contributes to relapses and violent behavior. There is also some evidence that suggests many young people presenting to hospital emergency rooms with toxic psychosis have been misdiagnosed with schizophrenia, a diagnosis often transferred from clinician to clinician for years before the truth is discovered. (Brown et al., 1989).

Perhaps one of the most startling things in relation to mental illness and co-occurring disorders is that mental health professionals often lack knowledge or training in substance abuse, and substance abuse professionals receive little training in severe and chronic mental illnesses. (Ridgely, Osher & Talbott, 1987).

Substance abuse professionals traditionally use a didactic substance abuse treatment, one characterized by confrontation and ego reformulation, a significant problem for the substance abuse treatment professional working with an individual with mental illness, as they likely have deficits in ego functioning and a social inability to effectively work with didactical confrontation. (Brown et al., 1989). This suggests that traditional substance abuse treatment programs would not only be ineffective for individuals with chronic or severe mental illnesses, but that the implementation of these treatment procedures could possibly regress the individual more.

So while comorbidity is an important component, dangerousness stereotypes of individuals with mental illnesses are invalid and detrimental if assumed that because an individual has a mental illness, they are more likely to be violent or unpredictable. Research shows that much like individuals without mental illnesses, the most accurate ways to determine violent behavior is past violent behavior and substance abuse/dependence. (Skeem et al., 2005, Swartz et al., 1998). This knowledge is essential

for police officers, in order to assist them in being more educated about approaches to mentally ill individuals they interact with on the street. Because beyond anything else, it cannot be forgotten that ensuring safety is the first step in all interactions between officers and citizens. (Gentz & Goree, 2003).

The Public's Expectation of The Police

An important goal of community-oriented policing is to allow for opportunities for more proactive policing through greater public cooperation, requiring that the police assess the expectations of the community. (Salmi, Voeten & Keskinen, 2005). Ganjavi, LeBrasseur & Whissel (2000) state that the key to developing the most effective policing model is for each policing agency to determine the expectations from the community of them and adapt or change. Beck, Boni & Packer (1999) discovered that through the use of public attitude surveys, the public gave the highest priority of the police department to functions relating to crime fighting. Through the use of the Likert scale, researchers discovered that the most pressing concern the public had for their police was better detection and apprehension of criminals, followed closely by better control of drunken driving and then the prevention of disorder or chaos in public places. (Salmi, Voeten & Keskinen, 2005). Zhao & Thurman (1997) discovered that service-oriented law enforcement activities were ranked as extremely important by individuals within the community, including services generally viewed as less of a priority-stray animals, lost persons/property, public drunkenness, and order maintenance issues.

Yim & Schafer (2009) also remark upon how the public's expectations are based upon their lack of knowledge, which can contribute to the police department suffering from a poor community image, and that because of the nature of police work, many

officers view the public as resistant and unsupportive, while the public views their officers as cold and uncaring.

These results suggest a significant challenge to the community-oriented goal of fostering cooperation and understanding between the police and the community. Salmi, Voeten & Keskinen (2005) remark that while community policing remains a popular concept, very little education or effort has been conducted in order to better inform and educate the public about what community policing is and what the goals are. Gianakis & Davis (1998) believe that this failure must be remedied because the police function is inherently offensive, but that societies must reconcile themselves to its necessity.

It is also important to understand that most of the traditional literature that exists about community policing makes little attempt, if any, to specifically point out the definition of community being used, or literature specific to certain populations or communities, such as the mental health consumer community. The Austin, Texas Police Department, for example, in implementing its community policing initiatives, created a program referred to as the Community Immersion Program. The program, designed to teach new officers within the department about the diversity and cultures that not only exist within Austin, but the general culture of Austin as a whole, was formed by advocacy groups from within the community, and embraced by the police department, who recognized this program as a way to best approach the community's recognition of what it wanted from its police department-thereby validating the community policing initiatives. (Adickes, 2009).

So if community policing is an attempt to find out from the community what they expect from their police department, what does the mental health consumer population

expect of their police department? There is definitely room within the literature for research on this topic to help evaluate CIT programs. Agar-Jacomb & Read (2009) conducted research to determine what mental health consumers reported as their most immediate needs while in crisis, and the results are surprising. Research has revealed that multiple short- or long-term hospitalizations for mental illness can lead to traumatization, stigmatization, as well as an increased likelihood for future hospitalizations. (McGorry et al., 1991). Agar-Jacomb & Read (2009) discovered that 74% of mental health consumers and 87% of mental health providers wanted a range of non-hospital crisis services available, more autonomy for the consumer in decision making, more treatment choices beyond medication, and a holistic approach.

