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Editorial

In 2004, an unarmed security guard at the state capitol building in Springfield, Illinois, was fatally shot by a person with mental illness. This event demonstrates the tragic consequences that can potentially occur during interactions between law enforcement personnel and individuals with mental illness.

For the last several decades, the mental health system has undergone a tremendous change, shifting from institutional care to a community support model. Financial and ideological responsibilities for treatment of individuals with mental illness have been given to county agencies, rather than state and federal agencies. A significant number of mentally ill individuals currently reside in communities where they are engaged in numerous social interactions but receive inadequate, sporadic, or no mental health services. As a result, law enforcement agencies have had more contact with people in mental health crises. Police departments and correctional institutions are often the only social institutions that offer even limited treatment services. On any given day, the Cook County Jail in Chicago hosts more individuals with mental illness than any specialized hospital in the United States.

The scope of the problem is too broad to be solved exclusively through the efforts of the law enforcement community and requires a coordinated approach, with collaboration of stakeholders from all segments of the community including police, corrections, mental health providers, and families.

Although there is no single solution, the greatest successes to date have come when policymakers start with a vision of objectives for the service system, engage in comprehensive planning with stakeholder groups, and use collaboration and comprehensive training to reach those goals. The Crisis Intervention Team (CIT) model appears to be a useful, cutting-edge tool for achieving cost efficiency in a dynamic system while offsetting risks and protecting consumers. Strengthening ties between police and mental health treatment providers can improve consumer outcomes, enhance the quality of service, and provide more accountability.

The selection of the articles contained in this issue represents views of academics and practitioners with a focus on different theoretical approaches to the law enforcement mental health crisis challenge. Practical measures for controlling the problem and the need for effective management and policy review are addressed. The adoption of collaborative models in dealing with individuals with serious mental disorders is also explored.

Vladimir A. Sergevnin, PhD
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When Simple Solutions Are Part of the Crime: The Case of Police and Citizens with Mental Illness

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Here is a simple solution: prevent the criminalization of citizens with mental illness by providing mental health training to police officers and mental health treatment to people with mental illness. It is common to think, politically and practically, in terms of simple solutions like this. Simple, however, is often thinly veiled complexity. Take, for example, a classic but simple philosophical question: If a tree falls in the forest with no one present, does sound occur? The answer hinges on the notion of sound and whether sound requires a human agent to exist. The simple and reflexive answer to the falling tree question is, of course, sound is sound. Physicists can prove unequivocally that sound is simply vibrations in air. Existentially, however, the answer is more complicated because it requires human cognition. Like the case of the falling tree question, crime is an event that exists but is relational in the sense that it takes the awareness and action of the police. This article focuses on the simple solutions offered to correct the trend of incarcerating people with mental illness—solutions that focus on treating people with mental illness and training police officers. On their face, these solutions appear sensible, if not captivating in their simplicity. Yet their ability to correct the putative "criminalization" problem focuses less on their inherent sensibility and more on their implicit assumptions about the social complexity surrounding crime, both the event itself and its relational existence.

The representation of people with mental illness in correctional settings is well documented (Ditton, 1999; Jemelka, Trupin, & Chiles, 1989; Teplin, 1990; Wolff, Maschi, & Bjerklie, 2004). What gets them there is understood less in terms of facts and more as conjecture told as simple stories, stories that focus on a single difference from the other people in correctional settings—mental illness. It is mental illness, as the story is told, and its lack of effective and continuous management in the community that leads people with mental illness to crime and to the attention of police officers (Lamb & Weinberger, 1998). The fact that people in correctional settings, independent of their mental illness, are more likely to be young, nonwhite, unemployed men, often with drug-related problems, who have been removed from socially disadvantaged communities, is often overlooked (Fisher, Silver, & Wolff, 2006; Fisher, Roy-Bujnowski, et al., 2006; Silver, 2000). This single-factor story is politically appealing because it suggests that the incarceration of people with mental illness could be largely prevented, reducing their ranks in correctional settings, if their illness was continuously managed through effective mental health treatment.

In the event that effective mental health treatment, as professionally and clinically recommended, is not forthcoming in the community, the solution turns to the detectors

of crime—police officers. Their story begins with an incident, defined as a crime by the law, being reinterpreted by police officers as a situation warranting treatment, not punishment. Whether the incident is correctly interpreted as a crime or a cry for therapeutic help depends critically on the assessment abilities of police officers at the scene (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Teplin, 1984). With effective training, as the story goes, the officer will be able to calm the situation, correctly identify behavioral symptoms attributable to mental illness, and appropriately divert the patient to treatment and away from jail. This story, again simple and parsimonious, suggests that training and educating police officers about the symptoms and management of mental illness prevents crime and the incarceration of people with mental illness.

These stories are compelling in their procedural simplicity, as well as their prodigious expected performance. They also appeal to our collective belief that knowledge and science can solve social problems. Here, the story suggests that we, as a collective, can prevent incarceration and protect people with mental illness simply by applying and disseminating available medical technology. If police officers are more clinically sophisticated agents and citizens with mental illness are more compliant with modern, therapeutic practices, the criminal behavior of people with mental illness will be minimized and the innocent protected from harm and punishment. This type of storytelling offers medicalization as the solution to social problems, a solution that does not require changing or acknowledging the social or material conditions of crime. This article rejects this collection of simple stories and offers instead a more socially complex and nuanced story of constrained choices. The story told herein focuses on the social and material conditions in communities where people who have frequent encounters with the police live. We begin assuming equivalence: that people with mental illness are more similar to other people committing crimes in their communities than different because of their mental illness. It is argued that training and treatment capabilities are insufficient if resources and social conditions in the community fail to support and encourage the prosocial choices of the people living there.

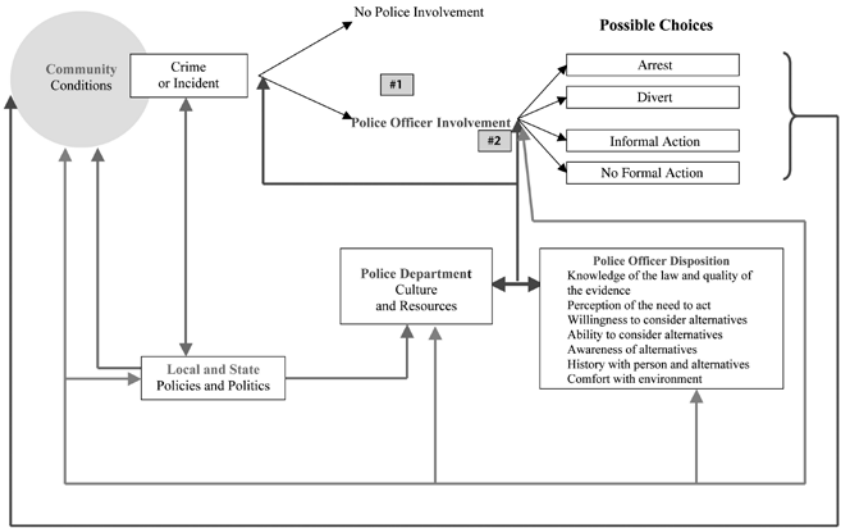
This article is divided into three sections. The first section provides a conceptual model of "crime" from the perspective of the police officer, the initial arbiter of crime, and the turnstile keeper to systems of social control: the mental health or criminal justice systems. Next, the "simple story" interventions for reducing the ranks of people with mental illness under the supervision of the criminal justice are critically reviewed in the context of this conceptual model. The last section develops recommendations for normalizing and equalizing the definition of the crime event and encouraging alternatives to criminalization for all people committing nonviolent crimes. The analysis concludes with a simple point: making good choices requires having good choices. Simple solutions, such as training or treatment focused on mental illness, without good material choices are part of the dark side of crime, which like a tree falling in a forest without human presence, goes unacknowledged.

Crime or Incident: The Role of Police as Arbiters and Turnstile Keepers

In this section, the role of the police in defining and managing crime is modeled. Discretion is a critical feature of policing (Bittner, 1967; Ericson, 1982; Riksheim & Chermak, 1993; Vollmer, 1936). It is the police officer's job to interpret the facts surrounding an event and make critical choices (Gottfredson & Gottfredson, 1980). The first choice is whether an event is a crime or an incident and then, the choice of

how to respond: formally, informally, or not at all. As decision makers, police act as the initial arbiters of crime and then as turnstile agents influencing the flow of people out of the community into the criminal justice or other public service and health systems while remaining in the community (Clark & Sykes, 1974). These decisions are set contextually within a community inclusive of and influenced by extralegal factors related to the interpersonal dynamics at the scene (Wilson, 1968), as well as by local and state policies and politics; the culture and resources of the police department (Crank, 1992; Klinger, 1997; Riksheim & Chermak, 1993; Wilson, 1968); and the material and social conditions of the community (Shaw & McKay, 1942). As shown in Figure 1, police act (and exercise their discretion) within a socially complex environment that is affected by personal, departmental, and local factors, which in turn are affected by local and state policies and politics and community conditions. The arrows in Figure 1 show that police make decisions dynamically that effect and are affected by a confluence of social forces. Their task, while simple, is to interpret incidents in the community and, once interpreted, to manage them in a way that maintains social order and preserves public safety.

Figure 1
Conceptual Model of "Crime" and the Role of Police as Arbiters and Turnstile Agents



"Crime" as the Falling Tree in the Forest

Crime, like the falling tree in the forest, must be detected to be officially acknowledged. Police involvement is the first step (#1 in Figure 1) in detecting a crime. Well established in the literature is the positive correlation between detection and surveillance (Draine & Solomon, 1994; Petersilia & Turner, 1992). Communities under greater surveillance by the police will detect more crime even if the incidence of crime does not vary among communities, yet higher crime rates are likely to justify greater community surveillance,

contributing to the spiraling up of crime rates in problem communities (Gottfredson & Taylor, 1986; Pattavina, Byrne, & Garcia, 2006; Sampson, 2004). Nonetheless, given limited police resources and the reluctance of victims to report crimes (BJS, 2004), most crime goes undetected. Known as the "dark figure of crime," the preponderance of crime remains hidden behind a community shadow (Coleman & Moynihan, 1996). Furthermore, within a given community, relative rates of crime detection among people are expected to vary. Teplin (1984) argued that the higher detection rates of crime among people with mental illness were a consequence of their less developed skills in evading the police after the commission of a crime. The evidence suggests that while the detection of crime is not random, it is far from complete or representative of all crime among groups of people with different evasion skills.

Once an incident is detected and determined a "crime," police officers make a second choice: how to respond to the crime (#2 in Figure 1). Here, there are several categories of choice. First, the officer could choose no formal action, which as in the "no police involvement" scenario, there is no official acknowledgement of crime. Second, police action could be taken, motivating a choice among three other options: (1) taking informal action, such as giving a warning or admonishment; (2) diverting the person to some other problem-solving agency, such as a mental health provider, or involving family members; or (3) arresting and transporting the person to jail for booking. Crime is officially detected when the latter of these choices is selected by the police.

It is not expected that police officers will act uniformly (Hochstedler, 1981); as a group, they are likely to consider different combinations of options as part of their decision-making process, and as individuals, they are likely to select different options even if confronted with the same crime and same set of options. Police officers have stylized responses (Black, 1976). Heterogeneity of action among police officers is a consequence of their discretion (Riksheim & Chermak, 1993), which varies with the degree of the offending behavior. In general, officers have more dispositional discretion for low-level offending behavior but considerably less to none in instances involving serious to violent offending (Black, 1971; LaFave, 1965). Police officers, like medically trained professionals, make decisions in the presence of professional uncertainty. The facts of their respective situations are rarely clear; the emotional intensity of the interactions is rarely dispassionate; and the "right" course of action frequently is not strictly determined by scientific evidence or the law. Consequently, the application of professional judgment under conditions of uncertainty produces variability. In the case of the police, the officer's judgement is a determination whether an event is defined as a "crime." Inviting subjectivity into decisionmaking, however, courts bias. Also, idiosyncratic, to varying degrees, is whether they give equal consideration to the choices presented previously and which of them is eventually selected in response to a particular situation. The following are a variety of factors that are likely to influence the choices made by officers in their exercise of professional judgment.

Interpersonal and Extralegal Factors

Much of the social science literature on variation in police decisionmaking focuses on gender, racial, and cultural biases (Alpert, MacDonald, & Dunham, 2005; Black, 1980; Krohn, Curry, & Nelson-Kilger, 1983; Smith & Klein, 1984; Smith & Visher, 1981; Worden, 1989). Given that mental illness, broadly speaking, is not differentially represented among women or minority groups, this factor alone is not likely to significantly impact police action towards people with and without mental illness

(Cooper, McLearen, & Zaph, 2004). Other more relevant literature has focused on the reaction of officers to the interactional style of people at the scene, referred to more generally as extralegal factors. Failing to show respect or politeness to an officer significantly predicts formal (punitive) police action (Brown, 1981; Engel & Silver, 2001; Engel, Sobol, & Worden, 2000; Klinger, 1994; Lundman, 1996; Riksheim & Chermak, 1993; Worden, Shepard, & Mastrofski, 1996). The demeanor of people with severe mental illness is likely to be important here. Some mental illnesses are manifested in interpersonal styles that are belligerent, offensive, and disrespectful (Teplin, 1984). Acting in a socially inappropriate manner in situations in which behavior could be determined criminal may provoke the officer to decide in favor of defining the incident a "crime" and selecting formal punitive action. Similar assessments are likely if a person acts in a socially inappropriate manner because he or she is under the influence of drugs or alcohol, or just uncontrollably angry, as in the case of domestic violence situations. Inappropriate behavior at the scene due to being under the influence is particularly relevant since upwards of 60% of people with and without mental illness under correctional supervision were under the influence of illegal drugs or alcohol at the time of their index offense (Ditton, 1999). In these situations, officers assess and presumptively assume that crimes involving people with below average social inhibitions will, if left unsupervised in the community, become more socially inappropriate, aggravated, and perhaps dangerous. Engel and Silver (2001) found that when controlling for extralegal factors, such as being under the influence of alcohol or drugs, disrespectful towards the officers at the scene, or verbally resistant, the police were not more likely to arrest people with mental illness.

Considerably less research has focused on the factors that influence the personal style of police officers; although, a framework was suggested by Mastrofski, Snipes, Parks, and Maxwell (2000). They explored the police response to citizens' requests to control others, emphasizing legal standards, need, situational attenuators, social relationships, and officer predispositions. This research found that of all the factors that might influence police response to citizen requests, the most influential predictor was quality of the legal evidence against the alleged subject, which was significantly attenuated by the characteristics of the requester. Police were less responsive to citizen requesters that were assessed as less reliable and more disrespectful. More specifically, male officers, those with less on-the-job experience, and those ascribing to community policing values were more responsive to citizen requests than their counterparts without these characteristics. This research is relevant to the arrest of people with mental illness because their family or friends and, in many cases, community residents, frequently demand a *parens partrie* intervention by the police—a removal from the community because they are unable to protect themselves from harm (Teplin & Pruett, 1992).

While the extant literature sheds partial light on some of the factors that are likely to influence the judgment of police officers, much is left unknown, particularly regarding how response choices are structured or selected. Making choices implies both an awareness of alternatives and a perceived need for considering them, as well as the willingness and ability to consider alternatives and an understanding of the historical and social setting surrounding the alternatives and decisionmaking (see box labeled Police Officer Disposition in Figure 1). While it is typically assumed that more choice is better, there is growing evidence suggesting that managing and collecting information to assess more options is burdensome (Iyengar & Lepper, 2000; Schwartz, 2004). Decisionmaking imposes costs, known as transaction costs, on the decision

maker. Searching for options and accumulating and assessing information about them takes time, a resource of which officers have little. Furthermore, their interest in incurring transaction costs is not self-evident. In his book entitled *The Paradox of Choice*, Schwarz (2004) argues that there are two types of decision makers: (1) maximizers and (2) satisfiers. Maximizers, in the pursuit of the best option, consider and experiment with many alternatives. By contrast, satisfiers are looking for the "good enough" option, which allows them to limit their search to a few alternatives.

It is unclear from whose perspective the "best" choice is defined when considering police action. Is it what is best from the perspective of the suspect, the community, the police officer, the police department, or the jail? The interests among these different stakeholders are unlikely to be mutually reinforcing or overlapping. For this reason, police officers are likely to default to decision rules that yield the greatest professional benefit at the lowest personal cost. If this accurately characterizes their motivation, police officers, given their binding and pressing time constraint and the limited professional benefit associated with making nontraditional choices, would be expected to fall into the satisfier group, restricting their interest to choices that require little deviance from standard police practices. The implications for people with mental illness, as well as other people that would benefit from expanded choice sets, is that habit persistence (i.e., arrest, informal sanction, or no sanction) among police officers will most likely prevail, unless the costs and/or benefits can be changed in ways that encourage officers to consider a broader set of choices.

Police Department Factors

The actions of police officers are influenced by the culture and resources of their police department (Riksheim & Chermak, 1993). Police departments, like any organization, are characterized by their culture. Organizational culture has been broadly defined in terms of shared assumptions or meanings that reflect the collective beliefs of the organization (Becker & Geer, 1960; Schein, 1988). Culture, while a complex and difficult concept to measure, has been found to significantly impact employee behavior and organizational performance (Deal & Kennedy, 1982; Denison, 1990; Wilkins & Ouchi, 1983). Likewise, police department culture has been found to shape police officer behavior (Ericson, 1982; Smith; 1984; Smith & Klein, 1983; 1984; Sparrow, Moore, & Kennedy, 1990; Wilson, 1968). Wilson, in his classic study, showed that variation in police styles, in the aggregate, varied systematically with the cultures of their police departments. That is, more variation in police officer styles was detected between police departments than within police departments, suggesting that the culture of the police department itself shaped the style of policing.

Interest in the effect of organizational culture on policing style has gained prominence in recent years with the diffusion of community-oriented policing and problem-oriented policing strategies. Here, there is a growing body of research showing that the adoption of community-oriented and problem-solving values and philosophies change the way officers interact with the community and people suspected of crime (MacDonald, 2002). Officers acting in accordance with community-oriented policing strategies (COP) are expected to do the following:

- Know their communities better (because they have a smaller designated "beats" and they spend more time walking the beat and formally and informally interacting with residents, shopkeepers, and community-based agencies)

- Be more active in problem solving with people and agencies located there in the management of problem behaviors
- Work in partnership with the community towards the shared goal of community safety

Everything else equal, COP officers, given their training, knowledge of the community, and the problem-solving orientation of their police departments, would be more likely to consider a broader set of alternatives for people suspected of crime than professional officers imbued with a more legalistic style of policing (in essence, the style of policing reduces the transaction costs associated with nontraditional choices).

Policing style, however, is also shaped by resources. While police departments may officially adhere to particular philosophies and values, their ability to implement them depends inextricably on adequate funding. Budget cutbacks or funding inadequacies can result in the implementation of staffing policies that reduce the presence of officers in the community, as well as stretch those officers in the community in ways that limit their ability to effectively problem-solve, reliably partner with the community, or pursue less traditional disposition options. Time, again, is the scarcest resource of police officers and departments. Reductions in police staffing reverberates into the community through the availability and styles of the officers assigned there (Bazemore & Senjo, 1997).

Local and State Policies and Politics

Police departments operate in a political environment. Concerns about crime, safety, and public well-being reverberate through state legislatures and county boards, influencing the nature and structure of public policies, which eventually affects the laws to be enforced by the police, the level of funding available for enforcement, and the management of crime and types of crimes in the community. Public concerns about public safety can lead to renewed political pressures on police chiefs and sheriffs to do more about crime. In response, police supervisors are often directed to increase the pressure on officers to do something—to enforce certain laws more stringently or to pursue crime more vigorously. Likewise, reductions in funding restrict the discretion of police departments and officers to experiment with innovation, refocusing their effort on the basics of policing and implementing them in more traditional and legalistic ways (i.e., "straight, by the book policing").

Concern about the incarceration of persons with mental illness has motivated specific state and/or federal legislation that draws attention to the "problem" and particular solutions. For example, The Mentally Ill Offender Treatment and Crime Reduction Act (S. 1194) of 2004, provided targeted support for the development of new programs to assure appropriate treatment for people with mental illness in contact with the criminal justice system, as well as for specialized training of police officers. The passage of this piece of legislation established funding for special programs, but it also provided financial incentives to states to adopt innovative practices with respect to the processing of people with mental illness.

While humanitarian legislation may create a more empathic environment for people with mental illness, public crises can bring about countervailing hostility flashes. Communities where a person with mental illness commits a violent crime are likely to coalesce and instigate political pressures for more conservative and restrictive

treatment laws, as well as for stronger enforcement response by the police and mental health providers (Wolff, 2002). Police departments, in responding to the public's concern, can be expected to reduce officer discretion and stress a more legalistic approach to policing.

There are policies and legislation at the state level that also shape the interactions between people with mental illness and the police. State statutes on competency, which vary in language and interpretation, may sharply limit the ability to engage people with mental illness with treatment (Hiday, 1981; 2003). Likewise, the existence and application of outpatient civil commitment laws alter the authority of the mental health system and the court to enforce treatment compliance in the community (Lamb & Weinberger, 1998). Everything else equal, the willingness of police departments to work cooperatively with the mental health system to resolve problems in the community involving people with mental illness would be expected to increase in states conferring greater civil authority to mental health providers over treatment compliance. That is, as the certainty of action by the mental health system increases, police departments may be more inclined to encourage the police officer's use of treatment as an action option. Yet, other problem behaviors co-occurring at the scene may sharply limit the discretion of the officer. Drug laws, in particular, strongly impact the department's and officer's discretion in cases involving the possession of illegal substances. Possession of illegal substances (especially within a school zone) may trump any special consideration that officers may be able to proffer. More generally, sentencing policies and practices within the locality and state may shape the options available to officers, either constraining or expanding the options that they are permitted to consider in cases that involve certain types of crimes.

Community Conditions

Community conditions also affect the way officers respond to incidents there. Police, in general, have been found to use formal arrest procedures more frequently in socially disadvantaged communities, compared to more advantaged communities (Smith & Klein, 1984). Theories of social disorganization (Shaw & McKay, 1942) and urbanization (Wirth, 1938) have been used to explain higher crime rates in areas with more material deprivation. It is well known that criminal behavior is an indicator of a myriad of social problems. Persons with mental illness charged with criminal behavior, like their general offender counterparts, are likely to have criminogenic characteristics, including substance abuse problems and lifestyles characterized by poverty, homelessness, unemployment, and social isolation. Similarly, geographical areas where crime takes place are likely to have higher levels of these criminogenic characteristics—poverty, homelessness, drug trafficking and use, unemployment, and gang activity (Sampson, 2004). Responding to these problems involves the police but also requires resources and support within the community. Community services and support are integral to responding holistically to the person's and community's complex needs (Wenzel, Longshore, Turner, & Ridgely, 2001).

The availability and depth of community services impact the choices available to police. The experiences of police officers with the mental health system or agencies within the community are likely to shape their interest in exercising this choice (Appelbaum, Fisher, Nestelbaum, & Bateman, 1992). If basic resources are constrained and social ties are weak in the community, options available to the police narrow to either letting the person stay in the community without support or putting the person

in jail with structure. It is not clear, however, in these situations that treatment is the primary or most pressing problem for people living in these communities (Draine, Salzer, Culhane, & Hadley, 2002). More basic needs might include their need for safety and opportunities to improve the other dimensions of their lives that influence their criminal behavior. These broader social problems may, in the short run, actually hinder the implementation of a comprehensive treatment plan and, in the long run, affect the person's ability to stay in treatment and abstain from criminal activity.

Competition for limited resources in the community affects the stability of the linkages between the police and community agencies and services. Agencies, in the face of scarcity, are likely to tend their borders more stringently (Wolff, 1998) and respond more slowly to requests for assistance by police. Their slowness to respond can be used as an avoidance tactic by community agencies. The people referred by the police may not be the type of clients preferred by these agencies (Swift, 1986). Resistance from community service providers could emanate from their lack of desire to take on clients with criminal backgrounds; their inability to address the particular medical, addiction, vocational, and/or social needs of persons with mental illness and criminal histories; and/or simply their inability to respond to the aggregate need in the community.

Passive resistance on behalf of agencies, however, may be a survival strategy. When faced with overwhelming need and no legitimate political power, criminal behavior may be the only way to expand the resource base available to individuals and communities. For example, if treatment resources are wholly inadequate such that the community provider is forced to triage available medications and treatments, it makes absolute sense for these providers to treat people who are more socially integrated in the community, while the jail treats those who are less socially integrated and have more problematic behaviors. This presumes, of course, that treatment is available in jail. This presumption on behalf of community agencies is informed by the constitutional requirement that correctional settings deliver medical and mental health treatment and the evidence documenting the availability of treatment there (Beck & Maruschak, 2001; Ditton, 1999). Consistent with this presumption is evidence showing that people with behavioral health problems are more likely to receive treatment in prison than in the community (Blitz, Wolff, & Paap, 2006). Jailing people in a socially disadvantaged community may be the most immediately effective way to expand the extensive margins of housing, food, and treatment for the people living there. Sadly, this may be the only way the community has to gain access to material resources.

The quality and availability of mental health services, as well as their accessibility to police-referred clients, are critical to the diversion of people with mental illness to treatment. It is reasonable to expect that police would be willing to consider diversion options in communities where mental health services are available upon demand, meet reasonable standards for quality, and are located in areas readily accessible to the police. Conversely, in communities with highly rationed treatment resources, the unreliability of services and the amount of time needed to complete the transfer of responsibility to providers could be reasonably perceived as inefficient, as well as ineffective. In this case, police resources would be more efficiently used by restricting the choice set to no action, informal action, or arrest and transport to jail. Police departments in these socially disadvantaged areas, already servicing an area of high demand for their services, may not have adequate time to consider alternatives and, instead, leave the processing of alternatives to the jails and courts.

The key here is that the demand for police involvement in an area relative to the available supply of officer time may require triage policing, which would not be optimal in a humanitarian sense but would be fully consistent with maximizing public safety given the allocation of existing resources.

Innovations for Diversion to Treatment

Reducing the ranks of people with mental illness in the criminal justice system has focused on two interrelated interventions: (1) diversion to treatment and (2) specialized police training on mental illness to facilitate detection and diversion. These innovations make sense if symptoms of mental illness are the primary cause of the criminal behavior. For the most prevalent type of crime—nonviolent, this causal relationship has not been demonstrated. It has simply been uncritically assumed in part because it fits the stereotype of people with mental illness as being potentially dangerous and in part because a statistical relationship exists between active psychosis and violent behavior. While research shows that people with mental illness who are actively psychotic have elevated rates of violent behavior, the effect of psychosis is small relative to the predicted effects of male, age, and nonwhite characteristics (Link, Andrews, & Cullen, 1992; Monahan et al., 2002; Swanson, Borum, Swartz, & Monahan, 1996). As shown by Engel and Silver (2001), once extralegal factors are controlled, mental illness does not predict the likelihood of arrest. More importantly, it has not been demonstrated that the average person with mental illness who has encounters with the police is *not* already receiving treatment or taking medications as prescribed or that symptoms of mental illness are affecting his or her judgment at the time of offense. Again, it has been simply assumed that the majority of people with mental illness who have encounters with the police are not receiving treatment.

Arguing for more treatment as a preventive strategy, however, will not depopulate people with mental illness from correctional settings and supervision if these two assumptions are invalid. Yet, all the interventions to reverse the flow of people with mental illness into the criminal justice system have focused on treatment as the pivotal factor, which may explain why diversion programs for low-level offenders with mental illness are found only marginally effective. The logic here is analogous to how criminalization enlarges the resource base of poor communities. For poor communities, criminalization has ostensibly expanded their resource base to respond to the health, shelter, food, and education needs of the socially disadvantaged removed from there. Similarly, for proponents of treatment, the criminalization of the mentally ill has provided a politically salient platform to argue for and secure expanded funding for community-based mental health treatment, which has been underfunded since the advent of deinstitutionalization (Lamb & Weinberger, 1998). Prior efforts to expand the treatment base in terms of better and more access to medications, outpatient treatment, vocational training, and other community-based services have fallen on deaf political ears. In contrast, the connection between criminalization and treatment has gained political traction and brought success at the state and federal levels.

Yet the success of more treatment in terms of promoting less criminal behavior hinges on the uncertain validity of assumptions about symptoms and treatment at the time of the person's encounter with police. Treatment is not a remedy for the other social problems that are veiled by these assumptions, particularly co-occurring problems such as poverty, idle time, unemployment, substance abuse, and geographic proximity to the crime culture. It is important to keep in mind that

people with serious mental illness who are actively engaged in treatment still have unemployment rates that are 10 or more times above the national average (President's New Freedom Commission on Mental Health, 2003). Without employment and relying primarily on public entitlements, individuals with serious mental illness have a lot of idle time and very little money, creating the opportunity and motivation for goal-directed criminal behavior. For this reason, it is not surprising that people involved in the evidence-based treatment programs, such as assertive community treatment, still have rates of encounters with the police in the 50% range (Clark, Ricketts, & McHugo, 1999; Wolff, Diamond, & Helminiak, 1997).