The number one concern for nearly half of the individuals who responded stated that when they were suffering a mental illness crisis, the biggest concern or need they had was a sense or feeling of safety. (Agar-Jacomb & Read, 2009). Closely following the need for safety was communication from individuals involved in the crisis and a feeling of autonomy, as well as a holistic approach to their treatment from treatment providers. (Agar-Jacomb & Read, 2009).

It appears that individuals suffering from mental illness crises are quite open with what needs they felt needed to be met during their crisis, specifically the need for open communication and a sense of safety and/or security. It is important, however, to also analyze the needs of another population: the caregivers/family members of mentally ill individuals.

It is estimated that 25%-33% of all chronically mentally ill individuals currently live with family members, but that the number increases to almost 65% with the inclusion

of individuals discharged from inpatient mental health psychiatric facilities. (Intagliata, Willer, & Egri, 1986). So just as the police department has become the default social service that responds to mental illness, family members have become the default case managers for a large portion of the mentally ill individuals in communities across the nation, and as such play a tremendous role in the treatment process.

The most important role of a case manager is to be aware of the comprehensive needs of their patient and to have the ability to meet those needs, which correlates to the wishes expressed by those suffering from mental illness crises for a more holistic approach to their treatment. In other words, it is recognized that consumers want someone to look at the whole picture in order to determine the best treatment for one part, which also reflects the wish for autonomy and respect from mental health consumers struggling with stigmatization; it is also recognized that competent case managers provide a comprehensive view towards their client and make every attempt to provide a holistic or treatment-focused response.

In taking only that prior paragraph, it seems that there are few people more qualified to fulfill this role than a family member: an individual who spends a significant amount of time with the consumer, more so than a professional could or would, and therefore would be best able to provide a complete picture of the consumer, not just detailing the symptoms exhibited during a crisis. Empirical evidence also suggests that family members' ratings of their ill relative's behavior are as valid, generally, as those of professionals in predicting length of hospitalization, severity of symptoms, and future community tenure. (Intagliata, Willer, & Egri, 1986).

With this knowledge, there has been an advocacy movement to integrate family members more in the treatment plans and process for individuals receiving treatment for mental illnesses. The most important aspect in crisis intervention is timing, and there is no bigger player in the support role than a family member/caretaker who can recognize the early stages of decompensation or possible crisis vulnerabilities. (Intagliata, Willer, & Egri, 1986).

There is definite room for research relating to what family members/caretakers of the mentally ill expect from police departments-specifically in relation to mental crisis response.

Furthermore, individuals with mental illnesses are not just present in the community as the offenders or subjects of police calls, but their vulnerability can also make them a significantly victimized population as well. In fact, surveys of adults with mental illnesses have found extremely high rates of victimization experiences, but it remains unclear how police departments learn of these victimizations, if at all, and what their responses are once they are made aware of them. (Marley & Buila, 1999).

47% of females with mental illnesses self-reported they disclosed a victimization to the police, while 53% did not; the numbers for males were that 57% disclosed to the police, while 42% did not. (Marley & Buila, 1999). Both males and females indicated that the response of the police officers was helpful/professional (females = 53%, males = 52%.) with less than 3% reporting that the response was rude or sarcastic. (Marley & Buila, 1999). As stated by the Marley & Buila (1999), the fact that the majority of the respondents received a positive or helpful response from law enforcement is extremely encouraging. However, other studies show that while 71% of mentally ill individuals

report being victims of a crime, 30% would not report the incident because of prior negative contacts with police departments and/or police officers. (Valios, 2008).

Of the respondents in Marley & Buila's (1999) landmark study, the majority of females were victims of sexual assault by a known perpetrator, but all the female respondents reported some form of sexual assault in their past. This speaks to the overwhelming vulnerability of the mentally ill population, specifically females. For the male respondents, the highest level of victimization was by aggravated battery with injury. (Marley & Buila, 1999).

Literature reviews into the victimization of mentally ill individuals reveals yet another wide gulf of valid information, something also remarked upon by Wallace (2007), as it is remarked that mental health care costs directly related to criminal victimization is the least researched area in victimization, followed closely by the lack of research in mentally ill victims. (Wallace, 2007). What is even more interesting to realize is that, despite all the focus on violence and dangerousness, 85% of all crimes reported are nonviolent, specifically relating to a form of property crime. (Elias, 1986).

The majority of studies or research actually conducted in relation to mental illness and its effects on victimization seem to focus on one crime: sexual assault. And although the research itself is meager, it recognizes that preexisting mental health variables are one of the most influential variables affecting levels of trauma after victimization. (Resick & Nishith, 1997). It was also found that victims with a history of psychotropic medications, substance abuse, and suicidal ideation or past attempts were significantly more distressed and affected in the months following their victimization than those victims without a history of those variables. (Resick & Nishith, 1997).

Herman (1997) states that 50%-60% of psychiatric inpatients and 40%-50% of psychiatric outpatients reported a history of childhood/adolescent victimization and abuse. All of this information is so influential for police officers to realize, not only to grasp the concept of the crimes and victimizations that go un-or under-reported, but also for a more complete understanding of the importance of trauma-informed care.

Trauma informed care is a professional model gaining acceptance within the mental health and human services fields, as it has professionals recognizing the effects of trauma, both short- and long-term, and the treatment of violence and trauma on individuals throughout their lifetimes. (The National Center for Trauma-Informed Care, n.d.)

Traditional Roles

Traditional measures of police work performance revolve around quantitative productivity: arrests, citations issued, complaints from civilians, or evaluations from supervisors. (Carr, Larson, Schnelle & Kirchner, 1980). As such, a successful officer is one traditionally seen as amassing a large amount of valid arrests, issuing large numbers of citations, obtaining few complaints from civilians, and receiving good reviews from their supervisors and colleagues.

Community-oriented policing, however, in its theoretical organization, values the relationship building between the police department and the community they serve, which presents a unique problem for police departments accustomed to measuring performance through statistics: crime rate statistics, cleared crime statistics, use of force statistics, citations issued, arrests made, time spent on calls, etc. These traditional markers of efficiency are also able to be summarized neatly, and disseminated to the public in a

manner that allows for almost everyone to understand them. For example, if a police department reports that 10% of all the crime in their city is a result of a mentally ill offender, the public feels they can grasp that concept. However, what often goes unnoticed or unreported, like much else in statistical analysis, are all the variables dependent upon that statement. To further explain, first analyze the statistic: 10% of all the crime in the city. For a police department to be aware of criminal activity means that someone disclosed the action (or inaction) to them, so in reality the 10% is only 10% of the reported crime. There is no way to measure something as intangible as "all crime".

Secondly, crime is a very broad term, in that it can encompass federal laws, state statutes, and city or county ordinances, as well as tribal laws, injunctions, or failures to abide by expectations. So in this case, the use of the word crime may strike up thoughts of significant criminal behaviors and activities such as assaults, homicides, and robberies, but in reality it also encompasses jaywalking, allowing a pet to run unleashed, or even having a tail light on a vehicle out. The large spectrum of activity that can be included in crime means that further definition or specificity should be required for a more comprehensive understanding of the real issue.

Third, the use of the term mentally ill is misleading. The term has been used in great measure throughout this paper to this point without further definition, and as such requires one. The American Psychiatric Association (2000) publishes the diagnostic criteria for mental illnesses in the Diagnostic and Statistical Manual of Mental Disorders-4th edition (DSM-IV) and elaborates upon the confusion surrounding its terminology and use, stating that like many other concepts within medicine and science, mental disorders lack a consistent operational definition that covers all situations. This lack of

standardization and formal definition closely resembles the controversy surrounding the concept of community-oriented policing.

However, the DSM-IV has provided a working definition of mental disorder, classifying it as a conceptualization of clinically significant behavior or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom, and the syndrome must not be an expected or culturally sanctioned response to a particular event, and is a manifestation of a behavioral, psychological or biological dysfunction in the individual. (American Psychiatric Association, 2000). In recognition of this, the term mental illness can refer to hundreds of different disorders or illnesses, and as such should demand the same respect in specificity as other medical disorders or illnesses.

As such, police departments and the communities they serve have been conditioned to rely on crime statistics and percentages in order to determine how effective or ineffective their police departments and police officers are. So in light of this, the challenge of community policing is in its proactive nature: how do you measure the intangible values of community policing, such as improved communication, relationship building with individuals in the community, and the mobilization of other agencies to assist in addressing needs that are not criminal in nature, such as mental illness. (Gianakis & Davis, 1998). In a government organization, as all police departments are, is it possible to analyze the value or benefit of a program or initiative, such as community oriented policing, without having some form of evaluative statistics in order to see if a change has been affected? As stated by Gianakis & Davis (1998), community policing manifests an

element problem in its theoretical implementation-the successful merging of the reactive emergency response mode and the proactive problem-solving mode.