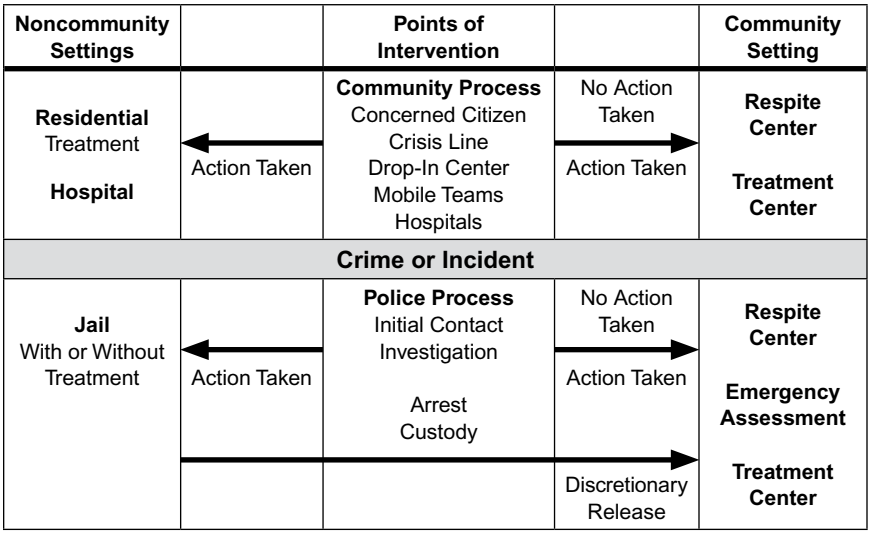
Appearance of difference remains a significant risk factor for people with mental illness. Treatment for serious mental illness does not fully normalize the person's appearance. Because of medication side effects, people with treated serious mental illness may talk or walk differently, have facial ticks or drool, and process information and respond more slowly. In addition, because of less practiced social skills, they may socially interact in ways that are unconventional. Poverty also limits their apparel and residential choices. Material deprivation motivates their need to "hunt" for survival, which might involve stealing things they cannot afford, panhandling, or selling drugs or their bodies in order to afford the things they desire. Treatment does not erase the visual and behavioral cues of difference that frighten and unsettle the public, often leading community members to call the police. Indeed, one of the leading reasons that people with mental illness are enrolled in assertive community treatment for having contact with the police is a consequence of a "suspicious person" complaint (Wolff et al., 1997).

Any intervention to reduce police encounters with people with mental illness has to begin with understanding and acknowledging the depth and priority of their needs, which are no different from other people without mental illness living in comparable communities. They want (and need) safe affordable housing, a meaningful job that pays a living wage, and quality health and mental healthcare that is delivered respectfully. Like us, they want the normal things of life. Treatment cannot correct for the social and material deprivation in which the person lives, nor mollify the desire to have a life worth living, even if ill-gotten. Moreover, offering treatment as the only social reward for acting good may not be valued enough by the person living without normal opportunities or conveniences.

Before discussing police interventions, it is important to note that police action is not the first or only line of response to incidents involving people with mental illness. As shown in Figure 2, there are other possible options available to citizens. Bittner (1967), in his classic article, noted that "it is usually assumed that the instrumentally related persons have exhausted their power and duty to help before calling the police and that there is little else left" (p. 284). Concerns about social deviance or behavioral distress could be managed in the community through the actions of concerned citizens who engage the assistance of informal or formal agents. Here, the options might include contacting a relation of the person (assuming that the distressed person is known to the neighborhood and has social connections) or calling a crisis intervention line or community help service (assuming they exist). Not reflexively calling the police requires efficient and effective alternatives to manage problem behaviors in the community, as well as an awareness among the citizenry that these alternatives exist. Some communities are developing and funding mobile crisis intervention teams. For example, New York City has 23 mobile crisis teams responding to the public's concerns about the psychiatric well-being of people in

community. LifeNet, a 24/7 mental health emergency crisis line, receives referrals directly from the public, including the police, and responds by providing assessment and referral services, via the 23 mobile teams, at no cost to the client (See www.mhaofnyc.org/2lifenet.html for more information).

Figure 2
Points of Intervention for Citizens, Community Agencies, and Police



These non-police options obviously must exist to be used. Yet whether they will be effective if funded depends centrally on the public's general awareness of their availability and the willingness of citizens to use them. Informing the public about programs like LifeNet is straightforward and reasonably inexpensive; venues such as public announcements on radio and television, posting of notices on buses and in public places frequented by residents, and word-of-mouth storytelling are particularly effective. Developing and marketing a simple message is also critical, and includes having a catchy and informative name and an easy-to-remember telephone number.

These programs, however, will not have the opportunity to develop a public reputation if citizens are not willing to engage them. This is particularly problematic in socially disorganized communities, whose hallmark is collective inefficacy (Rose & Clear, 1998; Sampson, Morenoff, & Earls, 1999; Sampson, Raudenbush, & Earls, 1997). Citizens there, on the one hand, may not have confidence in organized programs or, on the other, may be fully inured to problem behaviors. With frequent exposure, they become habituated to community norms of prostitution, drug use, gang violence, and crime and, as a consequence, do not perceive the putative "strange" behavior of people with mental illness as all that strange or distressing enough relative to all the other stressors in the community to take action. Either way, even if they are supplied, social and therapeutic services are not engaged by the community.

Failing to supply or demand social or therapeutic alternatives, by default, leaves only one possible alternative: the police. Yet even here, the community's propensity to involve the police will depend on their perception of the police. Citizens perceiving the police as helpful and trusted agents will readily contact them to deal with observed deviance. By contrast, if the police are distrusted or disliked by citizens, they may not be called by citizens to help in situations that involve people in distress. Delaying the involvement of police intervention with people who are spiraling out of control, as a consequence of unmanaged mental illness, drug use, or aggression, will limit the options available to police once the behavior of these individuals captures their attention. This pattern is analogous to situations in which people delay seeking medical treatment. By not treating medical symptoms immediately, they often become more serious and life-threatening, requiring more expensive treatment in the emergency room or hospital. This form of treatment, however, could have been avoided if the individual had sought outpatient treatment when the symptoms first appeared before they became more aggravated by neglect. This point more generally applied to criminalization is that the failure of the citizens to proactively engage "preventive" interventions increases the probability of police defaulting to traditional actions: arrest.

Interventions at the police level attempt to influence the turnstile function of the police, encouraging them to divert people with mental illness to treatment in lieu of jail. The goal here is to influence how the police officer manages, defines, and resolves the incident. This strategy of intervention involves, first, keeping the medicalization option open, which requires de-escalating the conditions at the scene to prevent harm. Calming the person, gaining his or her confidence, and keeping him or her safe are the goals of de-escalation techniques. A more directive, command approach to apprehending suspects elevates the likelihood of resistance and emotionality (Lamb & Grant, 1982), increasing the chances that the suspect and officer will be harmed and the suspect will accumulate assault charges. For this reason, virtually all specialized police interventions involve a special training module on how to de-escalate incidents involving people with mental illness, which enhances the officer's awareness of the presentation of mental illness under stress.

Educating officers about mental illness increases their capacity to respond more effectively and reduces any ambient fear of and negative attitudes they might have about people with mental illness (Nunnally, 1961; Patrick, 1978). Officers, acting on negative stereotypes, may be more risk averse in responding to situations involving mental illness (Green, 1997; Watson, Corrigan, & Ottati, 2004). Negative stereotypes about people with mental illness, if not corrected, may predispose officers to keep their social distance when defining and managing incidents involving people with mental illness (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Building officers' expertise and competence in handling situations involving people with mental illness, however, encourages the likelihood that they will medicalize the situation and consider treatment as an alternative. Specialty training also provides officers with an alternative way of interpreting extralegal factors, such as disrespectfulness, belligerence, or uncooperativeness. Instead of seeing this type of behavior as a sign of disrespect for the officer (i.e., a personal affront) or the law (i.e., a disregard for the law), they are trained to consider it as a symptom of the illness.

In terms of Figure 1, specialty training, as incorporated into police-based interventions to reduce the incarceration of people with mental illness, attempts to raise officers' awareness and understanding of mental illness in an effort to affect their perception of

the need to medicalize an incident (not criminalize) and to enhance their willingness and ability to consider resolving the incident through treatment (not jail). While training may be effective here, officers still must perceive the option of treatment as practical. Given that training-enhanced officers do not have the competency to diagnosis mental illness, uncertainty persists with respect to whether the person really needs treatment. While the officer could request a second opinion, pursuing this option takes time away from "real" policing. Uncertainty also exists in terms of whether there is a treatment alternative that is as efficient as jail and whether the symptoms of the individual are sufficient to motivate a provider response (Appelbaum et al., 1992). Risk aversion in the face of uncertainty pushes police behavior in the direction of criminalizing incidents, even with specialty training. This predisposition is strengthened if resources in the community or those available to the police department are constrained. It simply may not be cost-effective (i.e., practical) for officers to medicalize incidents.

While all police-based interventions involve mental health training modules, they differ in terms of whether all officers or only a specialized team of officers are provided with specialty training (referred to as the "generalist" or "specialist" approach) and whether specialized police officers work in concert with mental health providers. The most common approach here is the community intervention team (CIT) model developed by the Memphis Police Department (Deane et al., 1999). The CIT model provides specialized training to a select group of police officers who volunteer for the training and who, once trained, are dispatched exclusively to incidents involving persons with mental illness. This type of structure makes economical sense if the following conditions hold: dispatchers reliably identify situations involving people with mental illness so that the CIT officers are the first responders; the base rate of police encounters with people with mental illness is of a size that could be covered by a relatively small number of officers per shift; and the geographic area of the department can be efficiently and effectively covered by the CIT officers without impacting the ability of the remaining officers to cover all other incidents.

Only certain scale economies are consistent with the CIT model in its pure "specialized team" form. Assuming reasonable validity and reliability performance on behalf of dispatchers, being a police department that is either relatively large or small limits the feasibility of the CIT model. For example, for large, densely populated geographical areas, such as New York City, Los Angeles, and Chicago, both the frequency and spatial distribution of incidents involving people with mental illness is too large to cover with specialized teams. Similarly, departments with small numbers of officers cannot fully employ a CIT operating round the clock. While it is easy to determine scales of extremity that are incompatible with CIT, it is not clear what scale or range of scale is required to support specialized CIT; however, assuming that CIT requires a minimum of 1,000 full-time officers (Memphis has roughly 2,000) and a maximum number of 3,000, less than 1% of local police departments could support the CIT specialized model. Putting this into further perspective, less than 10% of local police departments employ 100 or more full-time officers (Hickman & Reaves, 2003).

Some police departments have established cooperative agreements with mental health agencies that support embedding mental health providers (e.g., social workers or psychologists) in the police response team. Depending on the model, either the specialized police officer and the mental health provider arrive at the scene together or the mental health provider is dispatched after the initial response by the specialized officer. Examples of these models can be found in the Consensus

Project Report (Council of State Governments, 2002). Each of these embedded models share the scale economy problems discussed above for the CIT model. In addition, the "arrive together" model is likely to overallocate clinically trained resources to the majority of incidents, which could be competently handled by sensitive officers and, in so doing, wastes scarce clinical resources.

Efforts to medicalize the officer's interpretations of incidents involving persons with mental illness are not as simple or as straightforward as they appear. First, police officers are not trained to distinguish symptoms of mental illness from other explanatory factors. Even professionals who are competently trained in psychopathology cannot determine, after several hours of observation, whether the person is mentally ill, high on alcohol and drugs, or both. For this reason, it is unreasonable to expect police officers in the heat of the public moment to distinguish biological disorder from criminal disorder. Furthermore, 40 or so hours of mental health training will not provide officers with the professional competency to gauge when symptoms are such that a clinical intervention could be implemented with or without the distressed person's consent. Simply transporting the person to a mental health provider may not resolve the situation if mental health symptoms are not the problem or are part of the problem but the provider cannot motivate or coerce treatment engagement. The failure of the mental health provider to remedy the problem behavior as expected by officers will, in all likelihood, influence their willingness to consider the treatment option in the future.

Not-So-Simple Recommendations for Depopulating the Criminal Justice System

Training and treatment as primary solutions to the trend of incarcerating people with mental illness are simple in their explanation but misguided in their application. No doubt, the police are in a strategic position to medicalize, socialize, or criminalize an incident involving people with mental illness. Training them to medicalize these incidents, however, is both discriminatory and counterproductive. It is discriminatory because it assumes that people with mental illness only engage in crime because of their symptoms, which is tantamount to saying mental illness causes crime. Such conclusions and theories, while unsupported by the evidence, subvert the very foundation of normalization—equivalence between people with and without mental illness—and perpetuates stereotyped differences. It is counterproductive in that it ignores all the social factors that might be motivating crime, such as poverty, homelessness, and drug addiction. Ignorance, like in the case of the dark figure of crime, veils the need to act socially and responsibility to improve the social and material conditions where crime thrives.

Separating out people with mental illness for differential (preferred) treatment by the police may, in the best case scenario, expand the mental health treatment services available to address mental illness. These services will do nothing, however, to change the material and social circumstances in the community where these individuals live, nor will they appreciably impact the individual's opportunities for affordable housing, "living wage" employment, or meaningful social engagement there. Targeted funding would be needed to expand the opportunities in these communities. Yet, policy makers thinking that they solved the criminalization problem with treatment dollars, will be disinclined to extend funding to affordable housing, job training, and skill building, especially if the crime rate remains unabated with the

expansion of treatment and training funding. While treatment and training dollars may be easier to extract from the political process, taking them may forestall any possibility of stopping crime or the criminalization of poor people with or without mental illness. A harmful social cost is attached to expanded funding for mental health treatment and training, which goes blithely ignored in the simple criminalization story where the protagonist is therapeutic science, not material conditions.

Reducing poverty and building social cohesion are daunting tasks from which even the richest nation in the world shies away. While the solution proposed here for depopulating the criminal justice system does not propose to "end poverty as we know it," it does attempt to ration and reallocate scarce resources in ways that give expanded opportunity a chance to take root in socially disadvantaged communities. The solution is premised on the following facts supported by the literature:

Premise #1: Crime is spatially concentrated in socially disadvantaged communities.

Premise #2: People with and within mental illness in these communities engage in crime for reasons related to the material and social conditions there.

Premise #3: Police officers will seek time-efficient ways to effectively manage incidents in the community.

Premise #4: Strong social ties within the community and between the citizens and police improve social function.

These fact-based presumptions, while not representative of all people, situations, and communities, are more representative of the conditions revolving around crime than are typically assumed in simple criminalization stories.

Starting from here, it is recommended that instead of training officers to respond differently to *individuals* with different problems that they be trained to respond differently to *crimes* with different characteristics, independent of the characteristics of the person who commits them. The advantage of a crime-based approach is that behavior is easier to classify by crime type than by the psychological condition or precondition of the person suspected of criminal behavior. Plus, perhaps more importantly, it builds on the strengths and orientation of the officers. Police officers receive extensive training on the law and the types of behavior that violate the law. Their expertise rests here. This is not to say that there is not professional discretion in assigning a particular crime label to a deviant behavior. There is discretion here in the same way that physicians have discretion in assigning a particular diagnosis to a set of symptoms; however, a crime-based rule to guide police action places their decisionmaking within the structure of the law and the strength of the supporting evidence, as well as within their professional identities as officers and enforcers of the law.

Once an officer assigns a crime label to an incident, the action required of the officer is predetermined. These "crime-rules" for police officers would be analogous to sentencing guidelines for judges. In operation, all crimes, as labeled by the officer, will require an arrest and transport; some people will be transported to a community-based social justice center, while others will be transported to jail.

As with sentencing guidelines, one of the critical steps of this recommendation is identifying crime types; clustering particular crimes within the crime types; and determining the appropriate police action for each crime type. While one can imagine this recommendation generating a tortured process and an exhausting and impractical list of crime types with connected responses, it could also be kept parsimonious if the goal of the guidelines directed the process and the outcome. Recall that the goal is to efficiently guide the officer's behavior in the dispositional decision of informal action, diversion, or arrest. As such, the crime typology would cluster around these points of action. If there is more than one criminal charge involved, the most serious charge would determine placement in the crime typology. A crime-type guideline for police might look as follows:

Crime Type 1: Social welfare-related behaviors would be defined as crimes (e.g., loitering, public nuisance, public urination, and so forth) but would not be criminalized. Any individuals engaging in these behaviors would be arrested only for the purposes of transporting them to a community-based social justice center for social service intervention. It is the responsibility of the agents there to assist the person with problems related to housing, unemployment, mental illness, addictions, and so forth.

Crime Type 2: Goal-directed behaviors (e.g., shoplifting, failure to pay, drug use) would be *temporarily* criminalized. Individuals engaging in these types of behaviors would be transported to a community-based social justice center where a judge would have the option to mandate treatment, encourage the use of other social and therapeutic service interventions, and order community service. These convictions would be removed from the person's record after completing the community service and treatment requirements of the court.

Crime Type 3: Violent crimes and certain nonviolent felony crimes result in transport to jail and culminate in conditions (e.g, bail) that could result in jail detention.

The types of crimes nested in each crime type would require consensus decisionmaking at the state level, involving key stakeholders at the local and state levels, with the final goal being the establishment of a uniform response guideline for police officers.

The implementation of a uniform response guideline requires two more things to happen. First, the geographical areas where people who commit crimes live must be able to "capture" the funding displaced by the depopulation of the local jails. Anti-removal strategies, such as this, could realistically cut in half the average daily census of jails if people were not detained for nonviolent, low-level crimes (Crime Types 1 and 2 above). State matching rates (say 25 cents on the local correctional dollar) could be structured to encourage and monitor the flow of funds out of corrections and into community-building initiatives, including the community-based social justice centers that receive people transported by the police for Crime Types 1 and 2. Socially disadvantaged communities must be able to capture the dollars that are currently used to provide housing, food, treatment, and education to their residents inside jails. This money is needed to build those same capacities for

residents now staying in the community. Citizen ownership in this process could be fostered if community-service orders were designed and implemented in ways that require people to fulfill their orders by building and rebuilding their communities. Mobilizing a Habitat-for-Humanity-like or a Works Progress Administration (WPA) movement inside these communities is opportunity building, as well skill-building, for the people living and serving their community sentences there.

The second requirement concerns the training of police officers to fully and consistently use de-escalation techniques at the scene. Indeed, training modules are diffusing that stress the "drop the John Wayne walk." It is recommended that de-escalation techniques be given the same status as universal precautions. De-escalation techniques, if implemented correctly, protect people from harm; their goal is to invite rationality and reduce emotionality at the scene. This is achieved by a fair and firm approach at the scene; it involves police officers practicing civility and nonconfrontational communication techniques and giving the person space to think. These techniques counter the primitive survival response of fight or flight.

Selective application of de-escalation techniques is consistent with contemporary police training and practice. As part of training, as is practiced now, police are taught how and when to adjust de-escalation techniques for the suspect's age (particularly, adults vs. juveniles), problem behavior (i.e., behaviors perceived as mentally and emotionally erratic or extremely hostile), and extralegal factors (e.g., the publicness of the situation, the suspect's demeanor). As a universal precaution standard, the application of de-escalation techniques would become the norm for all interactions between officers and citizens, not just special classes of citizens.

There are many reasons to doubt the feasibility of the proposed solution to the criminalization problem. Its success depends critically on the capture of displaced correctional dollars, the training of and cooperation from officers working the streets, the practice and financing of community-oriented policing in these communities, and the willingness on behalf of politicians and the public to try something new—something that, by its design, will rebalance the allocation of the public's tax dollars away from corrections and towards communities. While one can speculate about the challenges and pitfalls with this solution, the performance to beat is the current disjointed approach based on simple stories, which by all accounts is an economic and social failure.

It is misguided to expect, let alone fully finance, treatment or punishment to solve the confluence of medical and social problems of people with and without mental illness. Medicalizing or criminalizing expressions of the socially disadvantaged produces harm at the individual and societal level, and it is expensive to boot. Assigning a criminal label to people who are poor, addicted, and/or mentally ill only further isolates them from prosocial opportunities (Pogorzelski, Wolff, Pan, & Blitz, 2005). Likewise, stressing their illness label ignores their need for normal opportunities. Labels, like "simple therapeutic solutions," rob people of opportunities and trap them perpetually as victims of bad luck, bad health, and bad choices. It is time to give facts and complexity a chance in the form of a sensible approach to decriminalize social disadvantage in all its many different guises.

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Crisis Intervention Teams (CIT): Considerations for Knowledge Transfer

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Since its inception in 1987, the "Memphis Model" Crisis Intervention Team (CIT) has become one of the most popular U.S. law enforcement initiatives of its kind. The program emerged from efforts to heal a community divided by the fatal police shooting of a person with a mental illness in Memphis, Tennessee. By forging strong community partnerships and maintaining steadfast commitment, the Memphis community was able to fundamentally change the way that law enforcement personnel responded to, and handled, calls involving people with behavioral health disorders (i.e., mental health and substance abuse problems) in crisis (Cochran, Deane, & Borum, 2000).

In the ensuing years, other jurisdictions experiencing similar tragedies turned to Memphis for advice and guidance. Hundreds of individuals from around the country have visited the CIT program and attended their training, attempting to bring the knowledge and technology home to their own communities. Many have succeeded. Some have not. Most of the lessons learned have not been shared, so little is known about the principles and strategies needed to initiate, develop, and sustain CIT in a new jurisdiction. In this article, we offer preliminary observations and suggestions for a successful cross-jurisdiction transfer of CIT-related knowledge and practice. We draw principally from our experiences in supporting numerous communities—including more than 20 in Florida—who have implemented the CIT program model.

Historical Perspective

Most law enforcement administrators and managers know the challenges of responding to crisis situations involving people with behavioral health disorders (Borum, 2000). These encounters are common, but most officers feel poorly equipped to handle them. To resolve them successfully, law enforcement personnel often must navigate in the unfamiliar terrain of emergency rooms and mental health clinics where officers' idle time interferes with other priorities (Borum, 2000; Borum, Deane, Steadman, & Morrissey, 1998).

Nearly all law enforcement officers receive some training on behavioral health issues, but the nature and extent of it is quite limited (Hails & Borum, 2003). Standard training curricula most often focus on protective custody laws, emphasizing policies and protocols. In recent years, police recruit training has moved toward a problem-solving approach. This new training emphasis is designed to assist officers in applying their knowledge in a variety of simulated real-world scenarios.

These generalized training efforts alone, however, have failed to alleviate the operational challenge that behavioral health crises pose. Tragic—sometimes preventable shootings—continue to occur, and officers continue to experience

frustration as they attempt to get appropriate help for individuals in a behavioral health crisis (Borum, 2000). The police officer must balance the goal of service while safely meeting the multiple demands of their peace-keeping duties. Law enforcement administrators additionally must consider questions of departmental liability and damaged community relations when working with this vulnerable population. Police departments often struggle to fill gaps in community services for the large number of individuals who formerly may have been in state institutions (Borum, 2000). The CIT model is one model that has emerged from these struggles.

CIT operates on a generalist-specialist model. A select cadre of volunteer officers are chosen and trained to be first (and primary) responders to behavioral health crises. Such officers maintain the regular patrol responsibilities and geographic assignments, but they are given priority—and have citywide jurisdiction—to be dispatched to calls involving behavioral health crises. The operational objective is to have the most skilled officer for mental health problems positioned to respond to those calls first and be given authority as the "officer-in-charge" of that incident (Cochran et al., 2000).

An early NIJ-funded study found that CIT was rated by police officers (including non-CIT officers) as being highly effective in meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing the amount of time officers spend on these types of calls, and maintaining community safety. The CIT program also had the lowest rates, among the models studied, of arrest and use of force for mental health disturbance calls (Borum et al., 1998).

Since its inception, the Memphis-modeled CIT approach has been adopted by an estimated 100 or more jurisdictions throughout the United States (Spaite & Davis, 2005). In 2002, the Police Executive Research Forum surveyed and described 28 law enforcement agencies' police-based diversion programs for people with mental illness. Twenty-two of them (79%) were based on the Memphis Model CIT program (Reuland, 2004). In Florida, CIT programs cover county jurisdictions representing more than 73% of the state's population.

Model Adoption Overview

It is unusual for a grass-roots initiative to have been so widely adopted by law enforcement. At the time of implementation, almost none of these communities had statutory or policy initiates to spur its growth. No state or national funding backed its adoption. What then has contributed to the adoption of this best practice?

We suggest several reasons for its popularity. First, program costs are minimal. The Memphis Police Department has estimated that considering all program-related costs, including special duty pay, the cost per response for mental health crisis calls from CIT was approximately two dollars. Secondly, the CIT is a police operation. Departments need not deploy any additional personnel, including civilians. Because law enforcement will almost always be the first line of response for mental health disturbance calls, there is an operational advantage to locating the specialized response with operational personnel. Even if mental health professionals also become involved, the on-scene management and stabilization of the situation may improve by having specially trained officers serve as the primary response (Borum et al., 1998; Cochran et al., 2000). Spaite & Davis (2005) suggested that the

specific management issues of importance provided by the CIT model include the following:

- CIT officers are a select group of volunteers.
- CIT officer recognition by their communities is a valuable incentive.
- CIT officers function in both their patrol duties and as responders for crisis incidents. This strategy allows officers to acquire field experience in crisis management.

Finally, the model is rooted in a problem-solving approach, attempting to identify and ameliorate the underlying cause of the behavior that precipitated a call for police, rather than simply incapacitating the individual or removing him or her from the community.

The original goal of CIT was to improve the quality of the police encounter to reduce the likelihood of injury. As the program has evolved, however, many suggest that an equally important objective has been to divert people with mental illness from the criminal justice system whenever appropriate (Borum, 2000). The latter goal has garnered additional CIT support from national organizations and advocacy groups, such as the National Alliance on Mental Illness (NAMI), which has substantially advanced CIT's recognition and acceptance.

Factors Influencing CIT Adoption

Whether, when, and how a community adopts or sustains a CIT program will depend on a host of factors. Some are nearly universal, while others vary from community to community. Reuland (2004) proposed the following five steps for "Planning a Police Based Specialized Response Program":

1. Examining Available Models
2. Adapting the Model to the Locality
   a. Mental health services adaptations
   b. Training adaptations
   c. Response protocol adaptations
3. Educating the Community
4. Obtaining Necessary Reviews and Approvals
5. Setting Logistics and Administration

Adapting the Memphis model to distinct local characteristics seems to pose the greatest challenge for most jurisdictions. After 17 years of operation, CIT has become institutionalized in Memphis, and visitors are often struck by how smoothly the program operates there. The struggles of startup, planning, implementing, and sustaining the program are often less evident to outside observers. Here, we attempt to outline some of the common issues encountered in transferring and adapting the Memphis model to other localities, classifying these factors into three categories: (1) Community Readiness, (2) Implementation, and (3) Sustaining Factors.

Community Readiness Factors

Different communities will come to consider, and ultimately adopt, CIT for different reasons. Typically, communities are brought to action by the cumulative effects

of existing problems and triggered by an incident that is "the straw that breaks the camel's back" (Reuland & Cheney, 2005). The precipitating event, such as the shooting that occurred in Memphis, creates a community crisis. In classic crisis intervention theory, individuals are propelled into crisis when their normal coping mechanisms are overwhelmed or ineffective. In this state of disruption, however, exists the adaptive opportunity to buttress existing resources, garner new ones, and emerge from crisis even stronger than before. This principle applies to communities as well as individuals. A community must be "ready" before it can successfully implement a CIT program.

A variety of readiness models have been proposed and used in the social sciences. Most originated from the study of health behavior, but the general principles may apply to community changes, as well. One of the most commonly used is the Transtheoretical Model of Change (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997). The model is framed by a series of five progressive stages.

1. *Precontemplation* – Not planning to take any action in the near future (e.g., the next six months). May be uninformed about the nature or existence of the problem or be frustrated and demoralized because past efforts to change have failed.
2. *Contemplation* – Thinking about and intending to change. May be strongly ambivalent because of the possible costs, challenges, and difficulties. This ambivalence may cause some to "get stuck."
3. *Preparation* – Planning to take change action soon (e.g., within the next month). Probably has taken some small steps already and has a plan of action for change.
4. *Action* – Has taken effective action and recently made some meaningful changes (e.g., within the past 6 months). At this stage, there is a real danger of "dropping the ball" and reverting to old ways.
5. *Maintenance* – Change has occurred and is being maintained. The risk of reverting to old ways is greatly reduced.

Readiness for CIT applies beyond the law enforcement agency itself. The CIT program is built on community partnerships, and different partners may be at different stages at different times. If this is the case, one of the initial challenges is to "get everyone on the same page," usually by helping or leveraging the slower partners to move more quickly to preparation and action. Education and enhancing motivation typically are key interventions. Each partner may, however, have different motivations or potential gains from adopting CIT. The range of benefits to different stakeholders must be identified and respectfully considered.

The charge to adopt CIT may be "championed" by a particular group or individual such as a sheriff, judge, county official, mental health professional, or member of an advocacy group such as NAMI, but multiple agencies and stakeholders must ultimately be represented and actively involved. In one community, for example, the absence of consumer advocates was evident, and the initiative died after the first couple of meetings. Based on experiences in their state, NAMI Maine (2006), for example, suggests that CIT's success requires the following elements of community support:

- Leadership in the police department/jail fully supports the program.

- Leadership in the local hospital supports the program.
- Families, consumers, and service providers volunteer to participate in the training and to stay involved in the program once implemented.

The specifics may vary in other jurisdictions. Jails and law enforcement may or may not operate under the same administrative authority. Courts may or may not have a vital role in creating alternative dispositions for offenders with mental illness. Nonhospital-based mental health agencies, providers, clinics, and facilities may or may not be critical in a given jurisdiction. The underlying principle remains, however, that CIT is a community effort, sustained by partnerships. The community—not just the law enforcement agency—must be ready for change before meaningful and lasting change can occur.

Implementation

A program to be adopted must meet felt needs of a community. In the case of CIT, several diverse goals are addressed. A survey of 80 law enforcement agencies by the Police Executive Research Forum (PERF) in 2003 found four key stated goals of the agencies: (1) safety of officers and civilians, (2) increased officer understanding of mental illness, (3) reduced numbers of people with mental illness going to jail, and (4) improved relationships with the community, particularly with mental health professionals, people with mental illness, and family members. Of these stated goals, the most frequent noted successes are improved relationships with the community and improved safety of officers and civilians (Reuland & Cheney, 2005). Although CIT may not equally achieve all, these goals resound as important to various stakeholders involved in the program adoption.

Once a community makes an informed decision to adopt CIT in its jurisdiction, the core components of the model must be examined, adapted (if necessary), and implemented. This also requires a community effort. The CIT model, by definition, is designed to have a local, direct impact and a problem-solving focus. This model is consistent, philosophically, with the broader trend in U.S. law enforcement toward community policing models.