In analyzing the existing literature on community policing, it is interesting to note a research study conducted by Gianakis & Davis (1998) that discovered that the majority of community policing programs being implemented were centered on changing the attitudes and adding training to the patrol officers more than on decentralization of the police agency bureaucracy or on community education about the community policing programs and goals. As such, it appears that police departments are beginning the implementation process by attempting to change their officers before trying to change their communities. CIT training speaks directly to this scenario: a need is addressed by communities for a change in how mentally ill individuals are treated, the police department is essentially the first and only social service organization to respond to the problem, and in order to better serve the community, officers undergo more training to recognize the issue.

But to first understand the effect that CIT has on community policing, and vice versa, it is important to also understand the role of the police officer and the expectations placed upon them, both traditionally and presently.

Steadman et al., (2000) remark that the police have always been the immediate responders to the mentally ill, referred to as gate-keepers, street corner psychologists and street social workers. As such, it should not be surprising to realize that police departments are the primary referral source for psychiatric emergency departments. (Borum et al., 1998). And with the expansion of community policing programs nationwide, police officers have seemingly embraced their traditional role as community

problem solvers, which includes the general mandate of being the primary mental health resource to citizens. (Sellers et al., 2005).

But while the expectation was there for police officers to respond to calls involving mental illness, the training and education was not. Wilkniss et al., (2007) mention that without any special knowledge or skills training, police response to mental health crises often resulted in a greater risk of violence, arrest, and incarceration. Cordner (2006) looked at the calls for service from another perspective, stating the importance of remembering police officers are called to numerous unknown situations, and oftentimes do not realize a mental illness is involved, and in attempting to handle the situation in a traditional police manner (i.e. giving directions, issuing commands, etc.) and finding no compliance in the individual, tension can escalate and the situation can become volatile.

So exactly how much training does an average police officer receive on metal illness and crisis response or interventions specific to this population? Levin (2009) states that nationwide the average is 1-2 hours during recruit training. As stated by Borum (2000), the research conducted in this arena shows many officers do not feel adequately trained or prepared to assess or respond appropriately to crises related to mental illness. Or to be put more bluntly, Woody (2005) states that it is widely believed nationwide that police officers are highly trained professionals, but that nothing could be further from the truth. Sellers et al., (2005) remark that the lack of training leads police officers to make improper decisions regarding people with mental illnesses, and that linking police officers with mental health agencies ensures that police officers "no longer have to make a decision they are not generally qualified to make: determining the psychiatric status of individuals whom they contact on the street." Yuker (1986) discovered that 91% of

criminal justice professionals reporting having no training, either in school or on the job, in dealing with mental health related crises, and that officers who received 16 hours of instruction in abnormal psychology reported a significantly higher comfortability in working with individuals with mental illness. In analyzing the results of a minimal amount of introduction to mental illness (16 hours) provided to police officers, it was discovered that after the brief introduction, police officers not only self-reported improved perceptions of mental illness and consumers, but were also much more likely to accurately describe some of the symptoms of common mental illnesses. (Yuker, 1986).

This training was not affiliated with CIT, as the CIT model had not yet been created in 1986, but it suggests that providing even the briefest of introductions into mental illness did have an effect for officers. What was even more interesting to discover was that Yuker (1986) analyzed not only police officers' attitudes towards mental illness, but compared those results to the attitudes of lawyers, psychiatrists, psychologists, and counselors. In doing so, the results revealed that police officers, as a group, had a generally more tolerant view of mental illness, viewed social factors as a determinant of addiction, and were more concerned with the overt behavior of mentally ill individuals rather than internal distress. (Yuker, 1986). While it should be expected that police officers, by nature of the work, would be more interested in overt behaviors and symptoms, it was surprising to learn they were generally more tolerant of mental illness than counselors and other helping professionals. Lawyers had a more liberal view towards drug abuse and mental illness, were more in favor of involuntary commitment than police officers, and were much less likely to label someone mentally ill than police officers or mental health professionals. (Yuker, 1986). Psychologists and psychiatrists

generally had a much more negative view towards mental illness, especially alcoholism, than police officers did, with their perceptions and opinions strongly based upon their demeanor, physical appearance and affect, and the opinion of the professional on the viability of treatment. (Yuker, 1986).

Yuker (1986) concluded that police officers' attitudes were direct reflections of the extent of their formal education, as officers with higher education backgrounds were more likely to be accepting and empathetic towards mentally ill individuals, but that police officers were generally more open towards training and that training results revealed attitude changes within police officers.

It appears, therefore, that while the field of law enforcement has the most potential for training in relation to mental illness, they are also the most likely to implement the training and already have an innate openness towards working with the mentally ill. As already established, police officers are generally the most visible social service professionals within their community, the most likely to respond to individuals with mental illnesses, especially during a crisis situation, have the least training or education in relation to mental illness, but are the most willing and responsive towards training when offered.

Training and crisis intervention, however, will always take a back seat to law enforcement's traditional role: ensuring safety. Ensuring safety is the first step in all interactions between officers and the public, and only after this has been established are officers going to focus on using communication skills. (Gentz & Goree, 2003). Communication and problem-solving will always be next in line to the essential

responsibility of the police: safety; and as such, it should be thoroughly analyzed how police officers respond to calls.

Always the Unknown

"We always walk into the unknown-always. I never know what I'm responding to, I never know who is going to be there when I show up, and I never know what's gonna happen. All I know is that I'll be there, and I'll do all I can." (M. Wilson, personal communication, April 11, 2010). Law enforcement officers are trained, conditioned and rewarded from recruit school on to expect and prepare for the worst in every situation, with the mantra of "going home to your family at the end of your shift" something every officer has heard hundreds of times.

The dangerousness of police work is not something that can be exaggerated. Every year, more than 50,000 law enforcement officers are assaulted, 30% of them are injured, and on average, 70 officers are killed. (Pinizzotto, Davis & Miller, 1998). There is no single profile for an individual who would attempt to assault or kill a police officer, but it has been found 62% of offenders who attacked or killed police officers were using drugs or alcohol at the time of the assault, and while 38% of offenders who killed a police officer state they were attempting to avoid an arrest, 19% stated they specifically intended to kill a police officer. (Pinizzotto, Davis & Miller, 1998).

For more current statistics, the Federal Bureau of Investigation (FBI) publishes yearly statistics relating to Law Enforcement Officers Killed and Assaulted (LEOKA). In 2008, 41 officers were feloniously killed in the line of duty, 68 officers died in accidents on duty, and 58,792 were assaulted while on duty. (Federal Bureau of Investigation, 2009).

The majority of officers who were assaulted in the line of duty were responding to disturbance calls (32%), and were overwhelmingly attacked and injured with personal weapons (81%). (Federal Bureau of Investigation, 2009). The FBI also analyzes the circumstances surrounding both officers killed and assaulted and publishes the results.

Table 2

Law Enforcement Officers Feloniously Killed Since 2000

Activity/Circumstances	**Percent of Officers (Rounded)**	**Number of Officers (Rounded)**
Arrest Situation	23%	122
Ambush Situation	20%	106
Traffic Pursuit/Stop	19%	101
Disturbance Call	14%	76
Investigating Suspicious Persons/Circumstances	12%	62
Tactical Situation	6%	29
Handling/Transporting Prisoner	3%	13
Handling Person with Mental Illness	2%	13
Investigative Activity	2%	9
TOTAL FELONIOUSLY KILLED	--	***530***

(Federal Bureau of Investigation, 2009).

It is also important to look not only at the statistics of officers who are killed in the line of duty, but to also analyze the assaults that take place on police officers, as current medical technologies and emergency responses, as well as better weapons and training, likely drop the rate of officers killed due to assaults through intervention. While statistics do not exist on the number of police officers assaulted this year so far, the Officer Down Memorial Page (2010) website lists that as of June 12, 2010, there have been 75 officers killed in the line of duty in the United States.

Table 3

Law Enforcement Officers Assaulted Since 2000

Activity/Circumstances	Percent of Officers (Rounded)	Number of Officers
Disturbance Call	31%	181,943
Arrest Situation	18%	107,992
All Other	14%	82,168
Handling/Transporting Prisoner	13%	73,364
Traffic Pursuit/Stop	11%	65,147
Investigating Suspicious Person/Circumstances	10%	57,517
Handling Person with Mental Illness	2%	9,977
Civil Disorder	1%	7,042
Ambush Situation	<1%	1,760
TOTAL ASSAULTED	--	***586,915***

(Federal Bureau of Investigation, 2009).

The addition of a separate category specific to the handling of persons with a mental illness can be misleading, as it as already been established that police officers rarely know who they will be dealing with while enroute to respond to a call for service, so individuals with mental illnesses could also be the offenders or subjects in disturbance calls, arrest situations, traffic stops, investigating suspicious persons/circumstances, traffics stops, or the transporting of a prisoner. To directly set a category apart is questionable. As previously stated, it is estimated that 1 in 4 adults in America suffer from some form of a diagnosable mental illness, so chances are that police officers respond to and interact with individual with mental illnesses in capacities other than specific mental health related crises.