Key community stakeholders must come together in the planning and preparation stages, so the forum for partnering on implementation should already be established. When communities have difficulty getting certain stakeholders to the table, CIT is much more difficult—if not impossible—to implement. Even if one element of the system has agreed to CIT in principle, they may fall short at implementation. Reuland & Cheney (2005) report that the key to success has been the strength of partnerships formed by the program.

Many of the CIT core components primarily require support and change by the law enforcement agency (or agencies). Law enforcement "buy-in" is obviously essential, though several communities have started with only lukewarm participation of the sheriff and/or chiefs. In these cases, the training component has proceeded, but frequently, full-model implementation has stalled.

Memphis model CIT developer Major Sam Cochran is quick to point out that "CIT is more than just training" (personal communication, 2003). Training is, however, the most visible component. For some jurisdictions, the initial focus on advanced,

specialized training is an important starting point. Even if law enforcement administrators are initially resistant to or overwhelmed by changing their response system, training may be a "foot-in-the-door" that requires only the release of staff time to participate (Borum, 2000).

The CIT model for training provides an added advantage to building community partnership and full participation because *community partners provide the instruction.* The training itself is a vehicle for information-sharing and developing inter-system relationships. While training alone—no matter how competent—is insufficient to create a Memphis Model CIT program, the training courses have vital importance at many levels.

The low cost of the model both for the training and response system is an attractive factor. The most significant program costs are administrative and accrue from releasing officers from their regularly assigned duties to attend the training. Most communities receive donations to cover incidental costs of training events.

Sustaining Factors

Perhaps the most elusive issue in CIT knowledge transfer is how best to sustain and nurture a successful program. Unlike models of individual behavioral change, community actions have a wider range of vulnerabilities that threaten them. Conflicts within or between any of the community partners can destabilize a successful effort. Routine personnel changes can fundamentally alter dynamics with the program or relationships with partner agencies. Budget cuts in one part of the system can easily and profoundly affect the operation of the other components. The tendency to "drift" back to the old way of doing things can be an ongoing challenge. The lesson is that developing a successful CIT program is not a one-time activity. Like most worthwhile efforts, it must be actively monitored and maintained. How best to do that is a relatively open question, and the answer likely varies across jurisdictions.

In our experience, actively sustaining a CIT program first requires a feedback loop. There must be a way for program partners to share information and concerns about what is working and what is not. Ideally, this includes some formal evaluation of whether and how the CIT program is meeting its intended objectives. One suggestion is for the community partners to "brainstorm" about possible problems or threats to the program that may occur over time. The threats can be prioritized (in terms of likelihood and magnitude) and can often be preempted by creatively designing program operations to avoid them. Some problems, of course, are less foreseeable than others, which is why regular meetings among the partners and creating a feedback loop is usually recommended.

Over the past decade or so, at least a few CIT programs have faced challenges that threatened their very existence. Rarely did these come from the "outside." No external agencies threatened to "do away with" the program. Rather, the programs suffered through neglect or insidious erosion. Based on our limited experience, four of the main offenders are (1) loss of command support, (2) disrupted partner relationships, (3) loss of program leadership, and (4) inadequate recruitment and retention.

Command commitment is often (though not always) a sustaining condition for program leadership. CIT is not the only issue, however, with which they must contend. Law enforcement administrators and command staff must pilot moving vessels through changing terrain. At the time the decision is made to adopt CIT, that issue may be the sheriff's or chief's highest priority. He or she may never lose that commitment in spirit, but over time, other matters will inevitably demand attention. Without the active, unequivocal, and ongoing support of top-level agency leadership, adherence to CIT procedures is likely to drift, officers' interest will wane, and community partners will perceive that the law enforcement agency is no longer committed.

If community partners believe that the law enforcement agency has "bailed" on the project, tensions can build, and a number of dysfunctional systems responses can occur. The same is true if law enforcement perceives that one or more of its partners is "not pulling weight." Community partnerships in this arena—as with others in community policing—are based on ongoing relationships that must be actively managed. Communication is essential.

The CIT program leader (often called a coordinator) is an essential part of sustaining a successful program. The coordinator, regardless of rank, must be respected by sworn personnel at all levels. She or he must keep CIT on the command staff "radar screen," liaise effectively with community partners, sustain the morale of existing team members, maintain quality control, stimulate and preserve interest in the program and its reputation, identify and remediate any CIT-related problems, and seek lessons and information from programs in other jurisdictions. Without energetic, committed program leadership, CIT is at risk to "die on the vine."

One common result of inadequate program leadership is an inability to recruit and retain high-quality CIT officers. In some jurisdictions, the reputation of CIT programs has devolved from that of an elite, skilled group to that of marginalized "social workers" in uniform. The team image affects whether the best officers will want to sign-up or continue to participate. Retention is also an ongoing struggle because of transfers and promotions that routinely occur in law enforcement agencies.

Program Barriers

While CIT has gained wide acceptance and acclaim, certain barriers can impede or reverse progress at any stage of readiness, implementation, or maintenance. For law enforcement agencies, the primary implementation challenges seem to be administrative resistance to creating a specialized unit and inertia in changing the response system so that CIT officers are primary responders to behavioral health crisis calls.

The "over-specialization" concern is only one of perception. As we noted, the CIT program operates on a generalist-specialist model. CIT officers are not taken from their regular patrol duties, and the agency is not responding to a "new" set of calls. The perceived disadvantages of a creating a specialized unit simply do not apply to CIT. Regarding the change in response/dispatch protocols, the logistical adaptations are minimal. Call centers and dispatchers must also have a mechanism in their system to "flag" or otherwise identify CIT officers and procedures allowing them to send those officers first to behavioral health crisis calls.

Several of the more commonly encountered barriers or challenges are the following:

- **Difficulty adapting the Memphis Model of CIT for small and/or rural jurisdictions**
  Discussion – The Memphis model functionally requires that at least 15% to 20% of an agency's patrol officers be trained and identified by dispatch as available CIT officers. The purpose of that requirement is to provide adequate 24/7 CIT coverage throughout the jurisdiction. In small jurisdictions, however, a community could not have full coverage without a majority of the patrol officers being trained. If that is done, many of the advantages of having an interested, volunteer team are lost. As of the year 2000, a majority (52%) of the 18,000 U.S. local and state law enforcement agencies employed *fewer than 10 full-time sworn officers* (Reaves & Hickman, 2002), so the scope of this challenge is not insignificant. CIT will require some adaptations to the Memphis Model to function effectively in smaller agencies.

- **Lack of modifications or cooperation by system segments**
  Discussion – It is not uncommon for mental health advocates and behavioral health providers to put the onus of CIT almost exclusively on the law enforcement agency, emphasizing their need to better train officers and to their response methods. The behavioral healthcare systems sometimes do not desire or see the need for change. Accordingly, in some localities, the barriers to effective implementation have not come from law enforcement but from the behavioral healthcare system. This is only complicated by the dynamics and incentives of privatization. For example, when protective custody admissions are debated by hospitals that want more referrals or those that resist referrals, the efficiency of CIT can be adversely affected.

- **Question of official state or federal endorsement or regulation for CIT training and program standards**
  Discussion – Florida jurisdictions and its statewide CIT coalition have debated whether to seek endorsement of the 40-hour training by the State's Department of Law Enforcement to facilitate state funding, or at least, garner authorizations for mandatory retraining credits. Many CIT training officers have expressed concerns that if the training is subsumed by state authority, CIT program control over the curriculum content and teaching methods will be lost. This may dilute the programmatic aspects of CIT by promulgating it as a "stand alone" course. Community steering committees also have expressed major concern that state or federal standardization would eliminate the strength of involving key community stakeholders. Conversely, CIT officers spend 40 hours in this specialized training, which is the amount of mandatory retraining required for their recertification every 4 years. Agencies around the country have adopted training courses of varying types using the CIT concept but without the core program elements that define CIT as a program.

- **Inter-jurisdiction conflicts**
  Discussion – Several of our Florida counties have 20 or more law enforcement jurisdictions, each with its own agency. Behavioral health systems throughout the state also have multiple agencies whose services overlap. Especially when the police force has very limited personnel, it is necessary to develop a cooperative response system. This had led to some jurisdictions creating interagency CIT

teams, some with community partners that cross jurisdictions. The issue is navigable but is best addressed proactively through Memoranda of Agreement, building boundary spanners, and interagency partner relationships.

- **Financial or manpower crunches**
  Discussion **–** Law enforcement trainers, community citizens, and behavioral healthcare providers typically volunteer their time for CIT training. This has kept the cost of training from being a major barrier to program implementation; however, diverting 20% of an agency's patrol force (although not all at once) for 40 hours of training may be burdensome for certain departments. It is not unusual for law enforcement agencies to be generally understaffed due to budget crunches, recruitment problems, and officer deployment to the Middle East.

Evaluating the Model

Documentation regarding CIT's effectiveness is continuing to build. Anecdotal reports are almost uniformly positive. Hundreds of websites, newspaper articles, and statements from agencies and consumers offer praise and stellar reports of success. Although these reports do not provide definitive evidence of positive outcomes, they do support the model's adoption in varying degrees. These reports clearly indicate that the programs are well regarded and meeting the needs of at least some stakeholders.

More agencies are gathering data pertaining to the number of calls and patrol time involved. Data on injuries and jail diversion is collected in a few of the existing CIT programs (Reuland & Cheney, 2005). Satisfaction studies of law enforcement, mental health professionals, consumers, and family members are the most commonly used outcome measures for the qualitative method utilized (Reuland & Cheney, 2005).

Experimental designs in naturalistic emergency settings are nearly impossible to implement; however, empirical investigations regarding CIT's effectiveness have been conducted with very positive results (Steadman, Deane, Borum, & Morrissey, 2000).

A CIT evaluation report from NAMI Ohio (Spaite & Davis, 2005) lists the following program benefits identified in prior CIT studies:

- Fewer injuries to police officers
- Reduction in arrest rates and use-of-force incidents
- Fewer repeat commitments to inpatient care
- Reduction in patient violence
- Less officer time involved per call
- Reduction in jail days for offenders with mental illnesses

Teller and colleagues' study of dispatch logs from the Akron, Ohio, CIT program reported that more voluntary police transports to emergency treatment facilities occurred after CIT training (Teller, Munetz, Gil, & Ritter, 2006). They conclude that CIT can assist persons in crisis in gaining access to the treatment system. They did not, however, find a significant change in the rate of arrest. PERF's (2003) survey noted that the specialized response programs have "infected" other parts of the criminal justice system and often prompted nearby agencies to adopt similar programs (Reuland & Cheney, 2005).

Conclusions

The widespread adoption of the CIT model for responding to individuals in behavioral health crises has been remarkable. The use of new technology by a community is not always determined by the amount of money available or the mandates from state or federal authorities. The volume of CIT programs in the United States reminds us that other more compelling factors are involved in social change. This article has attempted to provide anecdotal information as to what factors are important in efforts to adopt a "best practice" policing model that has been successful in other communities.

In the near future, it will be important for researchers and law enforcement agencies to partner in carefully evaluating the process and outcomes of implementing a CIT program. Understanding how the model is implemented and adapted by localities and their adherence to the model's core tenets is crucial.

Potential barriers and possible solutions must be more systematically identified. Associations should be examined between the perceptions of non-CIT officers and, among other factors, the degree of departmental involvement in planning, program philosophy, and CIT officer retention. Comparisons concerning program effectiveness should also be made from differing vantage points including those of consumers, members of AMI, mental health providers, officers, and law enforcement administrators. Perceived and objective measures of effectiveness should also be linked to features of the community's human service and behavioral health infrastructure, such as the existence of a crisis "drop-off" point and the degree of its cooperation with the police.

Communities are strongly encouraged to consider ways to collect data and evaluate the benefits and outcomes of their CIT programs. These methods should include collecting incident data through standard, brief CIT tracking forms; continuing to examine program perceptions by all relevant segments of the community; measuring—as objectively as possible—how well the goals and objectives of the program are met; and assessing the potentially broader impact on improved community understanding, communication, and system development for serving individuals with behavioral health conditions.

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The State of CIT in the State of Florida: The Evolution of a Multicounty and Multi-Jurisdictional Coordination of CIT Across the State of Florida

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The Problem

In Florida, there are approximately one million people who are experiencing a serious mental illness. This is based on the estimate by the National Institute of Mental Health (2006) that 6% of the general population over the age of 18 has a serious mental illness. Many people with serious mental illness have limited access to treatment or do not remain in treatment. As a result, these individuals are at an increased risk for crisis escalation.

Law enforcement officers are often the first responders in crisis situations that arise in the community. In crisis situations involving individuals with mental illness, family or community citizens will often call law enforcement to get help. As first responders, law enforcement officers need to quickly assess the situation and facilitate a resolution to the crisis.

Crisis Intervention Team (CIT) as a Response

Crisis Intervention Team (CIT) has emerged nationally as a best practice model for law enforcement's response to people experiencing behavioral health crises.

> The Memphis Police Department pioneered the Crisis Intervention Team (CIT) in 1988 after the police shooting, a year earlier, of a 27-year-old man who had mental illness. The people in Memphis—including the Police Department, the city administration, family members of people who had mental illnesses, and those individuals themselves—were determined to change law enforcement crisis services and to do so within a context of safety, understanding, and dignity. Fifteen years later, the CIT model has proven so successful that similar programs have been established in approximately 50 to 80 diverse communities, cities, and counties around the country. (Cochran, 2004)

In the late 1990s, several communities in Florida began to develop and implement CIT as a response to their community's need to improve police response to people experiencing a behavioral health crisis, to increase officer and consumer safety, and to promote jail diversion whenever possible.

Most communities currently implementing CIT start with a multi-jurisdictional approach that includes the sheriff and local police chiefs. I was directly involved

in developing and implementing CIT in Orange County, Florida, in 1999 with a multi-jurisdictional approach. The CIT program in Orange County consists of the sheriff's office, 11 police departments, and Orange County Corrections. Orange County CIT is in its sixth year, has held 28 training schools, and has trained over 600 deputies and officers.

Challenges of a Multi-Jurisdictional Approach to CIT

Many of the CIT communities acknowledged that not all law enforcement agencies were initially willing to participate in the CIT program. For some counties, engaging all the law enforcement agencies from a multi-jurisdictional perspective has been challenging.

An initial challenge cited has been keeping the local CIT workgroup together. A few key individuals who are known as "champions" are necessary in order to keep focused on the overall goals of the program and the process. It is critical that there are some point people to organize meetings, keep records of meetings, organize the trainings, and manage follow-through with the group.

Another challenge identified is maintaining an adequate number of people and resources to keep the training going. Although most of the trainers volunteer their time, trainers periodically leave, and new ones need to be cultivated. Ensuring that trainers understand the nature of the training and the culture in which they are training is imperative. Also, the 40-hour training can be time intensive for the organizers, trainers, and attendees.

When taking a multi-jurisdictional approach, it becomes apparent that although officers from different agencies are trained together, each agency may be at a different stage of implementation from within. Some agencies will prioritize their CIT officers for call outs, while others have not yet put that type of system in place. Some agencies may still need to write standard operating procedures to identify CIT as a response for mental health calls, and some agencies already have established a follow-up procedure. Some agencies are tracking CIT interventions, while others are not. Working to get all the agencies operating similarly can be difficult. This takes a lot of time, attention, communication, and support.

Change of leadership with top management creates challenges. Obtaining the buy-in and commitment from new leadership is critical. A new leader may not prioritize CIT the same way the previous leader did. Building relationships with new leadership and showing the benefits to CIT is a must.

Other challenges noted include funding for sustainability. Although much of the program consists of donated time by the community partners, there are costs that cannot be overlooked. For law enforcement agencies, there is the cost to send an officer to the CIT training for a week. This may result in overtime pay. Some trainers require payment for their time. Reproduction of materials, CIT pins, and any other items that may help promote the program and the identity of the CIT officer is an expense. Some of these expenses are provided in kind or absorbed within agency budgets; however, not all agencies can afford these items.

In addition, communication is a multi-jurisdictional coordination challenge. It is important that all agencies and community partners are kept abreast of CIT activities, outcomes, and availability of training. Furthermore, getting updated information out to previously trained officers is difficult. It requires each CIT coordinator to be responsible for this communication. There are some communities that have established websites, newsletters, and annual reports as a means to share information.

Many communities have been successful in addressing the challenges and implementing a multi-jurisdictional approach to CIT. They have attributed their success to the following key elements:

- There is buy-in and approval from top management in law enforcement.
- There is a task force/workgroup willing to devote time to the development, implementation, and sustainment of CIT.
- Each law enforcement agency has identified a CIT coordinator for the agency.
- All partners in the development and implementation of CIT contribute to the program (partners include law enforcement, mental health/substance abuse treatment providers, hospitals, county and state government officials, judges, public defenders, state attorneys, National Alliance on Mental Illness (NAMI), other advocacy groups, families, and consumers).
- There is a recognition program to recognize and honor CIT officers.
- There is ongoing inservice training.
- There are regular meetings of the task force to problem solve and ensure that information about CIT is being communicated to top management and the community.
- There are champions who keep the group together and moving forward.

The Formation of the Florida CIT Coalition: A Multicounty Approach to CIT

I became aware of the various communities implementing CIT and wanted to create a forum in which communities could learn from each other, share challenges and successes, problem solve, refine their programs, and help other communities develop CIT. It was also important that the fidelity of the Memphis Model be retained as CIT was expanding in Florida.

Members of Orange County's CIT task force strongly believe that the core elements developed by Memphis are important to its success. As more communities were starting CIT, I had an interest in bringing them together to discuss CIT in Florida. I held a meeting in March 2004 of the 13 counties in Florida that were operating under CIT in order to determine how they were implementing it and to see whether the group could develop a consensus to maintain fidelity to the Memphis Model and create a Florida CIT Model that would respond to the needs of Florida's communities.

The first meeting focused on each CIT community sharing its developments, strengths, weaknesses, barriers, successes, and needs for sustainability. The group also discussed the Memphis CIT model, its core elements, and how the group wanted to proceed in creating a Florida CIT Program based on the Memphis Model. The group agreed that there are certain critical elements that determine the

effectiveness of CIT, and absent these core elements, CIT will be less effective. The group agreed to continue meeting and made its first task the development of the Florida CIT Program.

The group named itself the Florida CIT Coalition and dedicated its first year of organizing to creating an outline of the core elements for the Florida CIT Program, developing the program document, and then obtaining consensus for the program from all members. The process for obtaining consensus on the program document was long and arduous as it required a lot of discussion, the sharing of different beliefs and ideas, working through differing agendas, and then finding the common points on which the Coalition could agree. The Florida CIT Program is a culmination of the entire members' thoughts, ideas, and practices; it takes into consideration urban vs. rural implementation of CIT and allows for flexibility so it can be tailored to communities without losing the fidelity of the core elements.

An overview of the core elements identified by the Florida CIT Coalition for the Florida CIT Program is as follows:

1. Using a Generalist/Specialist Model – Officers are drawn from the patrol officer base and within their general duties as a patrol officer. These selected officers are the ones with the specialized training to respond to crisis calls involving people with mental illnesses, including those with co-occurring substance use disorders.

2. Selection of CIT Officers After Training – Although potential CIT officers should be identified prior to the training, it is after the training that the final selection of CIT officers for the agency CIT team should be made. CIT officers should be patrol officers who volunteer. There should be a selection process to identify those officers with the interpersonal and communication skills that would make them good candidates for CIT. There can be different methods used by different agencies to select CIT officers. Suggested methods for selection may include the following:

    - An application to join CIT
    - Interview to determine motivation
    - Review of personnel file (performance and discipline)
    - Psychological assessment/testing

3. CIT Pin – Officers who are selected to be on the CIT team will be issued agency-authorized CIT pins to wear on their uniforms. The pins establish the identity of the officer as a CIT-trained officer and provide recognition to consumers of CIT-trained officers.

4. Size of CIT Force – The goal of CIT is to have enough CIT-trained law enforcement officers to allow for maximum and adequate coverage 24 hours a day, 7 days a week.

    - Smaller agencies may need to train all or most of their officers to achieve adequate coverage.
    - Generally, it takes several years for a department of any size to develop an optimal number of CIT officers.

5. An Identified CIT Coordinator Within the Police/Sheriff Department – This person is committed to the program with enough authority to oversee the program within the law enforcement department.

    - Ideally, each law enforcement agency with a CIT program has a designated CIT coordinator.
    - The CIT coordinator should be a person who is given the authority to coordinate and oversee the program, as well as ensure maintenance of the program for the agency.
    - Policies and procedures should be implemented to identify who the CIT officers are on each shift, and a call-out process should be developed to ensure that a CIT officer handles the encounter whenever possible.

6. An Identified Mental Health/Substance Abuse Coordinator(s) – This person is committed to the program with enough authority to coordinate and oversee the program from the mental health/substance abuse treatment system side. This coordinator will be actively involved with planning and implementing the training of CIT officers as well as participating in the maintenance of the program.

7. Representation from NAMI, Mental Health Association, or Other Mental Health Advocacy Organizations – These individuals also provide coordination and oversight within CIT from the perspective of family and consumer involvement.

8. Mental Health/Substance Abuse Treatment System That Is Responsive to CIT Officers – This will allow for a smooth transition for CIT officers as they transport individuals for crisis services.

    - The mental health/substance abuse system will receive individuals identified by CIT officers who are in need of crisis services, voluntary and involuntary.
    - A user-friendly "drop-off" process is in place, which provides quick turnaround time for the officer.

9. Policies and Procedures Within Both the Law Enforcement Agencies and Mental Health/Substance Abuse Agencies that Outline the Roles and Responsibilities of Each Party – Where written and mutual agreements are necessary or desirable between and among agencies, this will be accomplished.

10. CIT Training Class Offered at Least Annually Within Existing Resources – The intensive training attempts to provide a common base of knowledge about mental illness and co-occurring substance use disorders and a basic foundation from which officers can build. The program is not aimed at making CIT officers mental health/substance abuse professionals. The program is intended to provide officers with the skills to . . .

    - Understand and recognize signs and symptoms of mental illness, including those with co-occurring substance use disorders, as well as understand how mental illness and co-occurring substance use affects individuals, families, and communities.

- Recognize whether those signs and symptoms represent a crisis situation.
- De-escalate mental illness crises.
- Know where to take consumers in crisis.
- Know appropriate steps in following up on these crises (e.g., contacting case managers or other treatment providers or providing consumers and family members with referral information to mental health/substance abuse treatment agencies or advocacy organizations like the local NAMI and Mental Health Association).

11. Trainers/Presenters Who Are Willing to Learn About Police Work and to Become "Police Familiar" as They Provide Training to the Officers – Trainers/presenters must include mental health/substance abuse treatment professionals, family members of individuals with serious mental illness, individuals who themselves have serious mental illness ("consumers"), and people (preferably experienced CIT officers) who are able to assist in role-playing to help officers develop their de-escalation skills.

    - Each trainer/presenter will develop their lesson plan around the goals and objectives established for each section of the curriculum.
    - The class or school coordinator should meet with trainers/presenters prior to training for coordination and continuity of the materials.
    - Trainers/presenters should be encouraged to go on "ride-alongs" with police officers to experience what it is like walking in police officers' shoes.
    - Trainers/presenters are informed about officer and community safety issues and about the use-of-force continuum used by each law enforcement agency.
    - Trainers/presenters receive an evaluation to obtain feedback and to ensure that the most effective trainers are retained.

12. Periodic Refresher Training, Updates, and Reviews, Provided to CIT Officers – This should occur at least on an annual basis and focus on issues related to dealing with persons with mental illness in crisis, including those with substance use disorders.

13. An Abbreviated Form of CIT Training/Awareness Provided to Dispatch/Phone Call Takers – This will ensure that dispatch personnel are knowledgeable about the CIT program and able to identify probable mental illness and co-occurring substance use disorder crisis calls.

14. Method for Collecting Data and Statistics on CIT Encounters and Their Outcomes – This may involve a tracking form. This information should be shared on a regular basis with CIT officers, upper management, and the mental health coordinator and at any community forum used for mental health system improvement and problem solving.

15. Processes or Systems in Place to Provide Regular Feedback to Both CIT Officers and Mental Health System Providers and Administrators – This is particularly important when problem situations arise. These may include formal and informal mechanisms for sharing information.

16. Regularly Scheduled Meetings of CIT Coordinators, Mental Health Coordinators, Family/Consumer, and Other Key Stakeholders – Such meetings allow parties

to address system concerns, ensure that the program stays on course, and work on growth and sustainability of CIT. These meetings may be conducted through already established groups such as coalitions, task forces, steering committees, advisory groups, etc.

17. Recognition of the CIT Program and CIT Officers – This is strongly recommended, when feasible. This may include an annual appreciation banquet or some other forum for community celebration.

18. Strategies for Maintaining and Sustaining CIT – Communities are encouraged to develop unique strategies for maintaining and sustaining CIT such as newsletters, websites, meetings with other jurisdictions, etc.

Along with the core elements, the Florida CIT Coalition also agreed to a standardized training curriculum to be used that focuses on six broad learning categories:

1. Introduction of CIT
2. Knowledge-Based Topics
3. Legal Issues and Processes
4. Family and Consumer Interaction and Perspective
5. Problem Solving and Skill Building
6. Community Resources

The Florida CIT Coalition hopes to turn its core elements into a fidelity self-assessment tool and lay the groundwork to promote the vision for CIT in Florida—that all communities will have a CIT program based on these core elements.

Upon completion of the Florida CIT Program Document, the Florida CIT Coalition members decided to solidify its identity by developing a mission, goals, and a strategic plan to fulfill its goals.

The mission of the Florida CIT Coalition is to promote the Florida Crisis Intervention Team (CIT) Program Model and encourage its adoption in all Florida communities.

The goals of the Florida CIT program are to . . .

- Better prepare police officers to handle crises involving people with mental illnesses, including those with co-occurring substance use disorders.
- Increase law enforcement officer safety, consumer safety, and overall community safety.
- Collaboratively, make the mental health system more understandable, responsive, and accessible to law enforcement officers to the greatest extent possible with community resources.
  - Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health/substance abuse treatment system.
  - Improve access to mental health/substance abuse treatment in general and crisis care for people who encounter law enforcement personnel.
- Divert people with a mental illness who are in crisis from the criminal justice system whenever possible, which is consistent with the Baker Act or Marchman Act.

The goals of the Florida CIT Coalition are to . . .

- Develop a marketing strategy to introduce CIT to other communities for adoption.
- Provide technical assistance to communities starting CIT.
- Promote additional educational opportunities to CIT programs.
- Institute a state-wide tracking tool for gathering CIT-related data.

Organizationally, the Florida CIT Coalition is a loosely structured group, consisting of representation from law enforcement, behavioral healthcare, consumers and consumer advocates, and state funders actively involved with CIT in their communities. The Coalition meets quarterly. The first part of each meeting is reserved for committee meetings, and the second part of the meeting focuses on reports from committees and determines action items to further the goals set forth by the Coalition. There are two significant outcomes for each meeting: (1) that there is a consensus around the action items recommended and (2) that there is an opportunity for CIT programs to network and learn from each other.

The Florida CIT Coalition has taken a multicounty approach for its development and implementation of CIT in Florida. Florida is made up of 67 counties, and within each county, there is a sheriff's office and multiple city police departments. The sheriff's offices have responsibility for the unincorporated areas of the county, and the police are responsible for the incorporated cities. In most Florida counties, the sheriff's office is also responsible for managing the local jail. The Florida CIT Coalition's plan is to continue to introduce CIT to counties who are not actively engaged and provide technical assistance for their development and implementation. The Florida CIT Coalition will use a multi-jurisdictional approach within each county to maximize inclusion of all law enforcement agencies, strengthen community partnerships, and use limited resources more efficiently. Furthermore, the Florida CIT Coalition will continue to provide a forum for all communities doing CIT as a way to continue to share ideas, strengthen their own program, and assist with statewide implementation of CIT.

The challenges communities experienced with a multi-jurisdictional approach represent a microcosm of the challenges the Florida CIT Coalition faces with a multicounty, state-wide approach for implementation of CIT. Additional challenges the Florida CIT Coalition faces with its intent for state-wide CIT include change of participants in the coalition; marketing to the sheriffs and police chiefs; developing consensus around issues that arise with growth of the Coalition, its goals, and the process to expand CIT; and having resources for technical assistance. Lastly, it should be noted that as the Florida CIT Coalition develops its strategic plan, implementation takes time since all the members are volunteering their time.

Although there are challenges to coordinating the work of multiple jurisdictions and multiple counties for consistent implementation of CIT, the Florida CIT Coalition believes the benefits to this approach outweigh the challenges.

Benefits of a Multicounty Approach to CIT

The benefits of the Coalition include sharing of resources, information, ideas, and best practices for further development and sustainability among existing CIT

communities; providing the ability for officers to move to other communities with established CIT programs and already be trained; improving relationships within communities and across the state among criminal justice, behavioral healthcare, and consumer/family groups; facilitating system changes that include jail diversion; having a group who can advocate legislatively for resources to the CIT program; and having a consistent, standardized CIT program that can be replicated in other communities and hold true to the fidelity of the Memphis Model.

To date, the Florida CIT Coalition has completed its consensus document outlining the Florida CIT Program and developed marketing materials and a plan to market to law enforcement and behavioral healthcare executives, a data tracking process to collect statistics from the various CIT programs that can be used to demonstrate the effectiveness of CIT to law enforcement executives as well as policy makers and funders, and a plan for regional training updates.

The Florida CIT Program is a work in progress as is the work of the Florida CIT Coalition.

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Michele's clinical work has included direct counseling practice in both private and public settings as well as clinical administration for adult and children services in a community mental health system.

Michele is currently the executive director of Florida Partners in Crisis, which is a statewide advocacy organization, comprised of criminal justice, behavioral healthcare, and consumer advocate leaders.

Michele is involved with many community projects including the development and implementation of the Crisis Intervention Team—which is a police-based crisis response model, developing jail diversion programs, and conducting training and educational workshops on mental health issues. Michele chairs the Florida CIT Coalition, a statewide group of CIT communities. She also participates on a number of community committees and coalitions working to improve the service delivery system for people with mental illnesses.