The statistics involving officers killed or assaulted show why officer safety takes precedence over everything else. The law enforcement culture clearly values prevention

and survival training, and officer safety training must be the number one training priority. (Gilmartin, 2002).

With the constant knowledge of the potential for violence and injury, recent research has focused on the short- and long-term psychological effects on police officers in relation to the constant expectation and preparedness they must practice. Anderson & Bauer (1987) state that giving officers the power and responsibility to enforce the law must also go along with the knowledge officers cannot do so and also remain immune to fear and anger and suffer the negative effects. As Gilmartin (2002) states, police officers must learn to see the world differently in order to increase their odds of going home after work, and learning to see the world differently entails seeing everything as potentially violent, so officers will be prepared for violence once it does take place.

Officers who are dispatched to a volatile or crisis call will immediately begin to have a physical reaction of the sympathetic branch of the autonomic nervous system, which includes body temperature, blood pressure, respiration and pulse. (Gilmartin, 2002). As officers condition themselves to respond to each call with the potential for injury or death, their bodies will begin to prepare for a possible fight, increasing the reaction time, raising their alertness level, and dumping appropriate levels of adrenaline and norepinephrine into the body in preparation for the call. Police officers, in response to this increase in hormones, are more likely to become animated, excitable, and energetic, results which often play a large role in how the officers interact with the individuals involved in the call once they arrive on scene. (Vrij & Dingemans, 1996).

So while mental health professionals, family members and advocates preach calmness and compassion in working with mentally ill individuals in crisis, police

officers are often responding to emergency calls with a heightened sense of danger and potential for violence and will act accordingly, also known as hypervigilence. As such, people outside police work observing officers practicing hypervigilence cannot understand why officers acted the way they did during the call. (Gilmartin, 2002).

It also cannot be ignored the effect that a police response can have on a crisis or situation, just from the presence of a uniform alone. Johnson (2001) studied the psychological influence of the police uniform, and found that police uniforms have an extraordinary psychological and physical impact, and the spectrum of that response will depend upon the background of the person viewing the officer. For an individual in the process of committing a criminal act, the presence of a police uniform will likely create fear, but for a victim of a crime, it may strike a sense of hope or security. Likewise, for an officer responding to a call for a mentally ill individual in crisis, the presence of a police uniform can have a wide variety of responses from the critical consumer, whether it be fear because of a misconception they will be arrested to fear because of paranoid delusions or negative prior experiences; or it could be a calming sense of security because a police officer has responded. The uniform itself stands as the most visible and powerful part of law enforcement. (Johnson, 2001).

Studies have shown that police officers are adept at making high-quality decisions within bounded and volatile environments. (Snook & Mercer, 2010). However, the decisions made by police officers are highly dependent upon reason and common sense, which can be almost counter-intuitive to dealing with crisis situations with the mentally ill, as reason is not something that will work in situations with individuals in crisis situations, especially if they suffer from a severe or chronic mental illness that prevents

them from achieving insight into their illness or in achieving culturally accepted reasoning skills. After all, police officers will generally interact or be called to interact with mentally ill individuals during a time they are experiencing symptoms of agitation and may be acting out of control. (Borum, 2000).

As established previously, there is no scientifically valid or research based information that shows a connection between mental illness and dangerousness or threat of violence, but the stereotype still persists. Watson & Angell (2007) explain that younger and less trained officers tend to perceive more danger when interacting with mental health consumers, but that officers from departments with a community policing focus and CIT program have a more positive perception of mental illness and are less likely to perceive mental illness as a constant predictor of violence.

CIT & Community Policing: 2 Birds with 1 Stone?

Borum (2000) explains that 45% of police departments report having some type of specialized response or policy for mentally ill individuals in crisis and that the responses conform to 1 of 3 models: police-based specialized police response, police-based specialized mental health response, and a mental health-based specialized mental health response. In evaluating the effectiveness of each of the models, researchers looked at community perception of the program, arrest rates of mentally ill individuals, and the amount of time spent on this type of call, and found that police-based specialized police responses obtained the highest ratings across all the objectives. (Borum, 2000). The CIT program, also referred to as the Memphis Model, is the most visible police-based specialized police response program.