Avoiding Tragedy: CIT Policing

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Introduction

Since the deinstitutionalization of the 1950s and 1960s, law enforcement officials have increasingly become first responders to mental health crisis situations. The increased contact between persons with mental illnesses and untrained law enforcement personnel has often resulted in tragic consequences. For instance, at least 18 persons with mental illness have been injured or fatally wounded by law enforcement in Miami-Dade County, Florida, in the last 7 years. Fatal encounters, nonlethal injury to police officers and persons with mental illnesses, the criminalization of mental illness, and negative media coverage on police departments are but a few of the unintended consequences of escalating encounters between law enforcement personnel and individuals with mental illnesses.

It has been well documented that there is a need for formal law enforcement training on mental illness (Husted & Nehemkis, 1995; Lamb, 1998; Lamb & Weinberger, 1998; McCarthy & Sharp, 2002; Murphy, 1989). Police officers have identified positive effects after receiving crisis intervention training. Both police officers and citizens have rated the handling of crisis calls as more effective as a result of training (Pearce & Snortum, 1983). As a result, addressing the increase in contact between law enforcement and persons with mental illnesses has recently become a priority for numerous communities (Bower & Pettit, 2001; Cochran, Deane, & Borum, 2000; Deane, Steadman, Borum, Veywey, & Morrissey, 1999; Hill et al., 2004; Reuland, 2004).

In Florida, Miami-Dade County has responded to this problem by implementing Crisis Intervention Team (CIT) policing. The following sections will provide an overview of CIT, highlight the local and national need for CIT, and discuss CIT in a large urban community. Additionally, a guideline for implementing CIT programs will be provided.

Need for CIT

It has been estimated that 17 million adults in the United States suffer from a serious mental illness (SMI) (Substance Abuse & Mental Health Services Administration, 2005), and approximately 3% have a severe and persistent mental illness (SPMI). Yet, national studies indicate that less than half of individuals with a mental illness seek treatment (National Institute of Mental Health, 2005). At the local and state levels, data indicates that almost 8% (7.94%) of Florida residents suffer from SMI (Substance Abuse & Mental Health Services Administration, 2005), while 9.1% of Miami-Dade County residents have SPMI. This means over 200,000 of the population in Miami-Dade County are seriously impaired with severe and persistent mental health disorders. As a result, Miami-Dade County appears to be one of the largest urban communities with the highest percentage of people suffering from mental illnesses in the United States.

It has been noted that many individuals with mental illness when left without adequate treatment eventually enter the criminal justice system (Lamb, 1998; Lamb & Weinberger, 1998; Lee-Griffen, 2001; Sigurdson, 2000). The prevalence of mental illnesses in correctional settings has been rising steadily since deinstitutionalization

occurred. For instance, the number of people with mental illnesses in jails more than tripled between 1955 and 1984. According to a national jail census, mental illness in jail has increased by 119%, and 15% of all individuals in jails have a major mental disorder (Walsh & Holt, 1999). In fact, Florida jails house five times more persons with mental illnesses than Florida psychiatric hospitals.

In Florida alone, law enforcement officers initiate 34% more involuntary psychiatric examinations than arrests for Driving Under the Influence (DUI) (Miami-Dade County Grand Jury, 2005). Additionally, approximately 100 cases per day are sent by police officers to psychiatric emergency rooms for involuntary examination in Miami-Dade County alone (Miami-Dade County Grand Jury, 2005). In fact, records from a local police department in Miami-Dade County indicate that over 3,000 calls related to mental health were dispatched in a one-month time period. On a local level, it is currently estimated that 20% of the inmates in the local jail have a serious mental illness. Additionally, they tend to remain in jail eight times longer, and at a cost seven times greater, than individuals without mental illnesses who are arrested for the same offenses.

Overview of CIT in Miami-Dade County

In 2000, the Eleventh Judicial Circuit of Florida's Criminal Mental Health Project (CMHP) undertook the monumental effort of transforming the relationship between the mental health system and the criminal justice system in Miami-Dade County. Based on the Memphis CIT Model, CIT in Miami-Dade County aims to prevent persons with mental illness from entering the criminal justice system by improving access to appropriate community treatment services. CIT originated in Memphis, Tennessee, after an unnecessary fatal encounter occurred between police and a person with mental illness (Jamieson, 2000). CIT in Memphis significantly reduced police injuries and the time it takes officers to return to patrol. Additionally, CIT was found to reduce the arrest rate of individuals with mental illness and recidivism among these individuals (Jamieson, 2000).

Other positive outcomes have also been associated with the use of CIT. For instance, increased access to mental health treatment intervention has been linked to persons with mental illnesses served through CIT (Bower & Pettit, 2001; Teller, Munetz, Gil, & Ritter, 2006). Local statistics from one police department suggest 88% of the mental health related calls answered by CIT resulted in diversion to a treatment facility instead of arrest (Rivers, 2005). In addition, a decrease in police-related killings involving persons with mental illnesses has been associated with the use of CIT (Bower & Pettit, 2001). The benefits of using CIT have also been documented at the local level. For example, in the past 2 years, the City of Miami Police Department responded to over 7,200 calls involving persons with suspected mental illnesses without once resorting to the use of lethal force. This same department experienced a remarkable period of 22 months during which not a single officer discharged a firearm in the line of duty.

CIT is made up of uniformed police officers who receive special training on how to deal with individuals who may be in crisis due to mental illness. Instead of taking individuals in crisis to county mental health facilities, police officers without the proper training often arrest them, thus leading them into the revolving door of the criminal justice system or worse, escalating the situation into a violent encounter. CIT requires that trained officers respond to calls for law enforcement that may

involve persons with mental illnesses. Once at the scene, CIT officers evaluate the situation and, if needed, de-escalate and transport individuals suffering from a mental illness to appropriate mental health facilities for evaluation, treatment, and referrals, instead of subjecting them to immediate arrest.

In keeping with the Memphis model, CIT officers are volunteer patrol officers who offer 24-hour coverage for their jurisdiction. Officers go through a department screening process before they begin CIT training. It has been found that good problem-solving, tactics, and communication skills are essential in CIT candidates (Bower & Pettit, 2001). CIT officers complete a 40-hour course, which includes sessions on mental illness, substance abuse, psychotropic medication, civil commitment law, patient rights, and nonlethal techniques for crisis intervention (Cochran et al., 2000). Although CIT curricula are specific and may vary from site to site, the core aspects of training should be included. Interactive components to training—which include role-playing exercises; interaction with consumers, families, and advocates; and visits to local crisis stabilization facilities—are also incorporated.

The Eleventh Judicial Circuit of Florida's CMHP collaborates with community partners to coordinate CIT trainings for law enforcement agencies in Miami-Dade County. Training is provided free of charge and is overseen by the CIT training coordinator employed by the CMHP. Instructors consist of volunteer agencies and experts from the local community. In addition to the 40-hour CIT course, the CMHP coordinates a variety of other educational activities in the community including update training, training for call dispatchers, and training for crisis negotiators.

Guidelines for Implementing CIT

There are three core components associated with CIT that need to be remembered in the planning stages of a new CIT initiative. They include training, law enforcement partnerships with community mental health resources, and implementation of a new role for police (Reuland, 2004). Ten guidelines for the implementation of CIT in other communities are offered below:

1. *Identify a problem in your community.*
   The problem in Miami-Dade County was identified by examining the relationship between the existing criminal justice system and persons with mental illnesses. The Eleventh Judicial Circuit undertook the task of reviewing and reforming how the Miami-Dade community dealt with individuals entangled in the criminal justice system due to mental illness and substance abuse. The key was intersystem communication. This was facilitated by securing a small grant from the GAINS Center to help facilitate a meeting of traditional and nontraditional stakeholders. Stakeholders included the following: the Eleventh Judicial Circuit County Courts, State Attorney's Office, Public Defender's Office, various local police departments, local community hospitals, public community mental health centers, local and state governmental departments in charge of implementation and funding of local social services, local government officials focusing on the homeless problem, and the National Alliance for the Mentally Ill.

   The GAINS Center helps communities identify gaps in services and develop integrated approaches. They provide target technical assistance through the use of national experts and a comprehensive database for access to research, innovative programs, and other resources. Additionally, the GAINS Center helps to foster

new policies on key issues affecting the treatment and management of people with mental health and co-occurring disorders in the criminal justice system.

2. *Set community goals.*
   Once the problem was identified, goals were set for CIT in Miami-Dade County. These goals include improving public safety, saving critical tax dollars, reducing police and civilian injuries, saving lives, reducing recidivism to jails, and improving access to mental health treatment for persons with mental illnesses.

3. *Decide how CIT will work in your community.*
   Most communities adapt CIT to their jurisdiction's particular conditions and circumstances. For instance, it is important to use a centralized drop-off site for CIT police officers to bring individuals in need of psychiatric evaluation and treatment (Deane et al., 1999; Steadman et al., 2000); however, agencies must first identify the availability of mental health services in their community. In some instances, creative approaches will be necessary to meet the need for mental health services when they are lacking (Reuland, 2004). In addition, standard operating procedures are modified by agency.

   Training curricula have also been adapted to fit agencies' particular needs. The core aspects of CIT are maintained, but agencies have the freedom to tailor lesson plans, choose appropriate topics, and determine the length of training. Additionally, agencies also identify the target audience for training and can select trainers representing a variety of community stakeholders. For example, CIT training in Miami-Dade County has been offered to police dispatchers, correctional facility staff, and university-based police departments.

4. *Obtain law enforcement commitment.*
   Resistance to implementation of CIT by law enforcement has been credited to historically poor encounters with persons with mental illnesses (Reuland, 2004). Misconceptions about mental illness and traditional beliefs that law enforcement's role is not one of social work have also served as obstacles to CIT. Setting goals that are consistent with those of law enforcement, such as improving public safety, can align CIT with the traditional philosophy of police. In addition, demonstrating CIT's successful outcomes can help to improve confidence in the program (Reuland, 2004); therefore, it may be easier to get law enforcement to commit to a pilot program before full community-wide implementation can occur. The involvement of officers, police unions, and police administration in CIT development has been shown to improve acceptance (Reuland, 2004).

5. *Obtain commitment from mental health community service providers, advocates, consumers, families, and other stakeholders.*
   The relationship between mental health service providers, the mental health community, and law enforcement is a vital component of a CIT program. Developing a strong working relationship among all parties can be a challenge. Distrust and misconceptions about each stakeholder's philosophies and roles have proven to work as obstacles; however, mental health community involvement in the planning stages of CIT can improve communication between all.

   In Miami-Dade County, mental health community and service provider stakeholders were invited to join the first and all subsequent roundtable

discussions with law enforcement, the judiciary, correctional personnel, and other nontraditional stakeholders. Opening the lines of communication between mental health and law enforcement helped in overcoming previous misconceptions. Focusing on common goals, such as diverting persons with mental illnesses from the criminal justice system to the mental health system, fosters the beginnings of a strong working relationship.

Statistical information and cost analysis of the problem can assist in securing commitments not only from law enforcement but also from other stakeholders. For instance, CMHP conducted a cost analysis of services utilized by 31 jail recidivists in Miami-Dade County. It was found that local and state governments and the judiciary were spending over half a million dollars combined to incarcerate and provide emergency psychiatric treatment to this population for just one year. In addition, this was an underestimation of the true costs. This summary of costs does not include police time, court costs, ambulance services, mental health outpatient services, involuntary service treatment costs, substance abuse treatment services, or administrative costs associated with these services.

6. *Get input from existing programs.*
   Studying successful CIT programs in other communities before implementing one in your community has proven to enhance success (Bower & Pettit, 2001). Also, avoid costly mistakes by obtaining valuable input from existing programs. For instance, some programs have noted the importance of involving advocacy groups in the planning and implementation phases of a new CIT. Others have emphasized the importance of partnering with mental health service providers (Reuland, 2004). In 1999, only 3% or five urban police departments in the United States had a CIT program. By 2004, the number had grown to 28 police agencies (Reuland, 2004). The trend appears to be growing across the country as more police departments adopt CIT.

7. *Recruit CIT officers*.
   Every police agency has the option to implement its own recruitment process for CIT; however, some successful programs have noted important elements to consider when recruiting new officers for CIT. Many agencies have stressed the importance of using volunteer officers (Bower & Pettit, 2001; Cochran et al., 2000). The CIT officer should possess a genuine interest in serving the mental health population and be sensitive to its needs. It takes a special kind of officer with good communication and problem-solving skills to succeed as a CIT officer. After the selection process has been completed, some agencies have offered a financial incentive. For example, the City of Miami Police Department compensates active CIT officers with a 2% pay increase.

8. *Commence training.*
   Once CIT officers have been chosen, training must begin. The development of a strong curriculum ensures that proper training is provided to CIT officers. Instruction on the general signs and symptoms of mental illness, substance abuse, psychotropic medication, civil commitment law, patient rights, and nonlethal techniques for crisis intervention need to be included. Again, after inclusion of the core elements of training, the specific curriculum can be tailored to fit particular agency and community needs. For example, CIT training in Miami-Dade County encompasses the following additional areas: assessment

of suicidality, effective communication techniques, mental health issues for children and adolescents, community resources, and tactical deployment of CIT. Role play exercises, interaction with consumers and their families in a forum, and tours of the local jail's psychiatric area and local psychiatric emergency stabilization facilities are also included in training.

9. *Get information to the public.*
   Dissemination of information to the public is essential to the effectiveness of CIT. The public needs to be made aware that CIT exists. Public relations campaigns should include a description of the local CIT program and instruct the community on how to access CIT and when it is appropriate to use CIT.

10. *Maintain community relationships.*
    Maintaining strong relationships with all stakeholders is the essence of maintaining a successful CIT program. Without the cooperation of the mental health community, law enforcement, the judiciary, and advocates, CIT efforts will prove fruitless. Relationships essential for CIT in Miami-Dade County continue to be strengthened by using effective open communication. Regularly scheduled meetings are held between all stakeholders. Roundtable discussions in which problems, concerns, and successes are debated continue to be utilized. Finally, an annual awards luncheon brings together everyone involved and honors those who have demonstrated exemplary service and commitment to the program.

Conclusion

It has been documented that training for law enforcement improves encounters between police and persons with mental illnesses. CIT programs have been implemented across the country in response to fatal encounters between police and persons with mental illnesses. They have been shown to decrease recidivism to jails, decrease arrest rates, improve officer and civilian safety, improve officer efficiency, and improve access to mental health treatment services. Implementation of such programs improves communication and working relationships across systems, and has the potential to break down barriers between law enforcement and the mental health community. CIT in Miami-Dade County has proven to be effective and continues to demonstrate that law enforcement and the mental health community can work together to improve the lives of individuals suffering from mental illnesses.

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The Illinois CIT Initiative

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The Illinois Statewide CIT Initiative

Police officers have a long history of responding to calls involving individuals with a mental illness (Borum, Deane, Steadman, & Morrissey, 1998; Bittner, 1967; Cumming, Cumming, & Edell, 1965; Finn & Sullivan, 1988, 1989; Teplin & Pruett, 1992). Given the changes in social context and public policy, law enforcement contact with individuals with mental illness has become more frequent (Gillig, Dumaine, Stammer, Hillard, & Grubb, 1990). Law enforcement agencies across the nation have responded to this issue by developing specialized response teams (Deane, Steadman, Borum, Vesey, & Morrissey, 1999).

One such specialized response team, the Crisis Intervention Team (CIT) program, was developed in Memphis, Tennessee, in 1988. CIT programs utilize specially trained officers to respond to calls involving individuals with a mental illness (Dupont & Cochran, 2000). Recent studies have indicated that when CIT is implemented in a law enforcement agency, officers feel more comfortable handling mental health calls (Borum et al., 1998), officer injury rates decrease, arrest rates for individuals with a mental illness decrease, callout rates to tactical teams decrease, and referral rates to emergency mental healthcare increase (Dupont & Cochran, 2000). Based on these proven positive outcomes, the Illinois Law Enforcement Training and Standards Board (ILETSB) began the statewide CIT initiative in May of 2003 with the implementation of the Central Illinois Crisis Intervention Team, consisting of the Springfield Police Department and the Sangamon County Sheriff's Department. Building on the success of this team, ILETSB has developed and implemented a total of 12 CIT programs in key areas of the state, as well as two pilot projects in the Chicago Police Department. Of these 12 programs, 11 are multi-jurisdictional. The current teams are operating out of 63 departments with over 700 state-certified CIT officers. Although there are numerous CIT programs in existence nationally, the ILETSB initiative is unique in that it was planned as a statewide effort.

Program Site Selection

Traditionally, CIT programs are adopted by a single department. Because of the size of many law enforcement agencies in Illinois, it is often more effective to develop multi-jurisdictional teams. The communities for the 12 programs were selected based on a number of factors. An interest in developing and maintaining a CIT program was an essential element. After interest in the program was expressed in an area, some other considerations included number, size, and geographic proximity of the interested departments, availability of resources, and commitment of command staff.

Officer Selection

A key element in the effective operation of a CIT program is the CIT officers themselves. Departments who have established CIT in the past have reported that it is essential that the officers on the team volunteer. The departments involved in the ILETSB initiative vary in their officer selection process. Some departments choose to send out a memo to all sworn personnel explaining CIT and inviting letters of interest. The command staff then selects officers from the pool of volunteers. Other departments utilize a less formal approach when selecting officers and rely on supervisory staff to identify officers with the skills and traits appropriate to the assignment.

Some characteristics sought in CIT officers include patience, empathy, effective communication skills, and the ability to work productively with other agencies to resolve issues. It is interesting to note that many volunteer officers have experienced mental illness in their family or among their friends.

The long-term goal of each program is to have 20% to 25% of their sworn patrol force certified as CIT officers. The first offering of the CIT training is rarely able to meet this goal; however, as additional courses are offered to existing teams, the number of CIT officers increases significantly.

CIT Task Force

In each CIT area, the first undertaking is the establishment of the CIT Task Force, which brings key leaders of the community into the development process of the program. At a minimum, the task force is composed of law enforcement agencies, mental health service providers, the local NAMI affiliate, and the mobile training unit. Some areas have opted to include other entities such as the telecommunications supervisors, the fire department, and the emergency room administrator from the local hospital.

The function of the task force is to assist the CIT coordinator in developing the team in a way that will work for each particular area. The task force assists in identifying the training needs of the involved law enforcement agencies; identifying local instructors; developing the policies, procedures, and protocols for the team; and identifying any obstacles or barriers that might hinder the smooth operation of the team. Additionally, once the training is complete and the program implemented, the task force continues to meet on a periodic basis to resolve any emerging issues and plan ongoing training or other activities necessary for the successful continuation of the team.

Collaborative Efforts

To be successful, it is important that a CIT program have the full support of the community and involved agencies. The collaborative efforts of these agencies have led to the resolution of issues that were making it difficult for officers to effectively and appropriately handle calls involving individuals with mental illness and to the modification of policies and procedures at social service agencies to become more police friendly.

For example, one area's law enforcement officers were required to wait in the emergency room with individuals they had taken into protective custody for the purpose of an emergency mental health evaluation until the individual could be seen by a mental health professional. The time this required created a burden on the officer and the department. In some cases, officers were forced to take an individual to jail, as manpower issues precluded the officer from utilizing the preferred disposition of transporting the individual to the hospital. As a result of the CIT initiative, the mental health center created a drop-off site on the grounds of the hospital where officers can bring individuals in need of an emergency evaluation. The drop-off site is staffed with crisis workers; therefore, the officers are no longer required to wait for long periods of time.

In another area, officers were not allowed to bring individuals directly to the emergency room of their local in-patient mental health facility. Instead, officers were required to transport individuals to their police station until such time that a crisis worker from the community mental health center could evaluate the individual. This sometimes took two to three hours on overnight shifts, weekends, and holidays. Through the work of the CIT Task Force, the hospital agreed to accept individuals into the emergency room solely on the emergency petition of a police officer. This eliminated the need to hold someone who is already in crisis at the police station, taking the unnecessary risk of exacerbating someone's symptoms or escalating aggressive behavior. This also decreases the chance of officer/consumer injury and police department liability.

After CIT officers complete their training, they create opportunities to interact with mentally ill individuals when they are not in a crisis situation. Officers may attend community meetings at local mental health centers. This gives the officers and consumers a chance to meet in a safe environment, as opposed to a crisis situation. The officers meet the actual person, not the illness. The consumers are able to build trust with the officers and also learn to recognize the CIT officers by the blue CIT pin the officers wear on their uniform. CIT officers can also present to community groups, neighborhood watch groups, or business groups to educate them about the CIT program and mental health issues in their community.

CIT Training

To date, ILETSB has completed 27 CIT trainings. The CIT training is a one-week/40-hour block of instruction. Topics covered include mental illness recognition, substance abuse and co-occurring disorders, geriatric issues, child and adolescent disorders, psychotropic medications, homelessness issues, developmental disabilities, risk assessment, and crisis intervention skills.

In addition to the previously mentioned training units, students also participate in a variety of valuable exercises. In one such exercise, each student is provided with a personal cassette player with headphones. The officers listen to a tape playing "voices" that simulate the auditory hallucinations that some individuals with a mental illness may experience. While listening to this tape, students rotate through a series of workstations where they are required to perform a cognitive task. This exercise allows students to gain insight into what an individual who is psychotic might experience. This also helps officers understand an individual's decreased ability to focus when interacting with a police officer.

Each student has a unique opportunity to participate in panel discussions with individuals who have a mental illness and their family members. Panel members share their personal experiences and are able to explain to officers what their needs are in a crisis situation. Panel members are able to relate to officers what has and has not been helpful in their interactions with law enforcement in the past. Officers also learn that information gained from family members on a CIT call can be an invaluable asset. Students are then able to ask questions of panel members.

Site visits to area mental health service agencies are arranged for officers during the week of training. Students visit their area agencies in small groups and are able to meet staff, learn about available resources, and become familiar with the procedures of referring an individual for services. Because of the geographic size of some areas, it is sometimes necessary to divide the class geographically so that students visit the agencies that they are most likely to access.

On the last two days of training, students spend a total of 6 hours in scenario-based skills training. Officers are given factual scenarios that include suicide interventions, de-escalating a potentially violent situation, responding to a call involving an individual experiencing paranoia, and interacting with an individual in a manic episode who is behaving in an inappropriate manner. Role players are professional actors who have been trained in crisis intervention skills. All scenarios are facilitated and evaluated by instructors in the mental health field and certified CIT officers.

CIT in Rural Communities

Prior to December of 2005, the ILETSB CIT programs were developed primarily in metropolitan areas. Nationally, there is little precedent for CIT in less densely populated rural areas. Because of the large number of rural communities in Illinois, the ILETSB began exploring the possibility of implementing a CIT program in a rural area of the state in August of 2004. Due to the small number of law enforcement officers in these communities, it was decided that, for the first time, ILETSB would join law enforcement agencies from several counties together to form a rural regional team. The counties of Bond, Clinton, Marion, and Washington in the southwestern region of the state were selected to participate in the first rural CIT program in Illinois, the Southwestern Illinois Regional Crisis Intervention Team (SWIRCIT).

Developing the program in a rural area did present some unique challenges. For instance, it was more difficult for command staff to leave their jurisdiction to attend task force meetings, as that would often mean their department would be under minimum staffing levels. To overcome this obstacle, ILETSB staff met with these respective chiefs and sheriffs at their location to provide them with information from the task force. Also, with the limited number of officers in each department, it was more difficult to send officers to the required 40-hour training. In order to ensure that the region has an adequate percentage of CIT-certified officers, a second training will be provided this year. Other issues that needed to be addressed by the task force included a limited number of mental health service providers available for referrals, lengthy travel times to hospitals, and the absence of security staff in some emergency rooms, which was making it necessary for officers to wait for long periods of time while individuals were being assessed.

Currently, there are nine law enforcement agencies participating in the SWIRCIT. By the end of the year, six more departments will join the team, and the number of trained officers will double.

The Future of CIT in Illinois

In the first and second years of the CIT initiative in Illinois, there was a strong focus on the development and implementation of new teams. The focus in the third year has slightly shifted to expanding and strengthening the existing teams by adding new departments to the current teams and providing additional offerings of the certification course in order to increase the percentage of CIT officers in each department. Looking toward the future, ILETSB is currently working with several new areas on the development of a CIT program, with the goal of implementing the new teams next year.

Implementing CIT on a statewide level is a unique situation and creates unique opportunities. In order to build upon the strong foundation that has been provided for the current teams and to encourage continuity throughout the state, it is necessary to develop a support infrastructure. The first annual CIT conference is being planned and will continue to be held on a yearly basis. This conference will provide additional training to officers, as well as a forum to exchange ideas and techniques. Other future plans include the creation of a newsletter to provide current news and information and the development of a website.

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Law Enforcement and Mental Health Professionals: A Collaborative Approach to Training

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Introduction

Deinstitutionalization, insufficient outpatient funding, and tightening of criteria for civil commitment of persons with mental illness have contributed to an increase in the number of contacts between individuals with mental illness and law enforcement (Appelbaum, 2000; Keram, 2005; Lamb, Weinberger, & Gross, 2004; Patch & Arrigo, 1999; Pinals & Price, 2004; Price, 2005; Teplin & Pruett, 1992). The release of persons from state hospitals in the late 1960s and 1970s is viewed as heralding this change.

Police officers often find themselves in the position of being the first and sometimes the sole community resource called upon to respond to crisis situations involving citizens with emotional disturbances (Lamb et al., 2004). As a reflection of this growing responsibility, police have been termed "de facto mental health providers" (Patch & Arrigo, 1999), "streetcorner psychiatrists" (Teplin & Pruett, 1992), and "frontline mental health workers" (Green, 1997). In 1969, Liberman commented that the police would continue to serve a role in the care of persons with mental illness as long as there were gaps in community treatment approaches, a situation that unfortunately still exists today.

Deane, Steadman, Borum, Veysey, and Morrissey (1999) conducted a survey of medium and large police departments in 194 U.S. cities with populations of at least 100,000 people. They found that 7% of police contacts (encompassing both investigations and complaints) concerned persons thought to have a mental illness. Sixty to 92% of officers reported responding to at least one mental health crisis call per month (Borum, Deane, Steadman, & Morrissey, 1998; Gillig, Dumaine, Stammer, Hilliard, & Grubb, 1990), and between 42% and 84% said that they had responded to more than one such call in the same time period. The study of officers in three U.S. cities by Borum et al. (1998) revealed that officers reported averaging six calls per month involving persons with mental illness who were in a crisis.

The prominent role that officers play is further reflected in the percentage of referrals for psychiatric emergency services that are made by police. In this regard, Redondo and Currier (2003) noted that 26% of patients evaluated by the psychiatric emergency service of the University of Rochester Medical Center were brought in by police. Police interact with persons with mental illness more than any other occupational group with the exception of mental health professionals (Kadish, 1965). Studies

have demonstrated that arrests of homeless persons and those discharged from psychiatric facilities are all too common (Belcher, 1988; Lamb & Lamb, 1990).

Officers have been required to assume the position of primary gatekeepers for the criminal justice and mental health systems. They must recognize an individual's need for treatment and divert that person to an appropriate mental health facility or make the determination that the individual's illegal activity is the primary concern and arrest that person. (Lamb & Weinberger, 1998; Patch & Arrigo, 1999). Unfortunately, this task is typically accomplished with insufficient training in mental health issues.

Police officers appear to be responding to the changing reality. A survey of police officers attending training sessions that were conducted by Vermette, Pinals, and Appelbaum (2005) indicated that police officers expressed interest in training about interacting with persons with mental illness, and officers considered their interactions with persons with mental illness to be an important aspect of their job. Over 90% of respondents reported that mental health training was either fairly or very important, and 68% preferred yearly training. Over half of the police officers had volunteered to attend, which would suggest an appreciation of the applicability of the subject matter.

Police officers in southwest Scotland were found to have a good knowledge base concerning mental illness (Carey, 2001). The officers in this sample accepted that mental illness was common, that there was effective treatment available in the community, and that patients were at greater risk of harm than others; however officers felt that they had not received sufficient training and were eager for more.

Cotton (2004) found that most of the Canadian police officers in her sample accepted their expanded role in working with individuals with mental illness. Officers viewed their interactions with persons with mental illness as a function of their jobs and in keeping with a community policing approach. As such, respondents to this study felt that they should receive specialized training. These attitudes appear to be in keeping with the shift from the traditional law enforcement model to one encompassing a community policing model that embraces a problem-solving orientation and the use of community partnerships to accomplish operational objectives (Borum, et al. 1998; Dupont & Cochran, 2000).

A Collaborative Approach to Training

Limited Access to Mental Health Training

With the change to a community policing approach, one might have expected that departments would encourage the development of mental health training programs; however, many departments still do not offer specialized mental health training and their patrol officers generally receive little post-academy mental health training despite being most likely to encounter situations involving persons with mental illness. California law enforcement agencies that were surveyed in 1995 about the extent of their mental health training indicated that the average number of hours devoted to this subject in the academy was 6.3. Moreover, only 83 out of 158 agencies provided post-academy mental health training (Husted, Charter, & Perrou, 1995).

Although one could argue that increased attention to mental health training for law enforcement officers has ameliorated the situation in the last 10 years, Cotton's (2004) survey of police officers of three different police forces in Canada revealed that agencies had failed to devote significant time or resources to mental health issues. There was a failure to incorporate specialized training for officers or develop a dedicated mental health program. Officers had been given only a brief one-hour inservice session, but there was no failure by officers to recognize the importance of expanded training. Senior officers identified mental health as an area of concern. In addition, officers expressed interest in obtaining more information about working with and understanding individuals who are mentally ill. Police colleges in Ontario had provided a brief exposure to mental health subjects, but unfortunately, only a few departments in large metropolitan areas had followed this up with further extensive training (Cotton, 2004). On a brighter note, however, 73% of the Massachusetts police officers in Vermette, Pinals, and Appelbaum's study (2005) who were attending a specialized mental health training had already previously attended at least some post-academy training.

Management of Persons with Mental Illness and Associated Training: Policy Considerations

Many law enforcement departments not only provide limited specialized mental health training but also lack a formal policy for dealing with persons with mental illness. Most departments do not have specialized mental health teams to respond to calls. Deane et al. (1999) found that 55% of the 194 departments with populations of over 100,000 that were surveyed lacked a specialized response for handling incidents involving persons with suspected mental illness or emotionally disturbed persons (EDPs).

Those departments that have adopted a formal policy or procedure have used one of three models in crafting a specialized response to handling calls involving EDPs (Borum, 2000; Deane et al., 1999; Dupont & Cochran, 2000). These models or strategies have been described based on the agency responsible (i.e., police- or mental-health-based) and the primary discipline of the responder (i.e., specially trained police officer or mental health professional) (Borum, 2000; Cordner, 2000; Deane et al., 1999; Dupont & Cochran, 2000; Pinals & Price, 2004). Models include a police-based specialized police response, a police-based specialized mental health response, and a mental-health-based specialized mental health response. The time devoted to training and the type of training offered by a department is often related to the strategy the department has selected in dealing with persons with mental illness (Deane et al., 1999; Price, 2005).

Officers in departments using a police-based specialized police response receive very intensive specialized training because of their expected role. This strategy involves having sworn officers with this specialized mental health training provide crisis intervention services and act as liaisons to the formal mental health system (Deane et al., 1999). Deane et al. (1999) found that only 3% of departments used this approach. The Memphis Crisis Intervention Team (CIT), which was started in 1998, uses this strategy. CIT officers would usually comprise about 15% to 25% of patrol officers and receive about 40 hours of training that focuses on scenarios derived from actual incidents. Officers receive extensive training in de-escalation techniques (Dupont & Cochran, 2000). This approach may be less feasible in small departments where all officers must have similar skills in order to be able to cover the work of the department.

The second approach, a police-based specialized mental health response, was used by 12% of the departments (Deane et al., 1999). Mental health consultants, who are not sworn officers, were hired by the police department to provide on-site and telephone consultation to officers in the field (Deane et al., 1999; Pinals & Price, 2004).

The third scheme, a mental-health-based specialized mental health response was used by 30% of the departments. This strategy involved reliance on mobile crisis teams that function as mobile crisis units. The teams are usually associated with the local community mental health centers or public agencies whose mission is to provide evaluations, treatment, and triage decisions at all hours. The teams foster relationships with the local police departments to provide assistance on the scene (Deane et al., 1999; Pinals & Price, 2004). For this model to work best, Lamb, Weinberger, and DeCuir (2002) cautioned that the mental health professionals assigned to mobile crisis teams need to be attentive to the limits of their expertise and not try to act as police officers. This model has the advantage of having mental health professionals available as crisis situations are occurring. Ideally, it requires ongoing collaborations; careful role delineation for management of crises, such as hostage negotiation scenarios; and parameters for allowed interagency communication.

When officers operating in departments using different schemes were compared, the crisis intervention officers in departments using the police-based specialized police response reported feeling the most prepared to handle calls involving mentally ill persons in crisis (Borum et al., 1998). These officers had volunteered for their position and generally received the most comprehensive specialized training. This finding indicates that this intensive training and preparation can improve officers' comfort and confidence in responding to mental health emergencies.

Teller, Munetz, Gil, & Ritter (2006) evaluated the experience of the Crisis Intervention Team in Akron, Ohio and illustrated that training can also result in changes in disposition. Since the initiation of the training, there had been an increase in the absolute number as well as the proportion of calls involving individuals with suspected mental illness and an increased rate of transport by CIT-trained officers of these individuals to emergency treatment facilities. There was also an increase in transport on a voluntary status but no significant changes in the rate of arrests by time of training. An earlier study by Steadman, Dean, Borum, & Morrissey (2000) revealed that all three approaches resulted in a relatively low arrest rate when a specialized response was made.

Goals and Advantages of Specialized Mental Health Training

Improving Interaction with Persons with Mental Illness

There are numerous benefits to providing at least some basic mental health training to all officers who interact with individuals with mental illness, which, according to anecdotal reports and the available scientific data, would include all patrol officers and senior level officers. It would be unreasonable and inappropriate to suggest that such training would allow officers to make formal diagnoses or treatment recommendations for persons with mental illness; however, mental health training can assist officers in identifying symptoms of mental illness and suggest approaches for managing persons with mental illness when encountered in routine

police work. This training can improve an officer's decision-making ability when faced with the choice of arrest for a minor crime versus diversion to the mental health system, especially if the training includes current information about local mental health services. It has been suggested that the lack of collaboration between law enforcement officers and mental health professionals has contributed to the criminalization of persons with mental illness (Teller et al., 2006).

Training in de-escalation techniques can serve to improve communication between officers and persons with mental illness and lead to safer handling of violent or potentially violent encounters. Several researchers have posited that the training would decrease the risk of harm to officers and persons with mental illness (Borum, 2000; Fyfe, 2000; Price, 2005). De-escalation training would assist officers in managing a person who is threatening suicide. Training would also provide guidance in identifying and gaining access to available community resources (Price, 2005).

Altering Attitudes and Combating Negative Stereotypes

It is important that training programs are designed with the aim of altering attitudes about persons with mental illness. A nationwide study conducted in 1999 investigated the experience of 1,301 persons with mental illness who had responded to a newsletter of the National Alliance for the Mentally Ill (NAMI) or had been solicited by members of NAMI's consumer council. Nearly 80% of subjects had direct experience with stigma and discrimination in a variety of situations including within their communities, their families, their churches, the work environment, and even the mental health treatment setting. Respondents reported attempts to conceal knowledge of their disorder from others. They worried about the effect that disclosure of their psychiatric status would have and feared being treated unfavorably. Public education was recommended as a strategy for reducing stigma (Wahl, 1999).

In 1999, a study by Link, Phelan, Bresnahan, Stuere, and Pescosolido noted that 75% of the general public perceives that persons with mental illness are more dangerous. Kimhi et al. (1998) demonstrated that police also share this attitude. Police officers may have this attitude because they interact with persons with mental illness during a crisis situation. Using vignettes, Watson, Corrigan, and Otari (2004a) found that police viewed persons described as having schizophrenia as more dangerous compared to persons for whom no information regarding mental illness was provided.

Redondo and Currier (2003) studied the characteristics of persons referred to the emergency room. They noted that there were differences between persons referred by police to a psychiatric emergency room and persons referred by other sources. They found that persons referred by police were significantly more likely to be male, to have been referred because of violent behavior, to exhibit violent behavior in the emergency room, and to have a lifetime history of violence. In addition, persons referred by police reported having more severe psychosocial stressors and spent more time in the emergency room than did those referred by other sources. Patients referred by the police, however, were not more likely to be admitted to inpatient psychiatric units.

Corrigan et al. (2003) studied perceptions of discrimination by 1,824 persons with serious mental illness who were recruited from community mental health centers. They found that 37.7% of the study participants reported discrimination due to their mental disability. One of the areas in which discrimination was frequently identified

included interactions with police. The researchers recommended targeting police for intervention because discrimination by officers was especially problematic for persons with mental illness (Corrigan et al., 2003; Corrigan, Watson, Warpinski, & Gracia, 2004).

Cotton (2004), on the other hand, found that police held a more progressive opinion of persons with mental illness compared to the general public and favored more tolerance by society. Very few officers in their sample favored the isolation of mentally ill individuals from society. There was support for the therapeutic value of the community, the importance of integrating persons with mental illness into normal neighborhoods, and a general acceptance of the principle of deinstitutionalization.

While there is often a focus on police officer encounters with persons with mental illness during a psychiatric crisis, training also promotes effective communication during other types of interactions. Persons with mental illness can also be victims or witnesses. Studies have shown that persons with mental illness are, in fact, more likely than others to become victims of crime (Marley & Buila, 2001). They are twice as likely to be subject to harassment in the community (Berzins, Petch, & Atkinson, 2003). Because of negative stereotypes, persons with mental illness who are victims may not appear as credible as those without a history of mental illness (Wahl, 1999) and may not be viewed as reliable witnesses. Watson, Corrigan, and Ottati (2004b) conducted a vignette experiment that explored police officers' response to a victim or witness. Police officers indicated that they were less likely to take action based on information from a witness or victim who was identified as having a mental illness absent a corroborating source.

Watson, Corrigan, and Ottati (2004a) also examined whether the knowledge that a person has a mental illness affects police perceptions and attitudes. Subjects were police officers who attended inservice trainings. They were given one of eight vignettes involving a person in need of assistance, a victim, a witness, or a suspect. This person was either described as having schizophrenia, or there was no mention of the presence or absence of mental illness. Police officers considered persons identified as having mental illness as being less responsible for their situation, more deserving of pity, and more worthy of help but, at the same time, more dangerous than persons for whom no mental illness information was available. Disclosure of a history of schizophrenia significantly increased perception of violence in all of the role vignettes. The researchers hypothesized that this exaggerated sense of risk might cause an officer to approach persons with mental illness in an overly aggressive manner leading to escalation of the situation. Being identified as having mental illness did not affect the credibility rating of a suspect or a witness but did lower the perceived credibility of the victim with a mental illness. The researchers noted that this attitude could cause officers to lose valuable leads and result in neglect of the victim. Education and opportunities for positive contact with persons with mental illness who are stable in the community was recommended (Watson et al., 2004).

Several studies have evaluated the effect of education. An early study found that while police exhibited greater knowledge related to working with emotionally disturbed persons following training, their attitudes were not altered (Godschalx, 1984). More recently, Pinfold et al. (2003) studied 109 officers and examined their knowledge, attitudes, and behavioral interventions both pre- and post-training workshops concerning mental health problems, legal issues, and ways for police to support persons with mental illness. There was no significant change in attitude

with regard to the linkage of mental illness with violence; however, one-third of the officers noted improvement in communication with persons with mental illness. Pinfold et al. (2003) concluded that education had resulted in officers being more informed and confident in dealing with persons with mental illness.

Corrigan and Penn (1999) noted that contact with a person with mental illness was more effective in improving attitudes compared to an educational program. In designing a mental health training program with the goal of combating stereotypes, one might wish to consider exposing officers to persons who suffer from mental illness but who are functioning well in the community (Corrigan & Gelb, 2006). Awareness training was found to be effective in improving attitudes toward persons with intellectual disability (Bailey, Barr, & Bunting 2001); however, Addison and Thorpe (2004) were able to confirm only a modest relationship between accurate knowledge of mental health issues or personal acquaintance with someone with mental illness and a more favorable attitude towards persons with mental illness. Affective information was viewed as explaining a greater percentage of the variance of the attitude factor score.

Encouraging Ongoing Communication Between Psychiatrists, Other Mental Health Professionals, and Law Enforcement Officers

Encouragement of a dialogue between psychiatrists and law enforcement officers is another desirable outcome of mental health training. Vermette et al. (2005) recommended that mental health training courses be jointly taught by a mental health professional and a law enforcement officer. This approach fosters a comfortable atmosphere for officers who may be wary of psychiatrists and other mental health professionals in part because mental health professionals may be viewed as overly sympathetic at the expense of public safety. This type of collaboration would allow an opportunity for mental health professionals and officers to discuss their own perspective and jointly problem solve (Price, 2005; Vermette et al., 2005). Husted et al. (1995) proposed cross-trainings between police and mental health professionals because this approach could be helpful in shaping attitude changes through improved communication and interagency satisfaction. Suggestions for cross-trainings included inservice trainings to officers presented by mental health agency representatives as well as opportunities for mental health personnel to gain exposure to police activities related to crisis calls. This might involve inclusion in ride-alongs and briefings. Keram (2005) recommends a multidisciplinary approach in developing a training program, citing the experience of the California Commission on Peace Officer Standards and Training that developed an 8-hour mental health training program.

Discussion: Considerations in Modeling Mental Health Training Programs

Implementation of a mental health training program should be a collaborative effort that includes representatives of law enforcement agencies, line officers, and mental health professionals. Law enforcement officers and mental health professionals together have an opportunity to intervene and begin the process of improving interactions with persons with mental illness. Although improvement of attitudes towards persons with mental illness through training has proven difficult to demonstrate, psychiatrists involved in education would maintain that increasing an officer's knowledge and understanding about mental illness is a step in countering stereotypes and improving attitudes and behavior over time (Pinals & Price, 2004). Negative attitudes toward persons with mental illness can impact a police officer's

response. Decreasing stigma may lead to improved communication skills of officers when responding to a call involving an emotionally disturbed person (Pinals & Price, 2004).

Officers receive comprehensive training on a wide variety of topics, both as recruits and during inservice trainings. Police departments are thus faced with difficult decisions when allotting time for specialized mental health education. Too few hours may jeopardize the possibility of improving attitudes and behavior toward persons with mental illness; although, additional studies would be helpful in assessing this further (Pinals & Price, 2004). Collaboration between mental health providers and law enforcement officers can be utilized to aid in designing a program within any imposed constraints. Representation by persons from advocacy groups (e.g., NAMI) in the planning process serves to ensure that the needs and concerns of the mental health consumer will be heard. In this way, the training can be maximized for its utility and relevance to the target audience and, at the same time, meet the goals of improving the interaction between law enforcement officers and persons with mental illness.

In developing a training program, a list of educational priorities should be determined with input from the agency executive, line officers, and mental health professionals. Practical considerations, such as the amount of time that can be allotted, the frequency of training, selection of the target audience, and modes of training, should be discussed early in the process.

Training programs will generally present information to aid officers in recognizing the symptoms and signs of mental illness so that they can intervene in an appropriate and timely manner. Emphasizing the biological basis underlying serious mental illness may diminish stigma and illustrate the potential need of persons in crisis to receive medical attention to rule out any medical causes for their behavior. Research about the effect of attributing serious mental illness to genetic causes, however, has yielded mixed results concerning orientation to treatment and perceived efficacy of treatment (Phelan, Yang, & Cruz-Rojas, 2006). Possible contributions to the behavioral emergency can be discussed. This would include stressors, the presence of mental illness, substance use, and medical causes (Pinals & Price, 2004). Given that police are often in a position to ascertain medications that may be on the scene of a crisis or recently ingested, training in basic information related to psychopharmacology (medications used to treat symptoms of mental illness) would also be important.

Pinals & Price (2004) noted that there are a variety of additional topics that could be of interest. Topics would include suicide and violence risk reduction, assessing a person for signs of a psychiatric disorder, assessing an emotionally disturbed person, communication with a suicidal person, communication with people with psychotic symptoms, written communication regarding observations, and mental health law. Borum (2000) suggests education aimed at reducing negative attitudes toward persons with mental illness that could interfere with interactions during stressful encounters. He suggested instruction about mediation skills, anger control, and de-escalation techniques. Learning de-escalation skills is particularly important because officers may be trained to use a forceful approach with rational offenders. This tactic could have the opposite effect and result in escalation of behavior when dealing with an individual with mental illness. One-on-one communication, with minimal intervention or interference from others at the scene, has a better chance of defusing the situation

(Fyfe, 2000). Officers may appreciate instruction that aids them in making decisions about disposition. This can take the form of discussing challenging situations and the considerations that guide the decisionmaking required in these encounters. Information about available mental health resources can also be of benefit. Mental health training could alert officers on how to access mental health services and avoid incarceration of the individuals.

Vermette et al. (2005) asked police officers attending a mental health training program to rate the importance of topics. They found that all topics were rated as important, but the subjects of "Dangerousness," "Suicide by Cop," "Decreasing Suicide Risk," "Mental Health Law," and "Your Potential Liability for Bad Outcomes" were given the highest ratings. Officers appeared to be most interested in these more advanced topics related to safety and liability issues. This finding could be a reflection of the police concern for potential for liability in the management of encounters with persons with mental illness. Modalities of training were also rated with "Role-Playing" being rated significantly lower than other training modalities. "Videos" and "Small Group Discussion" had the highest mean scores. Many established programs have used videos or manuals in their training (Keram, 2005; Pinals, 2000; Pinals & Galvin, 2003; Schorer, Haynes, & Pinals, 2001).

It is recommended that mental health and law enforcement professionals serve as cotrainers. This approach affords officers the opportunity to understand the perspective of each discipline and be exposed to differing areas of experience and approaches to problem solving (Vermette et al., 2005). Including a mental health consumer or a representative from an advocacy group (e.g., NAMI) in the presentation can help in countering negative stereotypes.

Given the inevitable intersection of mental health professionals and police, mental health training should be designed to foster a mutual sharing of experiences. Through such collaborations, mental health professionals and law enforcement officers need to capitalize on the expertise of each discipline. Meetings between mental health providers and police are a forum that can be utilized to develop target topics to cover in training. In addition, establishing openings to direct communication with mental health professionals may lead to the development of collaborative specialized response mechanisms, an approach that can further assist in the management of persons with mental illness who are in crisis. Given the prevalence of encounters between police and persons with mental illness and the potential devastating effects of an encounter gone awry, these interventions aim to achieve improved outcomes for all.

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Dr. Pinals has had an interest in the interface of mental health and law enforcement professionals for several years and has developed two separate curricula, developed a training video, and has been a co-author of various related publications. She has lectured extensively to both law enforcement and mental health professionals on issues of mutual interest. Dr. Pinals currently serves on the Law Enforcement Liaison Enforcement Committee of the American Academy of Psychiatry and the Law.

Asking the Right Questions: Developing an Effective Training Program on Mental Illness Crisis Intervention

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Introduction

Not long ago I found myself growing increasingly worried about the safety of my neighborhood. Crime and vandalism were on the rise. A friend was robbed at gunpoint near my house. For the first time in my life, I seriously considered purchasing a gun. I was aware that there are a wide variety of guns available—size, power, cost—but I had no idea what or even how to choose. I asked a friend of mine who is a police officer to advise me. To my surprise, he told me that I missed the first and most important question—could I *use* the gun if a situation called for it? The question stopped me in my tracks. It was something that I had not even considered. If I made the wrong decision, it could have dire consequences. I had to do a lot of reflection before I made up my mind.

I do not own a gun.

I believe the same process is applicable for developing or choosing an effective training program for law enforcement officers responding to persons who are mentally ill and in crisis. The first questions are not about the kind of program, the content, or the cost. I propose that there are three essential, preliminary questions:

1. What are the driving forces behind the program?
2. What characterizes an effective program?
3. What are the essential components of an effective program?

This article will examine each of these questions based on more than 8 years of experience collaborating with law enforcement agencies in developing, coordinating, facilitating, and teaching in training programs about mental illness. It is one perspective, but it is the result of the work of many law enforcement and mental health professionals. I believe it is a unique perspective looking from the outside in—a civilian's viewpoint.

What Are the Driving Forces Behind an Effective Program?

The first question to ask when thinking about developing or choosing a mental illness training program focuses on motivation; however, it is more than just "why are we doing this?" or ""what do we want to accomplish?" It essentially confronts

the issue of belief. The question "what do we believe?" is at the heart of motive and changes the reason to do something into the drive to do it well.

In 2001, the Cincinnati Police Department was mandated by the Justice Department to create a team of police officers who would be the first responders to all calls involving persons who are mentally ill. In creating the Mental Health Response Team (MHRT) 40-hour training program, the task force responsible for developing the curriculum came to realize that three beliefs had to drive the program: (1) safety, (2) staying "behavior-centered," and (3) collaboration.

Safety

This might not be as obvious as it seems. When I first got into mental illness training for police officers, it was dramatically clear that there was a very wide gap between the mental health and law enforcement communities. Many people in the mental health community, due to the recent death of a consumer who was shot by the police, insisted on the police getting mental health training because they felt that the police were "too eager to shoot." On the other side of the gap, the officers felt, and vocalized, sometimes bluntly, that the mental health community expected them to disregard their own safety when dealing with persons who are mentally ill. While neither side was insensitive to the potential injury or even death of the other, the dynamic in the room was one of anger and mistrust. In reality, both sides were calling for the same thing: safety. Thus, the safety of every person involved in an interaction between the police and a person who is mentally ill had to be taken into consideration when designing the program.

Safety as a driving force goes deeper than training to just avoid injury or reduce use-of-force incidents. It is not merely a matter of course content. What distinguishes safety as a driving force is the fundamental belief in and respect for everyone involved. It is an attitude that ensures that every aspect of the training will reflect that belief. It means that those same elements will foster mutual respect for the knowledge and skills of the other. It turns "us and them" into "we."

Safety then, as a driving force, starts with confronting stereotypes. Stereotyping is the single most contributing factor to mistrust. Essentially, stereotypes are the children of ignorance and apathy. The antidote is education and exposure. I think it is fair to say that most mental health professionals have little or no knowledge about law enforcement policy and procedure, and most police officers know little about the mental health system. Unfortunately, in far too many cases, neither one is anxious to learn about the other. In Cincinnati, programs like the Citizen Police Academy for Mental Health Professionals developed in collaboration with the Cincinnati Police Academy. Inservice programs that bring police officers into mental health agencies and the "shadowing day" of the Mental Health Response Team training program help bridge that gap through mutual education. These parallel programs break down the barrier of ignorance opening the way for effective training opportunities.

Staying Behavior-Centered

As a mental health professional who spent many years on the streets of Cincinnati working with adults who were severely mentally ill, I learned a lot about mental illness. When it came down to dealing with a crisis with one of my clients, however,

what was most important on a practical level was not the particular diagnosis he or she had but how to react and respond to his or her behaviors. The same is true for police officers.

Learning behavior-centered skills and understanding mental illness and the various diagnoses are not mutually exclusive. The first builds on the foundation of the other. It is the behavior, however, to which the person responding is reacting, not the diagnosis. The diagnosis is the cause of the behavior; behavior is the outward manifestation of the diagnosis. It is similar to how body language is the outward manifestation of a person's inner thoughts or feelings. Behavior, in a sense, is the language of the illness. Being behavior-centered means that all the elements of the training program in some way lead to presenting the safest and most effective behavior-related response skills.

The temptation in developing (or choosing) an effective mental illness training program is to spend an inordinate amount of time identifying the illness and not enough time on behavior-centered assessment and response. There are a number of problems that arise.

First, as already alluded to, police officers are called upon to deal with behavior, not arrive at a diagnosis. It's just not essential. For example, effectively dealing with a delusional subject that is threatening the safety of him- or herself or others rests first and foremost on the delusional *behavior*. On the most practical level, it does not matter in those first, most critical moments from what illness the delusions arise.

Second, in an interaction with persons who are mentally ill, time is often limited. It is important that officers learn to "slow down" in these encounters because it is essential for responding to someone whose ability to listen carefully, think clearly, and respond calmly is impaired. It is not to allow more time to figure out the illness. According to one of the psychiatrists who is an instructor in our program, it has taken him many years to learn how to diagnose, and it takes him hours to do a proper evaluation to reach a diagnosis. Even then, he says, it is not always accurate. He assures officers that there is no way that any of them, in the middle of a crisis response with limited time, can make a proper diagnosis. With practice, what they can do, he assures them, is assess behavior. When a program is behavior-centered, the focus is on assessment, not diagnosis.

The third problem concerns accuracy. Diagnosis is not an exact science. Many symptoms are not exclusive to one particular illness or even one category of illnesses. Conversely, not every person with the same diagnosis will show the same symptoms. Similarly, emphasizing diagnosis can create a false security or dependence on a "witness" diagnosis. In those instances, the accuracy of diagnosis is even more suspect. In Cincinnati, we are so convinced about the danger of depending on a diagnosis to decide how to respond that we worked with the Cincinnati Police Communications Section to amend their call-taker procedure manual. Formerly they would have asked whether there is a known diagnosis; they now ask for a detailed description of the behavior that is occurring so that the dispatcher can pass that information on to the MHRT officer. We also eliminated the insistence on asking about medications for similar reasons. People can be off their medications and doing very well or can be taking their medications and show symptoms. Some medications are used for more than one illness. In either case, however, if diagnosis

or medication information is given by the caller, it is passed on to the responding officer. He or she is trained to use it as supportive information but not to depend on it for choosing a response.

Finally, there is a very practical and useful reason to stay behavior-centered: the state mental hold. In Ohio, and most other states, a law enforcement officer can and often is required to "write a hold." This legal document allows the officer to take the person against his or her will to be evaluated at the hospital or some other mental health facility. The decision on the part of the attending psychiatrist of whether to admit an individual or not often rests on the quality of the "statement of belief" section of the hold that the officer completes. Keeping the focus on behavioral assessment and response helps in writing an effective hold. Behavior-centered training helps in three ways:

1. It helps the officer feel more confident with the decision to write a hold or not. Diagnosis doesn't matter; behavior tells the story.
2. It helps eliminate the frustration of persons being released from the hospital as a result of a poorly written hold.
3. By not focusing on diagnosis, it helps the officer avoid liability. By law, writing a diagnosis on the form is the role of the psychiatrist exclusively.

Behavior-centered training means focusing an officer's energy and skill in the most effective way on the subject's behavior resulting in the most effective response.

Collaboration

Of the three driving forces described in this article, collaboration has become my passion. In 1998, when the law enforcement and mental health communities in Cincinnati were thrown together as the result of a fatal shooting of a man who had walked off the psychiatric unit of the University Hospital, the relationship between the two was, for all intents and purposes, nonexistent. What little interaction there was clearly was rooted in mistrust.

As a case manager working with adults with severe mental illness, I called upon the police many times and witnessed many similar situations. I observed and concluded that there are three possible ways officers and mental health professionals can interact. The first is what I call "the PRN model." PRN is the medical term for "as needed." It's a perfect description. Mental health professionals call the police, often reluctantly, only when they are absolutely needed and usually when things have become out of control. The reverse is also true. When the police cannot figure out what to do with someone, they call the mental health professional. Like an aspirin or surgery, the other is only welcome, reluctantly in many cases, when they are needed.

The second pattern I noticed is most easily defined as "the Parallel model." Like parallel lines, the police and mental health professionals may be at the same place, dealing with the same issue or crisis but never intersecting. The attitude seems to be, "I won't tell you how to do your job so don't tell me how to do mine."

The third kind of interaction between law enforcement and mental health professionals is also the third driving force underlying an effective training program:

collaboration. The word *collaborate* comes from the Latin root words meaning "to work with." It implies a sharing of goals. To *compete* also means to seek the same goal. Collaboration, however, is the opposite of competition. There is no first or second place.

The Cincinnati MHRT program accomplishes this with two important segments of the week-long training: (1) Shadowing and (2) the Consumer and Family Panel. Shadowing is a reverse ride-along. Officers are assigned to "shadow" a mental health professional as he or she goes about doing their everyday work. Comparable training programs have a similar segment but instead have the officers spend some time at a variety of locations, exposing them to a broad sample of mental health services. That certainly has its benefits, but the shadowing day provides different benefits. Because an officer spends a full day with one agency, he or she gets a detailed picture of how the mental health system works by experiencing a more intense look at one kind of service. Officers are required to keep a journal of all that they see and experience, which is then used in a "debriefing session" the next day. By adding the debriefing time the following morning, the participants get detailed descriptions about the wide variety of agencies the others experienced. We utilize the assistance of agencies representing a diverse range of mental health services including a variety of children's services, case management agencies, psychiatric emergency services including mobile crisis, homeless outreach services, substance abuse/mental illness services, and housing services. In addition, when officers from outside the area attend a training program, efforts are made to see that their shadowing day is spent with an agency from their home area.

The one-on-one experience also allows the officers to get a more personal look at the people who are at the front lines of mental health services. The end result is not only a deeper understanding of the mental health profession but often the creation of firmly established professional relationships. In other words, collaboration.

Collaboration is generally thought of as a "working relationship"—people working together. Collaboration that drives a mental health program, however, needs to address not only the working relationship between law enforcement and mental health professionals but, just as importantly, the relationship between the community of mental health consumers and the police. Teaching about mental illness and effective, safe tactics is only half the picture. For these encounters to be truly effective, there has to be some level of trust between the police and the consumer. The Consumer and Family Panel, presented at the end of the first day, has had a tremendous impact on this goal. A panel of persons tell their stories of living with mental illness in their own lives or in their families. Officers have the chance to ask questions. By putting a human face on mental illness and giving mental health consumers the chance to meet police officers face to face, we create the opportunity to build trust.

We have seen the impact the Consumer and Family Panel has had on building collaboration. Two different groups within the mental health community, many of whose members have been regular participants on the panel, now give an "Officer of the Year" award, recognizing excellence in responding to persons who are mentally ill. Where there once was fear and deep mistrust, there is now trust and deep gratitude.

A second example is more personal. During one of the MHRT training programs, a sergeant pulled me aside after the Consumer and Family Panel. He told me that he, too, had a family member who had a mental illness: his mother. She had rarely taken any medication, so his entire life was spent watching mental illness slowly "take her away." He felt he had something he could share, and now, he told me, he had a venue in which to do it. He immediately accepted my invitation to participate in future panels. His impact is amazing.

These are examples of what happens when collaboration is more than just hoping to get cops, consumers, and case managers to "get along better." It goes deeper than knowledge, tactics, and cooperation. It would be easy to be satisfied with having a program that results in safer tactics or getting people to work together. Collaboration-driven programs are never satisfied with simply changing tactics. They change communities.

What Characterizes an Effective Training Program?

If driving forces answer the question "why have a program?", then the characteristics of an effective program answer the questions "what should it look like?" or "how will I know it when I see it?" There are many attributes that can characterize an effective program. I want to focus on three that have more meaning than one might guess. Mental illness training should (1) be practical (vs. theoretical), (2) be flexible (vs. "packaged"), and (3) have "qualified" instructors.

Practical

At the risk of oversimplifying, an effective program has to be practical. In the 8 years I have been doing mental illness training, I have seen groups large and small, with great intentions, attempt to teach police officers about mental illness. The programs that worked and the ones that failed hinged on this simple concept. A program that is behavior-centered, by default, will also be a practical one. It avoids the trap of too much information and not enough instruction. An officer during one of the trainings put it best when challenging a new instructor who was spending too much time lecturing: "The stuff in the textbook is interesting; now tell us what to do!"