For purposes of definition, there are numerous definitions of crisis and mental health related crises, with Viney et al., (1985) providing one that seems to encompass most of what is being referred to here, as a phase of disturbed psychological equilibrium, usually occurring as a reaction to a change in the individual's world or perception, and usually is a time of increased vulnerability to external influences. This definition is perhaps the one most in line with the idea of CIT in relation to law enforcement as well.

CIT is not without its detractors, however. Borum (2000) states that the recommendation for additional training is an almost reflexive public response to perceived issues, and while training is important, it is not a panacea. It may be helpful to train officers to recognize mental illness and understand the symptoms, especially in response to stereotypes that preexist that may negatively affect an officer's response.

Another considerable concern is that much of the research that exists about the effectiveness of CIT focuses strictly in Memphis, the city that created the program. The concern revolves around the uniqueness of Memphis's program, and how comparisons between Memphis and other cities implementing the CIT model are flawed. After all, comparing CIT in Memphis to CIT in other cities does not take into account the differences in the community-based service system, insurance systems, the public hospital system, and the emergency detention statutes and how those differences can wash out police training variables. (Geller, 2008).

In approaching the controversies of CIT, however, it should also be noted the benefits or successes of the program, and what the program actually entails. CIT is a police-based crisis intervention training specific to mental illness, with the goals of improving officer and consumer safety and the redirection of mentally ill individuals

from the criminal justice system to the health care system. (Dupont, Cochran, & Pillsbury, 2007). The Memphis Police Department, in collaboration with the University of Memphis, created the CIT model, and identifies the core elements of the program.

Table 4

Core Elements of the Crisis Intervention Team Model

Core Elements	Components of the Elements
Ongoing Elements	**Partnerships**: Law enforcement, advocacy, mental health professionals.
	Community Ownership: planning, implementation and networking.
	Policies & Procedures
Operational Elements	**CIT**: Officer, Dispatcher, Coordinator
	Curriculum: CIT Training
	Mental Health Receiving Facility: Emergency Services
Sustaining Elements	Evaluation and Research
	In-Service Training
	Recognition and Honors
	Outreach: Developing CIT in Other Communities.

(Dupont, Cochran, & Pillsbury, 2007).

The curriculum focuses on a 40 hour training block for law enforcement officers that consists of an introduction to mental illness, visits with consumers, crisis de-escalation techniques, and role-playing scenarios. (Levin, 2009). Wilkniss (2007) remarks that another notable outcome of CIT has also been that officers' confidence in their effectiveness in mental illness crisis response has significantly increased. Mental health consumers offer presentations to explain to the officers what their lives are like and what their perception of law enforcement is, and then the officers undergo virtual hallucination experiences, in which they are required to complete some daily tasks while

wearing headphones or other machines that give officers a sense of being mentally ill, through audio or visual hallucinations. (Woody, 2005).

The 40 hour training culminates with role-playing scenarios in which officers are given an opportunity to use their newly learned crisis intervention skills, in order to not only practice the skills in as real-life an environment as possible, but to also increase their emotional intelligence in crisis situations. Manzella & West (2003) define the key components of emotional intelligence as self-awareness and empathy. Police officers generally have the best sense of self-awareness while on duty (hypervigilence), and in attending CIT training, their empathy for mental illness is increased, resulting in a higher level of emotional intelligence. As such, it is suggested that officers with higher emotional intelligence are better equipped to successfully confront the challenges of their assignments when responding to demanding individuals and situations. (Manzella & West, 2003). This increase in interpersonal skill can also assist police officers in the aftermath of mental illness crises, as many officers may have a hard time in reconciling mental illness calls with little, if any, knowledge of mental illness. LeBlanc et al., (2008) state that officers who have knowledge about a situation and can utilized task-oriented coping are much less likely to suffer from any short- or long-term stress related to the job. Enhanced communication and interpersonal skills, developed or refined in the CIT training process, amplifies the ability of CIT trained officers to project a powerful and confident influence when serving individuals with mental illness, especially during times of crisis. (Gentz & Goree, 2003).

Newton's Third Law of Motion states that for every action there is an equal and opposite reaction. (Jones, 2010). The crisis intervention techniques taught to officers in

CIT follow a sort of transitive property, translating a classically physics-related property to the social sciences, allowing for the understanding that how officers react and treat individuals with mental illnesses, in crisis or not, is a direct relation on how the individual with mental illness responds back to the officer. This is reflected in the procedural justice theory of criminology, which holds that the fairness with which people are treated in an encounter with authority figures influences whether they cooperate with or resist the authority. As such, the manner in which an officer approaches a crisis situation determines whether or not a person cooperates and whether or not the crisis escalates to violence or is resolved without any use of force. (Watson & Angell, 2007).