Flexible

In order to most effectively teach law enforcement officers about mental illness, any program, whether it be an inservice day or a full week of training, has to be flexible. I am not referring here to schedules. There are two areas in which flexibility is especially important: (1) the problem of diversity and (2) the question of volunteers vs. "volunteers."

Mental illness does not discriminate. The diverse geographical, cultural, ethnic, and economic contexts in which it is found, however, impact the people who are ill and the way they deal with it. Law enforcement is itself very diverse. Agencies cover areas that may be rural, urban, suburban, or a mixture of these. The agencies themselves may be large or small or racially and culturally diverse. The first question to ask is "what do *we* need?" Will the program developed or chosen take into account these various contexts? Many times, the change flexibility requires is not dramatic. For example, in the Mental Health Response Specialist (MHRS) program (the MHRT

training tailored for agencies outside Cincinnati police department's jurisdiction) efforts are made to design the shadowing day and Consumer and Family Panel to reflect as much as possible the kind of people that the various agencies serve. More focus might be placed by an instructor on a certain culture that is present within a jurisdiction. In other words, an effective program adjusts to the needs of the participants rather than the participants adjusting to the needs of the program.

The second issue requiring some degree of flexibility might cause some debate. The common wisdom in the area of training officers to safely and effectively deal with persons who are mentally ill is that, first of all, it has to involve volunteers only. Should a program admit only officers who volunteer? At first glance, the answer seems to be an obvious "yes!" Ideally speaking, I agree. In some areas of police work, or any profession for that matter, there are aspects of the job for which some are more suited than others. Sometimes, however, what is ideal doesn't always match with what is real. Using only officers who volunteer has some significant drawbacks.

First, there are any number of situations in which having only volunteers is difficult or impossible. The Cincinnati Police Department's first major foray in mental illness training was in 1998 after the shooting death of an individual with a history of mental illness and violence. The resulting uproar from both the mental health community and the community at large resulted in the department's commitment to bringing in mental health professionals and consumers to provide an 8-hour inservice day for all 600+ of its officers. Since every officer was expected to attend, there was a chance that a "few" of them didn't volunteer to be there. That was my introduction to training police officers. Picture a room of 40 to 50 officers at each inservice, in full uniform, with body language that seemed to growl, "I dare you to teach me." Similarly, when the Justice Department mandated the Cincinnati Police Department to create a team of specially trained first responders (with just 90 days to have it up and running), the hope of finding 90 volunteers was slim. The only option was to develop training and utilize instructors that were flexible enough to respect and be attentive to both ends of the volunteer continuum and everyone in between.

There are other occasions when we have had to face nonvolunteers. Two local chiefs are requiring all of their officers to attend the MHRS training. When I asked one of them, Colonel Paul Toth of the North College Hill Police Department, why he didn't take only volunteers, he gave me two reasons. The first was a very personal one. Colonel Toth told me that, as a young officer, he found himself in a situation with no other choice but to shoot and kill a man who was mentally ill. He told me that he did not want to have any of his officers to have to go through that scenario. His hope was that the training that they receive will give them the skills to prevent it from happening. Chief Toth's second reason was a more practical reason. He explained that there just weren't enough officers in his department to have a designated team of first responders. In his judgment, every officer needs to be trained and ready when a situation arises. As a footnote, two officers from his agency, one of whom had attended the MHRS training, received commendations for heroic action in dealing with a man with mental illness who was armed and threatening himself and others. It was the skills the officer learned, according to the Colonel Toth, that allowed that situation to come to a safe resolution.

Secondly, and more significantly, the reality of having to deal with nonvolunteers may be inevitable. An article in the *FBI Law Enforcement Bulletin* in July 2004 predicts

that mental illness training will soon no longer be the realm of the specially trained officer:

> *What was once considered an area of special training may soon become a common practice, thereby raising the legal standard to which agencies are held* (emphasis added). Law enforcement leaders not offering similar training may find themselves at a disadvantage. Those who do offer it will find that the cost to train their personnel to deal with people who have mental illness proves less expensive than a civil action. (p. 24)

If this turns out to be true, then most certainly nonvolunteers will be trained alongside the volunteers. Effective training programs will be the ones flexible enough to recognize and speak to a diverse audience. Although this could be the topic of a future article, here are four simple rules to give to instructors faced with teaching such a "mixed audience":

1. *Lay it out on the table*. Acknowledge up front the various attitudes that are present and express recognition for the valuable experience and skills that each person present can contribute, but be careful not to patronize.

2. *Show no fear*. I personally like the "I dare you to teach me" challenge. I taught high school for over 10 years where that dare and challenge was an everyday part of teaching. Taking on that challenge just reinforces the importance of what you have to teach. Never apologize or back down.

3. *Believe in what you teach*. Many skeptical and resistant attendees are won over just by the passion and conviction of the instructor. Look them in the eyes, and dare them not to learn your stuff!

4. *Win allies*. Peer pressure isn't just for teenagers. Win over that large middle group who may not have volunteered but will do their best because they are good officers. Recognize and acknowledge their doubts, build on their professionalism, and respect their skills. Those first 90 MHRT officers of the Cincinnati Police Department taught me something very important. Nonvolunteer does not mean noneffective. Most of these women and men were not volunteers, but these outstanding officers rose to the occasion, not simply because they were told to but because they are committed, dedicated professionals.

The final danger in limiting this kind of training to volunteers is even a little more controversial. Certain personalities are naturally more suited to deal with persons who are mentally ill and in crisis. It requires patience and a ton of empathy. I would never hesitate to encourage officers with these and other skills to develop them through training. In the beginning, I was a firm believer that it requires a special person to respond to these situations. No longer. The danger, I now believe, is that mental illness and the people who live with it are categorized and isolated as especially difficult people. Without consciously intending it, mental illness is further stigmatized. One theme that I hear over and over from the people who make up the Consumer and Family Panel is the plea to be recognized as a full human being even when in crisis. That should be a human skill not a special skill.

Effective interaction with persons who are mentally ill requires learning and developing some important skills, but it's not rocket science. I am convinced as both a mental health professional and a law enforcement trainer that every police officer can learn the skills necessary for safe and effective response.

"Qualified" Instructors

Obviously, a training program about mental illness should seek out the best instructors who are experts in their respective fields. For a program to be most effective, however, "qualified" needs to be understood on two levels. The first is the obvious one: instructors should be well-educated and trained in their field and possess excellent teaching skills. Simply "wanting to teach" is not enough.

The second level is equally important. An instructor should not only know how to teach but should know how to teach cops. If that sounds a little odd, it's not meant to be. I learned it from a cop. As a "civilian outsider," that lesson didn't always come easily, mainly because what I was doing "wrong" was not a conscious thing. Not knowing, for example, what the "use-of-force continuum" was led to some interesting exchanges in the classroom. I was suggesting strategies that went directly against what an officer is taught. Afterwards, when I took the time to ask questions, do ride-alongs, and learn as much as I could, the quality of my instruction changed for the better. Since then, there is not an instructor or panelist who is not encouraged one way or another to learn about the profession of the men and women they are instructing. In addition, it means taking a good look inside and examining one's own attitude about law enforcement. It does not mean that only those individuals who have nothing but wonderful things to say to the officers should be allowed to be an instructor or part of a panel. On the contrary, we have a mixture of both. We don't, however, have "finger-pointers" or individuals who have a bone to pick with the police department.

A qualified instructor, in other words, knows him- or herself, the topic, and the audience.

What Are the Essential Components of an Effective Program?

We have looked at the driving forces of an effective training program about mental illness and learned what characterizes a program. The last of the three questions deals with the actual content of the program itself. It is important to recognize that there are any number of ways to present each of these components. What I want to address is the reasoning that should go into making those choices. The three components are (1) knowledge, (2) context, and (3) skills.

Much of what makes up the "knowledge" and "skills" components has been covered previously in this article, but some ideas are important to review.

Since *knowledge* is the foundation upon which the skills that are taught are based, the knowledge presented has to be determined by those skills. The foundation of a building does not determine the kind of building it will be; the kind of building will determine the foundation required. In other words, once the question "what kind of skills are we hoping to teach?" is answered, the information on which to build those skills can be determined. This distinction is important because it allows

only the necessary information and avoids wasting time on extraneous or irrelevant information. That said, since, in an effective training, the skills required need to be behavior-centered, the foundational knowledge needs to be behavior-centered.

As alluded to above, the *skills* that are taught need to be behavior-centered. There is another important consideration for the skills component. The specific skills that are taught to the officers should build on the tactical skills the officers already have. There simply is no truth to the idea that officers have to "unlearn everything they have learned" when it comes to interacting with persons who are mentally ill. The communication, listening, and assessment skills officers learned in the academy and have successfully used for years on the job are very valuable skills to build on and fine-tune for this type of encounter. When an officer can sense that his or her skills are valuable and have not been "wrong all this time," that officer is much more open to learning, can more easily make the connection as to how the skills work, and are less likely to be defensive or resistant.

Context brings together knowledge and skills. Mental illness does not occur in a vacuum. It affects people from every demographic category. It is not just a theory or a set of statistics. Mental illness has to be seen, heard, and experienced in the context in which it occurs—life. Again, in an effective training program, this can be accomplished in any number of creative ways. The MHRT training puts mental illness in context both in the classroom and in the field.

In the classroom, different instructors cover a series of topics called "special populations." The instructors are professionals who work specifically and directly with persons who are mentally ill and homeless, children and adolescents, individuals with substance abuse issues, and those who are developmentally disabled. Each instructor focuses in on how mental illness affects that particular population of individuals. I would rather a police officer complete the program—learning about mental illness and homelessness and how they affect each other, special considerations in interacting with them, and available resources for people who are homeless and mentally ill—than be able to list every symptom of schizophrenia.

All instructors, as a matter of fact, are encouraged to put their topics "in context." For example, it is of little benefit to know all about the various kinds of medications to treat mental illness without understanding them in context—how they work, what the side effects are, the many valid reasons why people stop taking their medications—and to hear from the people who face these issues every day.

The shadowing and Consumer and Family Panel are ways that the officers see and experience mental illness "in the field." The agencies to which they are assigned for shadowing include those that work with each of the special populations mentioned above. Consumers and family members, one way or another, are part of one or more of these same populations.

Connecting knowledge and skills by putting it all in context is taking the information off the chalkboard and making it real.

One final point: You may have noticed how many of the various topics in this article seem to overlap. That is precisely how an effective program works. It all interconnects. If the driving force is safety, then the skills will be practical and seen in

context. If knowledge is built on the skills needed, then it will be behavior-centered. What characterizes a program will reflect what drives the program and determine the content of the program. An effective training program on mental illness is not just a set of topics and instructors. As we have seen, it is so much more.

Conclusion

Law enforcement, as Captain Steve Luebbe, MHRT Coordinator for the Cincinnati Police Department, tells each new training class, is the only social service agency open 24 hours a day, 7 days a week. Police officers are called upon day or night to respond, under the scrutiny of an ever vigilant public, to a wide variety of people and problems. Knowledge is power, and effective training builds knowledge. Developing an effective training program about mental illness is not as daunting as it may seem. Taking the time to ask the right questions beforehand can make the difference between a nice, informative program and an effective training program.

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Police Handling of People with Mental Illness

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Major changes in mental health policies and laws have deinstitutionalized untold numbers of people with mental illness (PWMIs), releasing them into communities where they receive inadequate, intermittent, or no mental healthcare. These changes have brought criminal justice professionals into contact with PWMIs at every stage of the justice process. Police arrest PWMIs because no one else can handle their disruptive public behaviors. Jail and prison administrators strain to provide for the care and safety of PWMIs. Judges grapple with limited sentencing alternatives for PWMIs who fall outside of specific forensic categories (e.g., guilty but mentally ill). Probation officers struggle to obtain scarce community services and treatments for PWMIs and fit them into existing programs and case management strategies.

Nearly 10% of the people who the police suspect of criminal activity or involvement have a serious mental illness (Engel & Silver, 2001; Teplin & Pruett, 1992). Medium and large police departments estimate that 7% of their contacts with the public involve people with mental illness (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Police officers report such contacts as problematic and often find the mental health system incapable of resolution (Borum, Deane, Steadman, & Morrissey, 1998). Thus, police officers become the gatekeepers of the criminal justice and mental health systems, and their perceptions and actions can determine whether or not individuals receive treatment, remain in their current situation, or face a criminal justice system that is ill prepared to meet their needs (NCSG, 2002). The stigmatization of mental illness and lack of knowledge can cause police officers to respond with undue force (Ruiz, 1993), refuse to assist a victim with mental illness (NCSG, 2002; Watson, Corrigan, & Ottati, 2004a), or fail to refer a PWMI to appropriate community services.

Criminalization of PWMIs

More than 30 years ago, Abramson (1972) noted that the mentally ill were becoming criminalized (i.e., they were being processed through the criminal justice system instead of through the mental health system). Since that time, data has suggested that PWMIs are arrested and incarcerated at levels that exceed both their representation in the general population and their tendency to commit serious crimes. Based on this data, mental health advocates and researchers have asserted that people who have traditionally been treated in mental health agencies and psychiatric hospitals were being shunted into jails and prisons (e.g., Gibbs, 1983; Guy, Platt, Zwerling, & Bullock, 1985; Laberge & Morin, 1995; Lamb & Grant, 1982; Lurigio & Lewis, 1987; Morgan, 1981; Teplin, 1983, 1984; Whitmer, 1980). The criminalization of PWMIs can be attributed to the declining number of residents of state hospitals, the passage of

restrictive commitment laws, the splintering of treatment systems, and the war on drugs (Lurigio & Swartz, 2000; Teplin, 1984).

Deinstitutionalization

A fundamental change in mental health policy, known as deinstitutionalization, shifted the focus of care for PWMIs from psychiatric hospitals to local community mental health centers, and it is the single largest contributing factor in the criminalization of the mentally ill (Borzecki & Wormith, 1985; Grob, 1991; Lurigio & Swartz, 2000; Whitmer, 1980). After World War II, state mental hospitals began to release thousands of PWMIs to community-based facilities designed to provide follow-up psychiatric treatment and services.

The policy of deinstitutionalization substantially reduced the number of patients in state mental hospitals; this population fell, nationwide, from 559,000 patients in 1955 to 72,000 in 1994 (Center for Mental Health Services, 1994). The length of stay in psychiatric hospitals and the number of beds available for care also declined sharply (Kiesler, 1982). The deinstitutionalization movement was fueled by journalistic exposés of patient abuse, effective medications to treat severe mental illnesses, federal entitlement programs that paid for community-based mental health services, and insurance coverage for inpatient psychiatric care in general hospitals (Sharfstein, 2000).

The policy of deinstitutionalization was never properly implemented, however. Although it achieved its goal of reducing the use of state hospitals, it never succeeded in providing adequate, appropriate, or well-coordinated outpatient treatment for large percentages of PWMIs, especially those with the most severe, chronic mental disorders (Shadish, 1989). In other words, the unsuccessful transition to community mental healthcare took its most tragic toll on the patients who were least capable of the basic tasks of independent daily living. Many became unwanted charges of the criminal justice system because of the dearth of treatment and community social services (Grob, 1991; Torrey et al., 1992).

Restrictive Mental Health Codes

Mental health law reform has made it difficult to commit PWMIs to psychiatric hospitals and is the second contributing factor to the criminalization of PWMIs (Torrey, 1997). Tight restrictions on the procedures and criteria for involuntary commitment have sorely limited the use of psychiatric hospitalizations for PWMIs.

Most state mental health codes require the staff of psychiatric hospitals to produce clear and convincing evidence that people who are being involuntarily committed are either a danger to themselves or others or are so gravely debilitated by their illnesses that they cannot care for themselves. Moreover, mental health codes strengthen patients' rights to due process, which affords them with many of the same constitutional protections that are granted to defendants in criminal court proceedings. Thus, only the most dangerous or profoundly mentally ill are hospitalized, resulting "in greatly increased numbers of mentally ill persons in the community who may commit criminal acts and enter the criminal justice system" (Lamb & Weinberger, 1998, p. 487).

Fragmented Services

The third major factor in the criminalization of the mentally ill is the compartmentalization of the mental health and other treatment systems (Laberge & Morin, 1995). The mental health system consists of fragmented services for predetermined subsets of patients. Most psychiatric programs, for example, are designed to treat "pure types" of clients, defined as mentally ill, developmentally disabled, alcoholic, or chemically dependent. By the same token, the vast majority of drug treatment staff members are unwilling or unable to serve people with mental disorders and frequently refuse to accept such clients. Therefore, the individuals with multiple afflictions (i.e., dual diagnoses or comorbidity), who constitute large percentages of PWMIs in the criminal justice system, might be deprived of services because they fail to meet stringent admission criteria (Abram & Teplin, 1991). When people with co-occurring disorders—most with serious mental illnesses and substance abuse and dependence disorders—come to the attention of the police, officers are left with arrest as the only feasible response given the lack of available referrals within narrowly defined treatment systems (Brown, Ridgely, Pepper, Levine, & Ryglewicz, 1989).

War on Drugs

The fourth factor in the criminalization of PWMIs is the arrest and incarceration of people for violating drug laws. Offenders convicted of drug possession and sales (who also have high rates of drug use) constitute one of the fastest-growing subpopulations in the nation's prisons (Ditton, 1999). As noted previously, a fairly large proportion of these incarcerees have co-occurring mental illnesses (Swartz & Lurigio, 1999), which helps to explain the rising prevalence of arrested and imprisoned PWMIs (Lurigio & Swartz, 2000).

Police and PWMIs

Many of the untreated symptoms and signs of serious mental illness can be frightening or upsetting to the people who observe them. Public tolerance for the mentally ill has always been quite low (Torrey, 1997), and common stereotypes of PWMIs, held by the police and the general public alike, typically depict the mentally ill as dangerous, uncontrollable, or violent (Durham, 1989). As we discussed in the preceding section, a greater proportion of PWMIs are no longer in hospitals, so there are many more opportunities for those who are untreated to be symptomatic in public (Teplin, 1984). Thus, when confronted with PWMIs who are engaging in bizarre or threatening behaviors, citizens turn to police officers, who have become "street corner psychiatrists" and "gatekeepers" to the mental health system (Lamb et al., 2002; Sheridan & Teplin, 1981; Teplin & Pruett, 1992).

Police officers are often the first to encounter PWMIs and are a major source of psychiatric referrals. De Cuir (1982) found that police officers in Los Angeles spent nearly 20,000 hours every month responding to cases involving PWMIs. In two separate studies, data indicated that more than 30% of the people seen in psychiatric emergency rooms in Los Angeles and New York City had been brought in by the police (Way, Evans, & Banks, 1993; Morrell, 1989). Growing awareness that the police are increasing contact with PWMIs has led to several studies of police practices

with PWMIs and police departments' relationships with mental health and social services agencies (Wachholz & Mullaly, 1993).

Police Discretion and PWMIs

The police have historically played a pivotal role in responding to citizens' complaints about PWMIs, particularly in poorer neighborhoods (e.g., Gilboy & Schmidt, 1971; Warren, 1977). The legal foundation for police involvement with PWMIs is two-fold: (1) the police power function, exercised to protect public safety and (2) the *parens patriae* function, exercised to protect disabled citizens (Shah, 1975). Bittner's (1967) seminal research on the police handling of PWMIs found that officers generally initiate psychiatric referrals when an arrestee is violent, suicidal, or obviously symptomatic. Numerous other studies have shown that police officers are reluctant to escort arrestees who pose no danger to themselves or others to a hospital (e.g., Matthews, 1970; Rock, Jacobson, & Janepaul, 1968; Schag, 1977).

Other factors that the police consider in managing PWMIs are the person's psychiatric history and the amount of public disturbance that the person is creating (Schag, 1977). In addition, studies suggest that police are more likely to arrest people with mental illness when there is evidence that they have committed a crime, when the individual has a criminal history (Green, 1997), when the individual is both intoxicated and violent, when the individual is a threat to him- or herself (LeGrange, 2000), when the individual does not meet the criteria for admission to a hospital or other care-taking facility, when the person's conduct exceeds the community's tolerance of deviant behavior, and when it is likely the person will continue to cause a problem (Teplin, 1983).

Less experienced officers are more likely than more experienced officers to arrest people with mental illness (Green, 1997). More experienced officers are the more likely to take no action—informal or formal (Green, 1997). Officers are least likely to take formal action when there is no evidence of a crime and the person is homeless (Green, 1997). Overall, whether the police characterize PWMIs as "bad" and arrest them, as "mad" and hospitalize them, or as merely "eccentric" and resolve the situation informally, is as much a matter of discretion as it is of law (Teplin & Pruett, 1992). "Thus, the [police] disposition of incidents involving persons with mental illness is a complex social process, and the police develop an informal operative code to handle each situation" (Teplin, 1991, p. 174).

In most jurisdictions, the police can initiate emergency hospitalizations for PWMIs who are either a danger to themselves or others, unable to take care of their physical needs, or unable to protect themselves against serious harm (Lamb, Weinberger, & DeCuir, 2002). In practice, however, officers are quite restricted in their use of emergency hospitalizations (Bonovitz & Guy, 1979; Teplin, 1983). These restrictions include the stringent legal criteria for involuntary commitment, the lack of community-based treatment slots, the unwillingness of mental health facilities or emergency rooms to accept recalcitrant or intoxicated patients, and the bureaucratic obstacles inherent in the hospitalization process, such as complicated admission procedures and long waiting periods in emergency rooms (Durham, 1989; Laberge & Morin, 1995).

A study of police officers found that it takes significantly less time (27 minutes) to take a PWMI to jail than to take him or her to a mental health center (42 minutes) or hospital (45 minutes). Police officers reported frustrating experiences with the mental health system, such as encountering unresponsive providers and being refused hospital admissions because of a PWMI's lack of insurance (Falk & Watson, 2001). A police officer might even take mentally ill persons who have not committed a crime to jail rather than to a community service site because he or she believes that no appropriate community alternatives are available. This practice has been referred to as "mercy booking" (Lamb & Weinberger, 1998).

The mental health system, in general, is unwilling or unable to serve PWMIs with criminal backgrounds (Draine, Soloman, & Meyerson, 1994; Laberge & Morin, 1995). Hence, without recourse to state hospitals or community mental health centers, police have frequently had to arrest PWMIs, even for minor offenses that stem more from their illness than from their criminality (Dvoskin & Steadman, 1994). Arrest is often the only feasible mechanism to remove from the streets persons who are not "disturbed enough" for the hospital yet are regarded by hospital staff as "too dangerous" for inpatient care (e.g., they have a criminal case pending or a history of violence) (Teplin, 1983; Teplin & Pruett, 1992). As Kagan (1990) stated, the criminal justice system (i.e., police officers) has been assuming the state hospital's responsibility of removing PWMIs from the streets and placing them into custodial care (i.e., jails).

Police officers who respond to PWMIs are typically faced with logistical and other problems, as identified by Finn and Sullivan (1989, p. 2), Murphy (1986, pp. 61-62), and Gillig, Dumaine, Stammer, Hillard, and Grubb (1990, p. 663):

- Frustration at being unable either to help PWMIs in serious trouble or to respond to pressure from citizens to "do something about them"
- Stress from responding to a problem they are not equipped to handle and do not feel is their responsibility to solve
- Substantial loss of time trying to find a facility willing to accept PWMIs and then waiting around until they have been evaluated and admitted (or turned away)
- A lack of written directives providing specific information for managing PWMIs (This includes information on possible dispositions, mental health laws, and procedures for contacting mental health services.)
- A lack of training in techniques for dealing with PWMIs (Traditional police techniques are inappropriate for handling the mentally ill and often tend to exacerbate problem behaviors. Thus, officers feel responsible for responding to situations in which they have no expertise or resources.)
- Unfair criticism from mental health professionals for not understanding mental illness and for mishandling situations involving PWMIs

Encounters Between Police Officers and PWMIs

Teplin (1984) and her staff observed more than 1,000 police-citizen contacts and reported that for similar behaviors and offenses, people showing obvious signs and symptoms of severe mental disorders had greater chances of being arrested than those who did not. Police officers in Teplin's study were able to accurately recognize serious mental illnesses during their street encounters with citizens. Nonetheless, they arrested PWMIs because it was the best option for people who failed to meet

inpatient commitment criteria or who had been refused care in hospital emergency rooms or other facilities as a result of their recalcitrant or criminal behaviors.

Teplin (1984) found that evidence of a mental disorder is a critical, situational variable that shapes police-citizen interactions and guides the disposition of an incident, including the decision to make an arrest. Police officers are primarily motivated by a desire or need to bring a street encounter to a successful resolution so that they do not have to return to the scene.

According to Teplin (1984), police are most likely to arrest PWMIs under the following circumstances:

- When hospitalization is an impractical or onerous alternative (e.g., because of time constraints)
- When a PWMI's behaviors are disruptive and exceed the public's tolerance for deviance
- When there is a high probability that a PWMI's behavior will continue to cause problems and necessitate a return to the original site of the complaint
- When a PWMI obviously suffers from multiple problems (e.g., schizophrenia and alcoholism)
- When a PWMI behaves disrespectfully toward the police
- When hospital staff deem that a PWMI is dangerous and likely to become a management problem

Teplin (1984) also found that police officers regard arrest as an appropriate option for PWMIs because officers often mistakenly assume that mental health diversions are routinely initiated in the criminal justice system. Abram and Teplin (1991) summarized studies on the arrest of PWMIs as follows:

> Studies of police decisionmaking have demonstrated that police officers' proclivity to arrest the mentally ill is not due to maliciousness or naiveté. On the contrary, police are adept at their role of street-corner psychologist. The mentally ill are often arrested only as a last resort, when they have publicly violated community standards of behavior and a mental health disposition is unavailable. In short, the mentally ill are often arrested because of the failures of the mental health system. (p. 1037)

In summary, when no other community alternatives are available, arrest is an expedient way to get PWMIs into jail settings in which they have a chance to be assessed and treated by mental health professionals (Laberge & Morin, 1995). For PWMIs, the criminal justice system has become the "system that can't say no" (Borzecki & Wormith, 1985), and "families, friends, and others in the community call on the police to act as agents of social control for mentally ill individuals whose behavior, although disruptive, does not meet criteria for involuntary civil commitment" (Bonovitz & Bonovitz, 1981, p. 974).

In contrast to Teplin's (1984) landmark study, Engel and Silver (2001) reported that the police are no more likely to arrest PWMIs than non-PWMIs, all other factors being equal. Their data from 1996-1997 showed that the odds of arrest were reduced by a factor of 2.9 if the suspect had a mental illness. Factors that increased the odds of arrest included being a man, under the influence of drugs or alcohol, disrespectful

to the officer, noncompliant, and known to police. Arrest was also more likely when the suspect fought with a citizen or the officer, possessed a weapon, or committed a serious offense, or when there was clear evidence of wrongdoing.

One possible explanation for the contradictory findings is that between the late 1970s, when Teplin collected her data, and 1996-1997, when Eric and Silver collected their data, police policies and training have encouraged diversion to community-based services for PWMIs. Different criteria for determining whether subjects were mentally ill might also have contributed to the divergence in the findings. Teplin had field interviewers screen subjects for signs of mental illness. The interviewers were more accurate in identifying signs of mental illness than the police officers were. Engel and Silver used only information regarding whether the officer believed that the individual had a mental illness. In addition, using a case flow analysis of Teplin's data, Kalinch and Senese (1987) concluded that the data from Teplin's study indicated that persons with mental illness and nondisordered individuals were equally likely to be officially disposed (17%), with nondisordered persons being arrested at a higher rate than PWMIs (52% and 41.8%, respectively).

Looking at only police encounters with PWMIs in Honolulu, Hawaii, Green (1997) examined predictors of arrest, informal disposition, and no action on the part of the officer. Three factors predicted arrest: (1) whether there was evidence of a misdemeanor offense (as opposed to ordinance violation or no offense), (2) whether the subject was known to have a criminal history, and (3) the officer's years of experience (less experienced officers were more likely to arrest). Informal dispositions were more likely to be applied when the subject had committed an ordinance violation or no offense, was homeless or lived in a shelter, when the encounter occurred outside of Waikiki, and when the officer had more years of experience. No action was most likely when officers knew the subject by sight and had reason to believe that he or she had no intention of violating the law. The number of years of experience was positively related to no action. More experienced officers were more likely to intervene.

In their investigation of police-citizen interactions, Teplin and Pruett (1992) classified PWMIs who had been neither arrested nor hospitalized (i.e., those whose cases were handled informally) into three groups. The first group, "neighborhood characters," are known and tolerated by the police and the public; their behaviors are predictable and regarded as "eccentricities" rather than as criminal. The second group, "troublemakers," cause problems for the police and the public but are "thought to be too difficult to handle via arrest or hospitalization" (p. 151). The third group, "quiet crazies," exhibit unobtrusive symptoms and odd behaviors that are inoffensive to the public and the police.

Evidence suggests that police officers might treat PWMIs differently from nondisordered persons even when the PWMI is not the cause of a disturbance. Mastrofski, Snipes, Parks, and Maxwell (2000) found that when officers responded to citizens' requests to control another citizen, legal considerations were the strongest predictor of police response; however, requesters that appeared disrespectful, intoxicated, or mentally ill were less likely to have their requests fulfilled. Another study found that police were less likely to refer victims of domestic violence to shelters when they recognized signs of mental illness in the victim (Stalans & Finn, 1995). These findings are disturbing in light of the evidence that PWMIs are

disproportionately victimized (Chuang, Williams, & Dalby, 1987; Darves-Bornoz, Lemperiere, Degiovanni, & Galillard, 1995; Hiday, Swartz, Swanson, Borum, & Wagner, 1999; Jacobson, 1989).

Lewis and colleagues (1994) followed a random sample of PWMIs released from Illinois state psychiatric hospitals in the Chicago area for 12 months (see also Lewis et al., 1991). Their findings demonstrated that roughly 20% of the former patients were arrested within one year after leaving the institution. Approximately 75% of the offenses committed by the former patients were for municipal crimes (e.g., loitering, trespassing, public intoxication) or property crimes (e.g., theft, burglary, damage to property).

Lewis et al. (1994) also reported that the prehospitalization criminal histories of the former patients who were arrested were more extensive and serious than suggested by their arrests in the follow-up year. They had an average of nine prior arrests, 25% of which were for violent felony offenses, such as murder, rape, armed robbery, and aggravated assault. Former patients who were likely to pass through the criminal justice system during the investigation were also frequent residents of state psychiatric facilities. These PWMIs were apparently consuming the resources of both the mental health and criminal justice systems at an alarming pace. Patient arrestees, for example, were admitted for psychiatric treatment twice as often in the course of the study as were patients who had not been arrested. Chronic patients/arrestees moved back and forth between the mental health and criminal justice systems, each of which was ill-equipped to handle their complex combination of problems and needs (also see Teplin & Voit, 1996).

In another study, Lurigio and Lewis (1987) performed case studies of arrested PWMIs and found major differences in the types of crimes that they committed and their reasons for committing those crimes. Patients with criminal records fell into three categories. The first category consisted of patients whose criminal conduct was a by-product of mental illness. Their offenses frequently involved disorderly conduct, criminal trespass, disturbing the peace, and public intoxication. Their main "crime" was exhibiting the symptoms of mental disorder in public. About 42% of the arrested patients fell into this category.

George C. is typical.* A man in his early fifties, he had been arrested dozens of times for screaming obscenities, arguing violently with bus drivers over transfers, smoking on the subway, or engaging in other disruptive public behaviors. Several of his arrests occurred when George's brother called the police to stop him from pounding on the door in the middle of the night and demanding money. The police knew George well, did not regard him as dangerous, and generally released him right away, knowing that they would probably pick him up again soon.

The second type of PWMIs with criminal histories resorted to crime—primarily property offenses (petty theft and shoplifting) and prostitution—simply to survive. Their sporadic criminal activity was a means to obtain money when their wages or supplemental security incomes failed to cover their living expenses. Nearly 30% of the arrested patients were in this category. Twenty-two-year-old Sue R. had been in the hospital three times and diagnosed as schizophrenic. When her welfare check

* All names of patients in this article have been changed.

did not cover the bills, she shoplifted. At other times, when she was in desperate financial straits, she turned tricks or sold drugs.

The third type of PWMIs committed more serious offenses, such as burglary, assault, rape, and robbery. Their histories paralleled those of criminals without mental illness in the type, frequency, and repetitiveness of their offenses. They were the least seriously impaired by their mental illness, which seemed incidental to their crimes and co-occurred with heavy drug and alcohol use. Approximately 28% of the arrested patients were in this category. William F., 38, had been arrested nearly 20 times since he was 18. William spent 6 years in prison for armed robbery and was on probation for assault at the time of the study. He had been admitted to state hospitals numerous times, mostly for schizophrenia and chronic alcohol abuse.

Role of Stigma of Mental Illness in Police Decisionmaking

Stigmas about mental illness are widely accepted by the public. Studies indicate that many people in the United States (Link, 1987; Phelan, Link, Stueve, & Pescosolido, 2000; Rabkin, 1974; Roman & Floyd, 1981) and most Western nations (Bhugra, 1989; Brockington, Hall, Levings, & Murphy, 1993; Greenley, 1984; Hamre, Dahl, & Malt, 1994; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987) stigmatize people with mental illness. Stigmas depict PWMIs as "homicidal maniacs" who need to be feared; persons with childlike perceptions of the world who should be marveled at; or rebellious, free spirits (Farina, 1998; Gabbard & Gabbard, 1992; Hyler, Gabbard, & Schneider, 1991; Mayer & Barry, 1992; Monahan, 1992). One study found that although the public has a better understanding of the causes of mental illness, public perceptions and fears that PWMIs pose a threat have increased over the past 50 years (Pescosolido, Martin, Link, Stueve, & Kikuzawa, 2000).

According to the social psychological literature, people who are attracted to law enforcement professions might have stronger tendencies to stigmatize groups with lower status, such as PWMIs. Early psychological research on law enforcement has described a police "culture and personality," which are characterized by authoritarianism, conservatism, cynicism, emotional detachment, and suspiciousness (Adlam, 1982; Paoline, Myers, & Worden, 2000). Authoritarianism, in particular, is correlated with prejudice against marginalized groups, such as PWMIs (Altemeyer, 1996; Duckitt, 1993; Haddock, Zanna, & Esses, 1993; McFarland & Adelson, 1996; Peterson, Doty, & Winter, 1993; Pratto & Catley, 2002; Whitley, 1999; Zick & Pretzel, 1999).

Rather than being inherent traits of people who choose careers in law enforcement, elements of police personality are often shaped by a working environment that is defined by uncertainty, danger, coercive authority, boredom, lack of respect from the public, and excessive paperwork (Adlam, 1982; Crank, 1998; Teahan, Adams, & Podany, 1980). In order to cope with their working conditions, officers become authoritarian and suspicious, adopt an "us against them" attitude toward the public (Sparrow, Moore, & Kennedy, 1990), and develop a crime fighting rather than community policing focus (Walker, 1977). Thus, it is not surprising that authoritarianism is relatively high among law enforcement professionals (Pratto, Stallworth, Sidanius, & Siers, 1997; Sidanius & Pratto, 1999; see Ottati, Triandis, & Hui, 1999 for related evidence regarding the military). Because law enforcement

professionals are relatively authoritarian, they might be especially likely to stigmatize people with mental illness.

The nature of the contacts police officers have with PWMIs is also conducive to the development or reinforcement of stigmatizing attitudes. Although PWMIs constitute a small percentage of all individuals criminal justice professionals encounter, many PWMIs are in crisis or have been victimized. The concurrence of two distinctive stimuli, a person with mental illness and a crisis or crime, results in an overestimation of the pairing (Hamilton & Gifford, 1976). This erroneous inference about the relationship between mental illness and dangerousness and criminality and incompetence is an example of what social psychologists refer to as "illusory correlation." Furthermore, the overexposure to people with mental illness in negative situations makes these kinds of instances more available to recall, biasing professionals' judgment about the frequency of violence, crime, and incompetence among this population (See Tversky & Kahneman, 1973 for a discussion of the availability heuristic). Social psychologists have also found that people in positions of authority, such as police officers, are less motivated to attend to individuating information and more likely to rely on stereotypes (Fiske, 1993; Goodwin, Operario, & Fiske, 1998).

The type of personality characteristics that attracted police officers to law enforcement careers and the cognitive processes that make officers more prone to developing and relying on negative stereotypes paint an unfair and distorted picture of police officers. Clearly, most officers are diligent in protecting the life and liberty of all people in their community; however, any act of police officer bias can have costly personal and professional consequences. Thus, they must be especially aware of how their personal biases may influence their interactions with members of stigmatized groups, such as PWMIs.

Do Officer Attitudes Influence Their Interactions with PWMIs?

Most attitudinal explanations of police officer behavior are based on typologies of police officers, generally consisting of four types defined in terms of the valences of two attitudinal dimensions (Worden, 1989). In a study of situational and attitudinal factors, Worden (1989) measured police officers' "attitudes" along five dimensions: (1) role orientation, (2) legal restrictions, (3) citizen respect /cooperation, (4) legal institutions, and (5) selective enforcement. He found that although situational factors have significant effects on the decision to arrest, they have modest effects on the choice to initiate informal action. In addition, attitudinal variables accounted for a very small part of police behavior.

Worden's research suggests that police officers' attitudes do not predict behavior. (One might argue that it depends on what attitudes are measured; this study excluded attitudes about specific groups, such as persons with mental illness.). Instead, it focuses on structural features of police departments and suggests that police behavior and decisions are circumscribed by formal controls, training, socialization, and specialization (March & Simon, 1958; Simon, 1976). These controls diminish the effects of individual attitudes by enforcing formal rules and imposing informal organizational constraints and the expectations of the "police culture" (Worden, 1989). To the extent that this is true, we need to examine the

structural stigma imbedded in the formal and informal police organization (and in the community).

A more recent study suggested that both organizational and individual factors affect officers' attitudes about PWMIs. Bolton (2000) examined how individual and organizational factors influenced perceptions of dangerousness, credibility, and self-sufficiency of an individual presenting with symptoms of schizophrenia. Officers' age, race, and training were related to their perceptions of dangerousness, with younger officers with less training on mental illness perceiving more danger in people who have mental illness. Previous contact with individuals with mental illness was related to greater perceptions of PWMIs' credibility. Slight increases in training on mental illness and a departmental focus on community policing were also related to more positive perceptions of people with schizophrenia. The way in which these attitudes affect officer behavior was not examined in this study. Bolton, a former police officer and trainer, recommended future research to explore whether improving officer perceptions' of PWMIs increases officer safety and decreases unwarranted arrests, involuntary commitments, and lawsuits.

Contrary to Worden's claim that police officers' attitudes are not significant predictors of behavior, several studies suggest that stereotypes about mental illness influence police decisionmaking. For example, Finn and Stalans (1995) examined how police officers' stereotypes about PWMIs affected their interpretations of domestic violence situations and referral decisions. They found that when the offender showed signs of mental illness, he or she was viewed as more responsible for the situation, more dangerous, less in control of his or her actions, and less credible than "normal" and intoxicated offenders.

Based on these perceptions, officers were more likely to refer the victims of offenders with mental illness to domestic violence shelters. A related study (Stalans & Finn, 1995) found that when a victim of domestic violence showed signs of mental illness, police viewed the offender as less dangerous and the victim as more responsible. In these cases, they were less likely to make referrals to domestic violence shelters.

In an investigation of police officers' attitudes about mental illness, 382 officers completed a survey in which they were presented a vignette with a male subject in the role of a victim, suspect, witness, or person in need of assistance (Watson, Corrigan, & Ottati, 2004a). Some of these vignettes mentioned that the subject had schizophrenia; others did not. Officers perceived the subject with schizophrenia to be significantly more dangerous and less credible and felt both more pity and anger toward him. They viewed the subject with mental illness as less responsible for his situation and were more likely to endorse helping him and legally mandating him to treatment. Officers were less likely to act on information provided by the victim and witness with mental illness (Watson, Corrigan, & Ottati, 2004b).

Similarly, the results from an Illinois study of police officers' encounters with and responses to persons with mental illness indicated that police officers believe that they are at greater risk of violence when interacting with people with mental illness and claimed that their responses are hampered by a lack of training, lack of departmental policies for responding to persons with mental illness, and poor communication with mental health professionals (Wisnewski & Lurigio, 2003).

Improving Practices

Police departments should provide officers with recruit and inservice training on the signs and symptoms of serious mental illness. Although most law enforcement agencies provide some training related to mental illness (Deane et al., 1999), the amount of time allotted to this training is not commensurate with the challenges posed by calls that involve PWMIs (Hails & Borum, 2003 ; Nees, 1990; Teplin, 1984). Therefore, despite the proven benefits of such training (e.g., changing officers' attitudes toward PWMIs and improving their relationships with mental health providers), most departments' training curricula are deficient in this area (Murphy, 1986).

Husted, Charter, and Perrou (1995), for example, reported that law enforcement officers in California had been insufficiently trained in identifying, managing, and referring PWMIs, even though it was recognized that officers had extensive contact with the mentally ill in their routine law enforcement practices. Without special training, "law enforcement personnel are ill-prepared to effectively handle mentally ill citizens" (Teplin, 1990, p. 17). The content of such training is also important. Simply training officers in de-escalation and crisis management techniques can actually exaggerate their perceptions of the rate of violence among persons with mental illness and increase the use of unnecessary force. More intensive training that develops communication skills and describes the causes, signs, symptoms, and treatment resources for mental illness would improve officers' ability to handle all types of situations involving people with mental illness.

Officers should also be cross-trained with mental health providers, so that both groups can share their concerns and discuss the philosophies and exigencies that affect their respective expectations and responsibilities in responding to PWMIs. Cross-training can help establish effective working relationships between police officers and mental health practitioners (Murphy, 1986). In addition, family members of PWMIs could benefit greatly from cross-training by learning about appropriate police roles and practices pertaining to PWMIs (Hartstone, 1990).

Police departments' general orders should include clear guidelines for handling PWMIs (Murphy, 1986). These guidelines are most useful when they clarify the relationship between the police department and local mental health providers, which is based on written and formal memoranda of understanding and no-decline agreements. Officers need to know about accessible diversionary options for PWMIs who commit less serious crimes. Unfortunately, many jurisdictions lack the resources required for accessible diversionary options. Law enforcement and community mental health agencies must work together to lobby for the funding of these services.

Police officers are reluctant to work with PWMIs for the reasons that we have discussed here, but when police officers do work with PWMIs, their effort usually goes unrecognized (Hartstone, 1990). As Murphy (1986) stated, "departmental policies seldom offer incentives or rewards for successfully managing PWMIs, and officers seldom receive any feedback on the results of their efforts" (p. 62). Such activities are compatible with officers' duties in the areas of order maintenance and social service referrals, which are important components of many community policing strategies (Rosenbaum, Yeh, & Wilkinson, 1994).

Deane and colleagues (1999) surveyed nearly 200 police departments to examine their responses to PWMIs. More than half (55%) of the agencies completing the survey, reported that they had no specialized mechanism for dealing with the mentally ill. Those with special programs had implemented one of three strategies:

1. A police-based, specialized police response (3%), involving sworn officers who are trained to provide crisis intervention services and act as liaisons to the mental health system
2. A police-based, specialized mental health response (12%), involving mental health workers who provide on-site and telephone consultations with sworn officers.
3. A specialized mental health response (30%), involving mobile crisis teams of local mental health professionals who worked closely with the police and provided on-site assistance to PWMIs

The third strategy received higher effectiveness ratings than the other two strategies. Geller, Fisher, and McDermach (1995) also reported that mobile crisis teams delivered effective emergency mental healthcare.

Finn and Sullivan (1989) described eight model police programs for handling the mentally ill, operating in Birmingham, Alabama; Erie, Pennsylvania; Los Angeles, California; and Madison, Wisconsin. The model programs consisted of networks of law enforcement and social service agencies that shared responsibilities for PWMIs who came to the attention of the police for public disturbances or more serious criminal acts. The network partners signed formal agreements of collaboration that enumerated the responsibilities of each participating agency. At the core of each network is a crisis unit, on-duty or on-call 24 hours, to offer screening, referral, or on-scene emergency services.

The Birmingham program is an excellent example of a police-civilian partnership designed to serve the city's large, transient population of PWMIs (Finn & Sullivan, 1989; Murphy, 1986; Steadman, Deane, Borum, & Morrissey, 1999). The program, initiated in 1976 by the University of Alabama, was originally a pilot project to provide the police department with a team of in-house civilian social workers, known as Community Service Officers (CSOs). CSOs are liaisons between the police and PWMIs, between PWMIs and social service agencies, and between the police department and mental health facilities.

CSOs have become an integral part of the police department, operating out of police headquarters, 7 days a week, 15 hours a day, and relieving officers of the need to respond to mental-health-related repeat calls for service or to mental-health-related calls in which police action is unnecessary. When they are off-duty, CSOs remain on-call to come to the immediate aid of a PWMI in response to a police summons on their beepers.

In general, CSOs take control of the case at the scene, allowing officers to return quickly to their beats. CSOs work closely with the mentally ill person's family and the city's mental health centers and hospitals. The police accompany CSOs to hospital emergency rooms only when a PWMI is violent. After such an individual has been restrained at the facility, the CSO remains the police department's representative throughout the remainder of the admission proceedings. The University of Alabama hospital has psychiatric beds reserved for indigent people referred by the police.

In 1997, CSOs responded to more than 2,000 calls for service. Police officers are informed of the dispositions on all CSO-assisted cases.

A pilot survey of police officers was recently conducted by Vermette, Pinals, and Appelbaum (2005) with the goal of determining which modalities police officers prefer when they are being trained on the handling of PWMIs; the study also explored officers' attitudes to that training. Of the 150 police officers surveyed, over 90% stated that learning about mental illness was important. Police officers with more experience were especially emphatic about this point. Other topics that police officers rated as extremely valuable were dangerousness, suicide by cop, police officers' potential liability for bad outcomes, decreasing suicide risk, and mental health law. In response to preferred training modalities, police officers did not enjoy role-play techniques and considered them less effective than the other modalities. Overall, police officers appreciated the importance of learning more about mental illness as a way to help them deal more effectively with PWMIs.

Across the country, law enforcement agencies are attempting to improve their response to persons with mental illness. A more sophisticated approach that includes training has recently been adopted by many agencies. Based on a model developed by the Memphis Police Department, Crisis Intervention Teams (CIT) are composed of specially trained officers that provide first-line response to calls involving persons with mental illness; these officers are the department's liaisons to the mental health system (Borum et al., 1998). Although jurisdictions have adapted the model to their local jurisdictions, the essential elements of an enhanced police response are training, partnerships with mental health resources in the community, and a redefined response to mental health calls that incorporates changes in police officers' roles and organizational priorities (NCSG, 2002).

Key to CIT interventions are training officers, forging law enforcement partnerships with mental health community resources, and shifting police roles and organizational priorities from a traditional enforcement model that only reluctantly deals with PWMIs to a service-oriented model that focuses on the needs of PWMIs. CIT programs are intended to improve treatment for PWMIs and divert them from the criminal justice system. Through education, training, and changes in organizational practices, CIT programs might reduce police officers' stigmatization of and discrimination against PWMIs. These measures will improve officers' ability to interact effectively, respectfully, and safely with PWMIs.

Police officers have traditionally been hesitant to regard the assistance of PWMIs among their basic job responsibilities. In reality, however, they are often the first responders when a person with mental illness is in crisis. With scant mental health training , they are responsible for serving both the individual with mental illness and the community (Finn & Sullivan, 1987, 1989). Often, the resources needed to provide an appropriate disposition are not available. The gap between what officers are expected to accomplish and their means to do so might result in negative attitudes toward PWMIs.

CIT programs are designed to repair this disconnect and provide officers with the resources they need to manage mental health calls. Officers receiving CIT training have the knowledge and skills to assess mental illness, communicate with a person in crisis, and access community resources. CIT programs cultivate relationships with

mental health agencies in order to better understand their perspectives, procedures, and constraints and to share expertise and develop new collaborative procedures between police and providers. The implementation of CIT programs reinforces the expectation that assisting PWMIs is a legitimate police function, which can reduce the role strain that officers experience when they must respond to mental health calls. As such, CIT programs can improve officers' attitudes about PWMIs and their motivation and ability to serve everyone in their community without stigmatizing or discriminating.

In summary, several program models for training police officers and improving relationships between mental health and law enforcement agencies have been created. Because of the frequency of encounters between police and PWMIs, training police officers on the handling of PWMIs is critical.

Conclusions and Recommendations

Many PWMIs invariably come into contact with the police. One major reason why PWMIs are arrested at higher rates than other groups is the lack of treatment options in the community and the scarcity of options for police officers to help them manage their behavior. Arresting them is often the quickest way to secure their access to treatment. In addition, public tolerance of PWMIs is low, and both citizens and police officers often assume that PWMIs are more dangerous than they actually are. Police officers are also able to use their discretion for handling PWMIs, especially when the mental illness is unrelated to the crime for which they are being arrested.

In order to ensure that PWMIs are not being treated more harshly than people without mental illness, system-wide changes must be implemented. Lamb, Weinburger, & DeCuir (2002) identified treatment options for the mentally ill in the community as a critical component in reducing the criminalization of PWMIs and improving interactions between the police and PWMIs. If PWMIs receive needed services, their mental illnesses are less likely to result in police intervention. If their behavior becomes uncontrollable, both their family members and police officers will be able to take advantage of community resources.

Finally, in addition to increasing services in the community, police officers require more comprehensive training about PWMIs, which will encourage the officers to change their attitudes about PWMIs and improve their relationship with mental health professionals. Such training will also help eliminate the PWMI stigma, which often paints them as violent and dangerous. In short, improving police training and broadening the availability of mental health services in the community will most assuredly improve interactions between police officers and PWMIs.

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The Mental Health Effects of Racial Profiling

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Racial injustice and discrimination have been a part of American society for many decades. While the civil rights movement of the 1960s prompted a dramatic shift in America's overt and hostile racial behaviors and attitudes, people of color (i.e., Hispanics, Asians, African Americans, Native Americans), especially African Americans continue to experience subtle forms and overt acts of racism. In the recent years, racial profiling of drivers during traffic stops has become a central issue within the field of law enforcement (Farell, Rumminger, & McDevitt, 2004).

In February of 2001, President George W. Bush announced that racial profiling is wrong and that it could end in America. In June of 2003, the President released guidelines for the Department of Justice Civil Rights Division—Regarding the Use of Race by Federal Law Enforcement Agencies—and when these were issued, he stated, "America has a moral obligation to prohibit racial profiling" (American Civil Liberties Union, 2004, p. 1). The guidelines highlight the societal problem of racial profiling as a national issue. Even with national guidelines, racial profiling continues to occur at local, state, and federal levels.

According to the ACLU (2004), the federal guidelines had a serious flaw in that the content did not apply to many law enforcement agencies; it was mainly directed at federal organizations not mandated with security.

Due to the flaws of the Department of Justice guidelines, the House of Representatives and Senate introduced the End Racial Profiling Act to track and eliminate profiling based on race, ethnicity, and national origin. Yet, the history of racist ideologies and the way in which race has been treated in American society, in state laws, and in federal legal codes has led to established social traditions and customs that continue to promote, according to some scholars and officials, injustices based on race. Moreover, there has been a proliferation of laws and policies that attempt to address racial profiling as a violation of constitutional and legal rights, but the mental health impact of racial profiling on people of color has received little attention and is not adequately addressed or understood in the law enforcement and psychological research literature (Carter, 1995; Carter, Forsyth, Mazzula, & Williams, 2005).

It is our contention that it is important to recognize both the legal rights as well as the human toll that violations associated with racial profiling have on the health and well-being of its targets. Therefore, the purpose of this study is to discuss the psychological and emotional effects of racial discrimination and racial profiling.

Racial Profiling and Hostile Discrimination: Definition

According to the ACLU (2005), racial profiling is defined as an act that occurs when race is used as a proxy by law enforcement agencies to target individuals for criminal suspicion. Some would argue that racial profiling involves the use of racial bias on the part of law enforcement officials and officers regarding who is likely to be a criminal (ACLU, 2005)—a point that is often hotly debated. For example, police officers' use of race to determine which drivers to stop (e.g., "driving while black or brown") or to search and arrest is thought by some to be a form of racial bias and by others a reasonable law enforcement tool.

Carter and Helms (2002) proposed that racism be deconstructed and redefined so that its effects on the target can be better understood and to determine whether experiences with racism can and do produce traumatic stress reactions. In addition, Carter (2005) suggests that it is difficult to understand how racism affects mental health because it has not been connected to specific mental health outcomes. Carter (2005) suggests that definitions not currently recognized in the law make it possible to connect experiences of racism to specific mental health effects by distinguishing classes or types of race-based acts, such as aversive and hostile acts of racism. Aversive acts of racism are considered to be racial discrimination in that the acts are meant to create distance or reduce contact between the dominant and nondominant racial groups. Hostile acts are considered to be racial harassment, a form of dominative racism (Carter & Helms, 2002) used to communicate the inferior statue on nondominant groups (Kovel, 1970), manifesting itself in distinctive forms (e.g., race-based assaults, racial profiling). Therefore, Carter et al. (2005) consider racial profiling to be a hostile act that should be thought of as racial harassment (not the legal definition). The significant impact of this specific act of harassment on people of color will be discussed further in this article.

While Americans pride themselves in the notion of fairness and equality, racial profiling continues to thrive in American society, undermining the basic human rights and freedoms to which all Americans are entitled. Racial profiling contradicts the core principles of America that all people are created equal and should receive equal and fair treatment regardless of any immutable characteristic. Moreover, despite the President's challenge to end racial profiling and the recent policies issued by the U.S. Department of Justice (2003) regarding the use of race by law enforcement agencies, racial profiling continues to occur.

Studies regarding racial profiling (e.g., Novak, 2004; Rojek, Roenfeld, & Decker, 2004; Tomaskovic-Devey, Mason, & Zingraff, 2004) continue to show that minorities (blacks and Hispanics) are stopped more often than whites. According to the U.S. Department of Justice (2005), the findings from the Bureau of Justice Statistics 2002 National Survey regarding contact between civilians and police officers revealed problematic results. The study showed that during traffic stops, police were significantly more likely to search Hispanics (11.4%) and blacks (10.2%) compared to whites (3.5%). Moreover, the Department of Justice survey revealed that blacks and Hispanics were approximately three times as likely to be searched, arrested, or threatened by police officers compared to whites. In 1999, the ACLU and other coalition groups filed and won a lawsuit against the New Jersey State Police for their use of racial intimidation of people of color.

For some people of color, racial profiling results in the target receiving traffic summons from police officers; however, for others, the outcome is devastating and deadly. On February 4, 1999, Amadou Diallo, a young, West African adult was shot and killed near his residence by four white police officers who fired 41 bullets and hit Diallo 19 times during a "stop and frisk" technique used by the New York City Street Crimes Unit against African Americans (ACLU, 2005). According to the ACLU (2005), the New York State Attorney General issued a report on the New York City Street Crimes unit indicating blacks were stopped 10 times more than whites, and 35% of the stops had insufficient information to determine the victims' charge. Similarly, on April 7, 2001, Timothy Thomas, an African-American teenager from Ohio was shot and killed after running away from police officer. Thomas had 14 misdemeanor warnings, most of which were traffic violations such as failure to wear a seatbelt (ACLU, 2005). To date, several research studies confirm racial profiling in police officers' decisions to fire against the target. Researchers (e.g., Corell, Bernadette, Judd, & Wittenbrink, 2002) have found that participants were more likely to fire at African Americans than whites and failed to shoot at an armed target when the target was white.

While the exact reasons for racial profiling are not clear, the literature consistently demonstrates that racial differences exist in police stops, searches, and arrests (ACLU, 2005; Rojek et al., 2004). Black and Hispanic motorists are not only more likely to be stopped by police officers, they are also more likely to be searched and arrested compared to white motorists. Some argue that bias processes may explain racial profiling by law enforcement agencies (Tomaskovic-Devey et al., 2004). Police officers may perceive blacks and Hispanics as more dangerous. According to Holmes (1998), today's police practices are derived from the time when police officers were charged as an institution to control immigrants, poor racial minorities who were perceived as "dangerous groups." Holmes suggests that law enforcement agencies still operate under these bias processes. In a study of 817 participants from El Paso, Texas, Holmes (1998) found young minority males were seen, by the predominately Hispanic police force, as posing the greatest physical threat to police officers and were perceived as more likely to challenge police authority.

Studies investigating citizens' perceptions of police and law enforcement are consistent with the aforementioned different perspectives regarding the racial profiling debate. In a study of perceptions of the criminal justice system, Henderson, Cullen, Cao, Browning, and Kopache (1997) found that 80% of black participants believed they were more likely to be stopped by the police, jailed, and sentenced to death. The majority (95%) of white participants believed the criminal justice system was racially neutral and reflected equal treatment under the law. According to Henderson et al. (1997), "there is a cultural divide albeit, with roots in structural inequality—between black and white Americans in the understanding of the existence of injustice. Race is part of the lives of many people of color, a fact made clear through a host of daily interactions, which for whites there is simply indifference to race" (p. 457).

It is clear from the aforementioned reports that racial profiling continues to be a problem for Americans of color. These reports also provide a compelling argument to show that scholars and researchers are clearly documenting the violation of Americans' human and legal rights. It is also important, however, to document and understand the psychological and emotional effects of racial profiling on its targets.

Mental Health Effects of Racism

Racial profiling can have mental health consequences for the targets of the act. Yet, while hostile acts of racism, such as racial profiling, continue to be a reality for many people of color in American society, little is known about how they are affected psychologically and emotionally.

In has been found that racism in general may be a chronic stressor leading to various physiological problems (e.g., higher blood pressure) in addition to psychological and emotional effects (Clark, Anderson, Clark, & Williams, 1999). Several researchers (Clark et al., 1999; Ocampo, 2000) support this contention, demonstrating that the psychological and emotional reactions or impacts of racial discrimination may be similar to the experience of psychological trauma and stress associated with physical or psychological abuse, emotional and verbal assault, or rape (Dunbar, 2001).

Similarly, other scholars suggest that experiences with racism lead to subjective distress, accompanied by intrusive thoughts and avoidance behavior (Sanders Thompson, 1996) and psychological distress, generalized anxiety, and major depression (Kessler, Mickelson, & Williams, 1999; Williams, Neighbors, & Jackson, 2003). Moreover, according to Feagin and Sikes (1994), experiences with racism are not only painful for the individual at the time of the event but may also have continued effects that may influence the individual's life and worldview.

According to Carter et al. (2005), experiences of racial discrimination (aversive) and racial harassment (hostile) are stressors that may rise to the level of being traumatic and thus warrant further exploration; however, they suggest that racism, as a stressor is difficult to understand using the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (APA, 2000). We suggest that an understanding of Post-Traumatic Stress Disorder (PTSD) in war veterans and the general population exposed to potentially traumatic events helps to illustrate how people of color respond to such events and the types of symptoms of stress and trauma they exhibit. Researchers who study PTSD reactions have found that people of color experience more severe symptoms compared to the general population. Trauma researchers have noted that the mental health outcomes may be due to both exposures to racism and the stressful life circumstances that result in a PTSD diagnosis (for a review see Carter, In Press). Carter notes that PTSD and stressful life events investigators contend that racism may be a significant stressor for people of color. He argues that this provides indirect evidence that experiences with racism are associated with the elevated levels of PTSD found in most life-event research.

Racism, in general, appears to be a significant stressor for people of color. Despite the gap in the literature regarding the psychological and emotional effects, the human toll racism takes is gaining attention from scholars and researchers. Very little is known, however, about the mental health effects of racial profiling. The study by Carter et al. (2005) found mental health effects to be associated with racial profiling; therefore, the purpose of this article is to present the findings from that study that document the psychological and emotional effects resulting from racial profiling as well as analyses specific to the general experiences of racism or discrimination.