This knowledge has shown significant successes, for both CIT trained officers and the communities they serve. Research has shown that after the implementation of CIT at the Akron, Ohio Police Department, the dispositions of calls for service to individuals with mental health crises revealed 25% of the calls resulted in officers transporting the individual to psychiatric emergency services, 31% resulted in transportation to treatment facilities, 32% were handled informally (meaning the individual was not transported anywhere and the crisis was labeled as resolved on scene), and 3% resulted in an arrest. (Teller et al., 2006).

In Albuquerque, New Mexico, after the Albuquerque Police Department implemented the CIT model, 48% of their mental illness-related crisis calls resulted in the consumer being transported to a local mental health facility, with less than 10% resulting in an arrest. (Bower & Pettit, 2001). 45% of all the calls involving a CIT officer were suicide attempts or threats, and alcohol was present in 27% of the calls. (Bower & Pettit, 2001).

Memphis Police Department's CIT program is unique in that they have a collaborative relationship with the University of Tennessee's Medical Center Psychiatric Unit, allowing for police officers to transport individuals there and be back on patrol within 15 minutes. (Vickers, 2000). The concern of time is a significant one, especially for urban police departments with heavy call loads, as it has been found officers spend an average of 145 minutes on calls involving mentally ill individuals transported to treatment facilities or hospitals. (Reuland, Schwarzfeld, & Draper, 2009).

Other successes or benefits of the program include lowered injury rates, with San, Jose California's Police Department reporting a 32% decrease in officer injury after implementing CIT, and Memphis Police reported an 80% decrease in officer injuries. The Albuquerque Police Department also reported a 58% decrease in SWAT team involvement in mental health related crisis calls. (Reuland, Schwarzfeld, & Draper, 2009).

It appears that suicide-related mental illness crises are the most common calls for service officers receive, and that the most common police referral in emergency room departments is self-harm or suicidal ideation. (Lee et al., 2008). Suicide is a significant public health problem in every state, with the State of Wisconsin averaging 650 suicides per year, with 66% of those individuals successful in committing suicide suffering from a mental illness, and 25% of the victims having a history of prior suicidal attempts. (Kopp, Schlotthauer, & Gross, 2008). Another study states that 64% of individuals currently hospitalized for psychiatric reasons have a lifetime history of previous suicide attempts. (Links et al., 2005). In Wisconsin, as in any other state, police officers are frequently called to reports of individuals with firearms who are suicidal, a significant concern, as

50% of completed suicides were accomplished through the use of a firearm. (Kopp, Schlotthauer, & Gross, 2008). Police officers are also always aware of suicidal individuals who have plans or thoughts of suicide-by-cop, a phenomenon in which studies suggest that 16%-47% of police shootings involve an individual intending to die at the hands of the police. (Bower & Pettit, 2001).

Community Policing's Effect on Officer Job Satisfaction

White (2007) remarks that community oriented policing, at its heart, is all about the service aspect of police work and law enforcement, and that the opportunities within community policing for training in order to better meet the community's expectations can result in greater officer job satisfaction. Yim & Schafer (2009) remark that several studies have shown that officers who have greater job satisfaction and a positive professional self-image are more effective, are less likely to have civilian complaints, and receive better evaluations from both superiors and colleagues. It is also remarked that many officers who work within community policing report much higher job satisfaction and greater perceived community support than officers who work within regular patrol. (Yim & Schafer, 2009). If CIT can be seen as an extension of the community oriented policing philosophy, and the effectiveness of officers is positively influenced through their involvement in community oriented policing initiatives, it seems to suggest that officers involved in CIT are going to reap the same benefits as officers involved in community policing programs.

As Hibler & Kurke (1995) state, there is no other profession in our society has authority as intense or intrusive, so the recognition of the effects of training and the job satisfaction of the officers has a direct bearing not only on the police department but the

community as well. While there still exists a significant need for further research on numerous subjects about or relating to CIT, it appears that through the lens of the community oriented policing philosophy, the program and its initiatives and implementations prove to be a substantial benefit to both the community and its police department, and therefore by extension the police officers. As Kirschman (2007) states, police work can be described as three hours of boredom, two minutes of terror, and then six hours of report writing. Any attempt that can be made to not only increase police officers skills and interpersonal communication, but decrease the possibility of terror in relation to mentally ill individuals should be seen as a worthwhile endeavor.

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