Participant Description

The primary aim of this study was to document and understand the mental health impact of racism or encounters with discrimination. The study consisted of 262 black, Asian, Latino, and biracial respondents who reported whether they had encounters with discrimination and any resulting lasting psychological effects. The authors found that 29 (11%) of respondents did not have an encounter with racial discrimination and that 233 (89%) did. The respondents who had an experience(s) of discrimination were predominantly female (72%), and 27% were male. Sixty three percent were between the ages of 21 to 40, and 34% were 41 and older. Most were black (51%), followed by Hispanic/Latino (18%), Asian (15%), and biracial (10%). The participants were well-educated; 67% had some education or a degree, 30% had a college degree or some college, and 3% had a high school diploma or some high school education.

Types of Discrimination and Psychological Effects

Participants responded to open-ended questions about their experiences (see Carter, In Press). Ten racial discrimination response categories were developed from the participants' responses to the question, "What happened?" In addition, nine categories were developed for lasting psychological impact from responses to the question, "Were there any lasting effects?" Of the ten discrimination categories developed, two are the primary focus of this article: (1) Multiple Experiences of Discrimination (e.g., several acts of racial discrimination) and (2) Racially Profiled (e.g., followed in store, accused or suspected of theft, stopped by police).

The nine types of mental health or psychological effects for all forms of racial discrimination were as follows: (1) Extreme Emotional Distress (e.g., upset, multiple emotions); (2) Hyper-Vigilant or Arousal (e.g., more aware, self-conscious); (3) Mild Emotional Distress (e.g., single mild emotion); (4) Avoidance (e.g., stayed away, more distant); (5) Intrusion (e.g., recurring memories, nightmares); (6) Distrust (e.g., unwilling to believe other racial group members); (7) Lower Self-Worth (e.g., lower self-esteem, hurt performance or ability); (8) Positive Outcome (e.g., stronger, more determined); and (9) Other (i.e., psychological effects not captured by other categories).

Frequency of Profiling

We conducted specific analyses to examine the two categories that involved profiling; it was found that Racially Profiled (12%) and Multiple Experiences (18%), which included being "profiled," accounted for 30% of people's encounters with racism and discrimination. With regard to race, the results show blacks accounted for the largest number of those who reported being "profiled" (50%) followed by Latinos (29%).

For all types of respondents' experiences with discrimination reported, it was found that regardless of where the discrimination took place—at work, school, or in public, including multiple encounters and locations—the majority of respondents (64%) characterized the incidents as recurring. In particular, being racially "profiled" was something that happened over and over again.

Mental Health Effects and Differences Between Aversive and Hostile Racism

Based on Carter and Helms' (2002) definitions of *racial discrimination* as aversive or avoidant racism and *racial harassment* as hostile racism, we calculated the frequencies for each type. The results indicated that in nearly all locations, incidents of hostile racism or racial harassment (i.e., to demean) were reported more often than were incidents of aversive racism. Regarding being "profiled," it was found that when people were in stores, 74% of the events reported involved racial profiling (e.g., being stopped and searched or followed); whereas, 23% of the reported experiences were actions that were related to aversive discrimination (denied access or ignored).

Moreover, when taking all categories of reported encounters into account, the results showed that overall, 74% (173) of our respondents who had encounters with racial discrimination reported lasting mental health or psychological effects. For all types of discrimination categories, respondents who experienced racial harassment (hostile racism), such as being profiled or being demeaned, were more likely to report experiencing psychological effects compared to those who experienced aversive discrimination.

Because people differed in the types of discrimination experienced, they also varied in indicating whether they had any lasting psychological or mental health effects. Nevertheless, when people reported encounters that involved racial harassment or hostility, between 75% and 94% of respondents reported lasting mental health or psychological effects. In contrast, those who experienced racially aversive discrimination (being avoided) reported lasting mental health or psychological effects between 48% and 67% of the time. The frequency was somewhat less often, but still a fairly large proportion of the sample that was avoided experienced psychological effects as a consequence.

The utility of Carter and Helms (2002) distinction between aversive (racial discrimination) and acts of hostility (racial harassment) is shown in the findings of this study in that the two types of race-based experiences resulted in different psychological effects for the participants. Specifically, that hostile acts or racial harassment, like being "Profiled," resulted in more severe lasting psychological and emotional effects than acts of aversion or racial discrimination.

Mental Health Effects of Being Profiled: Racial Group Differences

Racial group differences in lasting psychological and emotional effects, depending upon the type of racial discrimination, were examined. It was found that among those who reported being profiled, blacks and Latinos reported experiencing psychological impact more than other racial groups. The most frequently reported mental health effects from being profiled were moderate emotional distress (24%), extreme emotional distress (19%), arousal (19%), and avoidance (19%). When racially profiled, blacks were three times more likely than Latinos to report experiencing avoidance and were the only ones to report moderate emotional distress. Latinos who were profiled were three times more likely than blacks to report reactions of psychological or emotional arousal.

Summary of Racial Profiling Findings

In summary, it was also found that Latinos and blacks were profiled more often than people from other racial groups. The findings indicate that racial groups differ in the way various types of racism impact them psychologically. Perhaps the variations are due to different cultural and sociopolitical histories and experiences. Of all the racial groups, blacks and Latinos were more likely to be targets of "profiling" and to be psychologically and emotionally affected by being "Profiled," and they tended to express their distress in racially/culturally unique ways. Latinos expressed distress more through arousal and hyper-vigilence reactions, while blacks tended to react with avoidance symptoms.

With regard to the mental health effects of racial profiling, it was found that 68% of those who were "Profiled," characterized their experience as repetitive, and 75% reported having lasting emotional and psychological effects as a result. Furthermore, 80% of those who reported being "profiled" were black or Latino. The four most frequently reported mental health effects were extreme (many strong and powerful emotions) and moderate distress (single emotion), hyper-vigilant /arousal (irritable), and avoidance (stayed away or withdrew).

Conclusion

The findings of the study are consistent with previous research that has shown racism to be a stressor that leads to various psychological reactions. The overwhelming majority of the respondents (89%) indicated that they had an experience with racism or discrimination. Of those who did encounter discrimination, approximately 75% reported some lasting mental health or emotional and psychological effect. Moreover, while black Americans have been historically the most visible target for overt and covert acts of racism, they are not the only racial group to report such experiences. It was found that Latinos, Asians, and biracial people also reported repeated experiences with discrimination and racism in the form of being profiled.

For most of the respondents, experiences with discrimination occurred in many aspects of their lives including, work, school, and social situations, as well as were they lived and shopped. Hostile discrimination or racial harassment occurred more often and with a higher psychological and emotional or mental health cost to the target.

Overall, the results of this investigation have shown that for people of color, experiences of racial discrimination and harassment were stressful, and signs and symptoms associated with traumatic reactions were reported. It was found that, in general, nearly all of the mental health effects reported by respondents were consistent with models of traumatic stress and that a smaller proportion also fit the narrower criteria for PTSD or acute stress. Additionally, the results revealed that there are apparent differences between the types of experiences that constitute hostile and aversive racism, and they result in different mental health effects. This later finding provides support for Carter and Helms' (2002) proposal to deconstruct and redefine racism into hostile and aversive forms. The frequency with which the participants in the study reported extreme distress and other psychological and emotional reactions suggests that mental health effects associated with racism including being profiled are both acute and chronic and as such violate targets'

rights and psychological well-being. Attention has been directed at the violations of legal rights in racial profiling and discrimination, but less attention has been directed at mental health violations. We hope more attention will be given to the mental health or psychological cost of racial profiling.

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Mental Health Problems and Criminal Justice Involvement Among Female Street-Based Sex Workers

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Previous research has delineated a variety of female sex worker typologies, including "call girls" and escorts working in the upper echelons of the sex industry; "in-house" sex workers working in parlors or brothels; "street-walkers" who sell sex for money through sidewalk solicitations; part-timers who supplement their incomes with sex-for-pay; and drug-involved street-based sex workers, the majority of whom shift between sex-for-money and sex-for-drug exchanges as circumstances require (Estébanez, Fitch, & Nájera, 1993; Exner, Wylie, Leura, & Parrill, 1977; Inciardi, 1995; Jones et al., 1998). Although most in this latter group express a preference for commercial solicitation along local "strolls," many typically resort to sex-for-drugs exchanges when they have an immediate need for drugs, when money is scarce, and when paying "dates" (customers) are few in number (Inciardi, Lockwood, & Pottieger, 1993; Inciardi & Surratt, 2001).

Street-based women typically occupy the "bottom rungs" of the sex-for-pay hierarchy. Concomitant with this position, street sex workers are exposed to elevated levels of violence, including rape and assault (Coston & Ross, 1998; El-Bassel et al., 1997; Farley, Baral, Kiremire, & Sezgin, 1998; Kurtz, Surratt, Inciardi, & Kiley, 2004; Penfold, Hunter, Campbell, & Barham, 2004; Surratt, Inciardi, Kurtz, & Kiley, 2004; Wenzel, Leake, & Gelberg, 2001), and because of their visibility on the street, the potential for arrest is high (El-Bassel, Simoni, Cooper, Gilbert, & Schilling, 2001; Jones et al., 1998; McClanahan, McClelland, Abram, & Teplin, 1999). Moreover, many are heavy users of cocaine, crack, heroin, and other drugs (Kilbourne, Herndon, Anderson, Wenzel, & Gelberg, 2002; Young, Boyd, & Hubbell, 2000), which places them at high risk for loss of social services and support structures, including family connections and stable housing (Spittal et al., 2003; Valera, Sawyer, & Schiraldi, 2001; Weiner, 1996). Homelessness is common to the lives of many street sex workers and has been established as a key predictor of increased drug use and HIV risk behaviors among this population (Surratt & Inciardi, 2004).

Within this unstable and often chaotic environment, researchers have observed poor mental health functioning among street-based women sex workers. In contrast to brothel-based sex workers, among whom measures of mental health tend to approximate those of the general population (Chudakov, Ilan, & Belmaker, 2002; Romans, Potter, Martin, & Herbison, 2001), street-based sex workers are more likely to exhibit psychological distress, including symptoms of psychosis and depression (Alegria et al., 1994; El-Bassel et al., 1997; El-Bassel et al., 2001). It has been suggested, furthermore, that the relationship between sex exchange and psychological distress may be related to increased victimization, including childhood physical and sexual abuse and adult violence, which are frequently reported among female sex workers (El-Bassel et al., 2001; Penfold et al., 2004; Silbert & Pines, 1983; Surratt, Kurtz, Weaver, & Inciardi, 2005; Valera et al., 2001). Childhood abuse has

been independently associated with an increased likelihood of adult drug use, psychological distress, victimization, sexual risk behaviors, and involvement in the criminal justice system (Goodman & Fallot, 1998; Johnsen & Harlow, 1996; Morrill, Kasten, Urato, & Larson, 2001; Widom & Ames, 1994; Wilsnack, Vogeltanz, Klassen, & Harris, 1997; Young et al., 2001). Adult violent victimization has also been shown to predict psychological distress among street-based female sex workers (Surratt et al., 2005). In addition, because street sex workers are engaged in stigmatized illegal activities, they are often reluctant to report violent victimization to appropriate authorities (Penfold et al., 2004), further isolating them from needed mental health support services.

As gatekeepers to the criminal justice system, police officers are typically the first point of contact for victims of violence and are frequently the sole resource for individuals suffering from mental health problems and urgent psychological crises (Corcoran & Allen, 2005; Lamb, Weinberger, & Gross, 2004). Because female sex workers have substantial exposure to street-based violence and unstable living conditions, they appear particularly vulnerable to a variety of mental health problems. In addition, their visibility on the streets and engagement in illegal activities makes the likelihood of arrest considerable. Within this context, this study examines the prevalence of specific mental health problems and criminal justice involvement among a cohort of drug-involved, street-based female sex workers in Miami, Florida, and reviews the development of local police responses to managing mental health crises.

Methods

The data for this study was drawn from a larger intervention trial funded in 2000 by the National Institutes of Health that was designed to test the relative effectiveness of two alternative HIV prevention protocols among drug-involved street-based female sex workers. Supplementary support was awarded by the funding agency in mid-2002 to conduct mental health assessments and provide case management services and referrals for women enrolled in the larger study. As such, mental health data is available on 343 street-based sex workers, who are the focus of this article. Eligible participants are women ages 18 to 50 who have traded sex for money or drugs at least three times in the past 30 days and used heroin and/or cocaine three or more times a week in the past 30 days.

Participants in the study were located for recruitment through traditional targeted sampling strategies (Watters & Biernacki, 1989), which are especially useful for studying hard-to-reach populations. Targeted sampling is a purposeful, systematic method by which specified populations within geographical districts are identified and detailed plans are designed to recruit adequate numbers of cases within each of the target areas. Several elements are necessary for this approach, including the systematic mapping of the geographical areas in which the target population is clustered, the examination of official "indicator data" (e.g., police arrest reports), information from professional and indigenous key informants, and direct observations of various neighborhoods for signs of sexual solicitation. Similar strategies have been used successfully in recent years in studies of injection and other out-of-treatment drug users (Braunstein, 1993; Carlson, Wang, Siegal, Falck, & Guo, 1994; Coyle, Boruch, & Turner, 1991).

A unique aspect of the project's sampling plan is the use of active sex workers as client recruiters. The effectiveness of indigenous client recruiters in drug abuse research has been well documented (Inciardi, Surratt, & McCoy, 1997; Latkin, 1998; Levy & Fox, 1998; Wiebel, 1990, 1993). Because active sex workers do the recruiting of study participants and because of their membership in the target population, they know of many locations on and off the primary strolls where potential participants can be found. In addition, sex worker recruiters are more likely to have familiarity with drug user networks, drug "copping areas," and markets. They typically approach potential clients with culturally appropriate language, dress, and methods; and their "insider status" helps to build the trust and confidence necessary for successful outreach and recruitment.

Client recruiters made contact with potential participants in various street locations to explain the nature and procedures of the study. Those meeting project eligibility requirements were scheduled for appointments at the project intervention center, where they were screened and interviewed by project staff members. The interview process took approximately 90 minutes to complete. All study procedures were reviewed and approved by the University of Delaware's Institutional Review Board.

Interviews were conducted using a standardized data collection instrument based primarily on the National Institute on Drug Abuse Risk Behavior Assessment (Dowling-Guyer et al., 1994; Needle et al., 1995; Weatherby et al., 1994) and the Georgia State University Prostitution Inventory (Elifson, 1990). This instrument captures demographic information, health status, criminal justice and treatment history, as well as lifetime and 30-day measures of drug use frequency and sexual risk behaviors. The following key measures of mental health and trauma were also utilized to gather symptom level information: Childhood Trauma Questionnaire (short form) (Bernstein et al., 1994), Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (Beck & Steer, 1993), and the Traumatic Stress Index (Dennis, Titus, White, Unsicker, & Hodgkins, 2003).

Descriptive statistics were compiled on demographic characteristics; drug use; experiences of childhood and adult victimization; symptoms of depression, anxiety, and traumatic stress; as well as criminal justice histories of the participants. All analyses were conducted using the Statistical Package for the Social Sciences (SPSS) v.13.0 for Microsoft™ Windows.

Results

The participants ranged from 18 to 50 years of age, with a mean of 36.5 years (see Table 1). Forty percent of the sample was age 40 or older. In terms of race/ethnicity, the majority (71.4%) were African-American, followed by Latina (14.9%), and white-Anglo (10.8%). The living situation of the sex workers was typically unstable, with 39.7% reporting that they considered themselves to be homeless. While the remainder were sheltered, they were often precariously housed in hotels, temporary public shelters, rooming houses, or the homes of acquaintances.

Table 1
Selected Demographic Characteristics of 343 Female Street-Based Sex Workers in Miami, Florida

Age	
18-24	9.3%
25-34	26.9%
35-39	23.6%
40+	40.2%
Mean	36.5
Race/Ethnicity	
African-American	71.4%
White-Anglo	10.8%
Latina	14.9%
Other	3.0%
Currently Homeless	39.7%

As illustrated in Table 2, the drug use and sex work histories of the participants were substantial. The participants were typically poly-drug users, and reports of past month activity indicated that alcohol and crack-cocaine were the substances most widely used (82.8% and 64.7%, respectively), followed by marijuana (63.9%), powder cocaine (57.4%), and heroin (14.5%).

Table 2
Drug Use and Sex Work Characteristics Among 343 Female Street-Based Sex Workers in Miami, Florida

Percent Using in Past 30 Days	
Alcohol	82.8%
Marijuana	63.9%
Crack-cocaine	64.7%
Cocaine	57.4%
Heroin	14.5%
Mean Years of Sex Work	13.4
Mean Number of Sex Partners	
Lifetime	1,222.9
Mean Number of Sex Partners	
Past 30 Days	19.8
Percent Soliciting from . . .	
Street	86.6%
Bars/clubs	18.7%
Convenience store	17.2%
Gas station	15.5%
Bus stop	10.8%

The sex work careers of the participants spanned an average of 13.4 years, with a mean of over 1,200 lifetime sexual partners. Current (past month) sex work activities most often included vaginal and oral sexual contacts, with a mean of 19.8 sexual partners. The vast majority solicited customers on the streets (86.6%), and many also made contact with clients in bars or clubs, convenience stores, gas stations, and bus stops.

Drug involvement and street-based sex work tended to expose women to violent episodes in their daily lives, often deepening and extending patterns of victimization from childhood. Interesting in this regard were the historical self-reports of trauma experienced by the participants as children. As indicated in Table 3, the prevalence of childhood abuse in this sample was extremely elevated: 54.5% reported a history of childhood physical abuse, 54.2% reported sexual abuse, and 70.0% reported emotional abuse. Similarly, 36.2% of the women reported some violent encounter while engaging in sex work in the past year (e.g., being "ripped off" or forced to give up money that was paid for sex, beaten, threatened, or raped by a customer or "date"). When individuals other than "dates" were considered as perpetrators of violence, the percentage reporting a violent encounter (physical or sexual) in just the past 3 months was 32.5%. Typically, these perpetrators were boyfriends, drug dealers, or other street people.

Table 3
Victimization Among 343 Female Street-Based Sex Workers in Miami, Florida

Childhood Victimization	
Emotional Abuse	70.0%
Physical Abuse	54.5%
Sexual Abuse	54.2%
Any Physical/Sexual Violence	
In Past 3 Months	32.5%
Violent "Date" Encounter	
In Past Month	16.9%
In Past Year	36.2%

Within the context of these violent life experiences, self-report mental health inventories administered to the participants revealed that significant proportions of the sample were affected by psychological issues, specifically, anxiety, depression, and traumatic stress (see Table 4). Nearly one-third of the women assessed were classified with moderate or severe anxiety symptoms (31.8%); almost one-half had symptoms of moderate or severe depression (46.2%); and 64.6% had symptoms of acute traumatic stress. A significant proportion of the sample reported previous mental health diagnoses (40.8%), including mania, depression, anxiety disorders, and schizophrenia. More than one-third had been prescribed medications to treat these conditions.

Table 4
Mental Health Status Among 343 Female Street-Based Sex Workers in Miami, Florida

Current Depression Symptoms	
Minimal/Mild	53.8%
Moderate/Severe	46.2%
Current Anxiety Symptoms	
Minimal/Mild	68.2%
Moderate/Severe	31.8%
Traumatic Stress Symptoms	
None	4.7%
Low	30.7%
Acute	64.6%
Previous Psychiatric Diagnosis	40.8%
Previous Psychiatric Medication	36.2%

Table 5 presents data on the arrest histories of the sample. More than three-quarters (81.9%) reported at least one lifetime arrest, and the mean number of arrests for the sample was substantial at 5.9. Not surprisingly, some 21% reported at least one prior arrest for prostitution; however, even higher proportions indicated having previously been arrested for drug possession (36.4%), shoplifting (24.5%), and assault (23.9%).

Table 5
Arrest Histories of 343 Female Street-Based Sex Workers in Miami, Florida

Ever Arrested & Charged	81.9%
Mean Number of Lifetime Arrests	5.9
Ever Arrested for Drug Possession	36.4%
Shoplifting	24.5%
Assault	23.9%
Prostitution	21.0%
Bad Checks/Fraud	9.6%
Drug Business	9.3%
Weapons Offense	7.9%
Robbery	3.8%
Homicide/Manslaughter	0.8%

Discussion

Although much of the existing research on sex workers focuses on health risks associated with HIV and other sexually transmitted infections (UNAIDS, 2004), there is a growing body of literature documenting elevated levels of other health problems

among this population, including violent victimization and symptomatology for depression, anxiety, and traumatic stress (Baldwin, 1992; Belton, 1992; Farley & Barkan, 1998; Giobbe, Harrington, Ryan, & Gamache, 1990; Kurtz et al., 2004; Mahan, 1996; Surratt et al., 2005). In this study of drug-involved, female sex workers recruited from the streets of Miami, Florida, a clear majority of the participants reported these violent incidents and mental health problems.

Of the 343 sex workers interviewed, 54.2% reported sexual abuse, and 54.4% reported physical abuse as children. These findings resonate with previous studies that have also documented elevated childhood abuse prevalences among adult female drug users (Freeman, Collier, & Parillo, 2002; Medrano, Hatch, Zule, & Desmond, 2003; Teets, 1995). Recent violent victimization was also commonplace, with 32.5% of the women in this study reporting sexual or physical assault during the 3-month period prior to the interview. Again, this proportion appears realistic, given prior research in New York City documenting past year physical or sexual abuse in 32.1% of the street sex workers sampled (El-Bassel et al., 2001). Perhaps most significantly, a recent National Violence Against Women survey sponsored by the National Institute of Justice and the Centers for Disease Control and Prevention placed the percentage of women in the general population experiencing rape or physical assault in the past 12 months at 0.3% and 1.9%, respectively (Tjaden & Thoennes, 1998). In this analysis of drug-involved sex workers, the rates of violence from dates and other perpetrators are many times higher, suggesting that female sex workers are located in a social environment where violence is commonplace. This data provides context to understand the elevated rates of acute traumatic stress observed in this sample.

This study also documented elevated prevalence rates of current depression and anxiety among the sample of women. This data is supported by similar studies reporting high levels of past-year depressive symptoms in 64% to 70% of street sex workers (Alegria et al., 1994; Burgos et al., 1999) and well exceeds the rates of current depression in both incarcerated women (10%) and women in the general population (5% to 9%) (Hutton et al., 2001). Moreover, these levels of depressive symptoms are significantly higher that those of other female drug users who are not necessarily sex workers. For example, in a study of 420 African American female, out-of-treatment drug users in St. Louis, only 11% reported depression during the past month (Johnson, Cunningham-Williams, & Cottler, 2003).

Finally, this study documented significant contact with the criminal justice system among this population of street sex workers. Eighty-two percent reported at least one prior arrest, and the average number of lifetime arrests reported approached six per respondent. Although this level of criminal justice involvement is not unexpected given that police are tasked with enforcement of prostitution statutes, this data documents the extent to which police officers are called upon to manage an offender population with significant mental health problems. This trend has become widespread in a number of communities, as there are typically insufficient community-based resources to adequately identify and treat individuals with mental health problems. As such, police agencies have increasingly assumed this role (Lamb et al., 2004).

In response, police departments have begun to develop innovative strategies to balance public safety and peacekeeping concerns with the need to provide appropriate intervention for individuals with serious mental health problems

(Corcoran & Allen, 2005; Matthews, 2005). Often, these strategies involve combining the efforts of police and social service agencies within the community or the establishment of formal liaisons between police agencies and mental health professionals (Lamb et al., 2004). Other approaches focus on increasing the training provided to police officers and first responders regarding mental health issues and the appropriate handling of individuals with mental health impairment. Although such programs are rarely subjected to rigorous evaluation, reports are beginning to emerge suggesting that such mental health training produces positive effects on police work, particularly in enhancing communication between officers and mentally impaired citizens and improving police attitudes toward people with mental health problems (Pinfold et al., 2003).

In this regard, the City of Miami Police Department has developed a particularly comprehensive approach to the management of individuals with mental health problems. Initially formed in 1999 with a cadre of 39 volunteers, the Crisis Intervention Team (CIT) remained somewhat undeveloped until an officer-involved shooting of a homeless, mentally unstable veteran in 2001 prompted the department to fully commit to the large-scale institutionalization of the program. Since 2002, the CIT has become a model program comprised of more than 70 officers and supervisors handling some 3,500 calls annually. These officers complete 40 hours of specialized training to become CIT certified, in which they learn key aspects of managing mentally unstable individuals, including appropriate positioning and posture, establishing rapport, nonaggressive dialogue, and handling the scene to reduce the likelihood of overwhelming the impaired individual.

The department has also implemented a number of strategies to encourage support for the program, including the provision of salary incentives for officers involved in the CIT. Other core policies that distinguish this program from different models are the 24-hour availability of CIT officers in order to provide complete coverage for mental health crisis calls and the development of officer logs that are used to track CIT call data in order to plan resource allocation and identify patterns that will assist future responders (e.g., repeat calls from the same location can be easily identified as necessitating CIT involvement). Perhaps most unique is the use of Field Training Officers (FTOs), all of whom are CIT certified. FTOs train all academy graduates in 4-month rotations and, in doing so, expose every new City of Miami police officer to crisis intervention techniques. By casting this wide net, the head of the CIT program, Captain Sebastian Aguirre, believes that the department can "change police culture and attitudes toward individuals with mental illness from the bottom up."

Our experiences with mental health crises on the Miami sex worker research project described earlier suggest that these policies are having a positive impact on police interactions with mentally unstable individuals. On two separate occasions in 2004, project staff were obliged to call for police assistance with unstable clients. In one instance, a client became visibly agitated and ran into the street yelling unintelligibly and displaying bizarre behavior. The police responded within minutes, parked down the street in order to avoid frightening the client, and talked to the woman without drawing their weapons. Although she was unwilling to go with them, one officer was able to approach and take her into custody with little apparent force. An officer who was trained in CIT response handled the paperwork to have her involuntarily admitted to crisis stabilization and transported her. Prior to leaving

the scene, the officer also provided the research program director with his contact number in the event of future need.

On another occasion, a client became despondent and unstable, repeatedly talking of ending her life. The program director informed her of the CIT-trained City of Miami police officers and asked whether she would like them to be contacted. She agreed, stating that she had talked to them before. On arrival, an officer spoke privately with the client, and the client went voluntarily to his car, where he made arrangements for her arrival, processing, and subsequent transportation to a crisis facility.

Given the increased role of law enforcement officers as first responders to mental health crises, the need for innovative approaches to manage these situations is apparent. The observations presented here suggest that the program development and policy changes instituted by the City of Miami Police Department are effective tools for managing crisis situations among female sex workers and other offenders with mental health impairment as well.

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Acute Psychological Intervention for Law Enforcement Personnel Following Trauma Exposure: What Is Current Best Practice?

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Introduction

The nature of law enforcement work is such that police officers are regularly exposed to highly stressful or "traumatic" experiences. These may include frightening incidents (e.g., threats to the life or physical integrity of the officer, his or her colleagues, or civilians), as well as events that may elicit feelings of sadness or distress (e.g., exposure to loss of life or human suffering).

It is now widely recognized that some kind of mental health intervention should be available to emergency services personnel exposed to traumatic events. The field, however, is in its infancy, with considerable disagreement regarding the nature and effectiveness of such interventions. Early interventions may take a variety of forms, ranging from low-key, practical assistance to highly specialized psychological and pharmacological intervention models. The purpose of this article is to review what is (and is not) known about the nature and efficacy of acute interventions following trauma, with particular reference to law enforcement and other emergency service personnel. Where reliable research data is available, the reference to the original publication has been provided. Where relevant research does not exist, recommendations and conclusions have been based on my clinical experience and knowledge of international practice; it is important that the reader interpret the content of this article in that context. It is acknowledged that, in the absence of a strong empirical evidence base, decisions regarding appropriate models may have to rely more on a consensus view of best practices than on research data.

Most of the interventions discussed in this article fall under the broad heading of primary prevention. For the purposes of this article, *primary prevention* is defined as those approaches that aim to reduce the incidence of new cases through intervention before the disorder occurs. These interventions, therefore, are applied nonselectively to the whole exposed population. Secondary prevention, on the other hand, aims to reduce the prevalence of disorders through early identification of problems with intervention before the disorder becomes severe. These interventions, therefore, are applied only to the minority of individuals who go on to develop significant adjustment problems in the first few weeks following the incident. Although it is often assumed that the earlier the intervention is applied, the better the chance of recovery (Neria & Solomon, 1999), such claims are yet to be supported empirically.

A fundamental starting point in the immediate aftermath of trauma is to expect normal recovery. The presumption of clinically significant mental health problems

in the early post-incident phase is inappropriate; organizational responses and clinical interventions should be carefully designed to promote normal and healthy adjustment processes. Equally, it is important to remember that a minority of personnel—for a range of possible reasons—will not show a normal recovery course following traumatic exposure. Detailed description of the clinical picture is beyond the scope of this article, but it is worth noting key features of post-traumatic mental health problems such as distressing memories of the event, sleep disturbance, anger, and being constantly on edge. Individuals may become emotionally numb and detached or try to manage their distress by turning to excessive use of drugs or alcohol.

What Constitutes a Traumatic Event?

Although there is no definitive answer as to what constitutes a traumatic event or critical incident, a useful starting point is Criterion A1 from the DSM diagnoses of post-traumatic stress disorder (PTSD) and acute stress disorder (ASD). This criterion emphasizes exposure to real or perceived threat to the physical integrity of oneself or others. Under certain circumstances, the person may not have been exposed to the event directly but may have heard about it later and/or from a distance. Thus, some kind of support may be appropriate following a broad range of events, including unexpected death or serious physical injury (or associated threats) to law enforcement personnel, their colleagues, or others (including civilians) with whom they have contact. More liberal definitions focus on the critical incident in terms of the psychological response rather than the event itself. Thus, any event that is likely to produce a strong emotional reaction would be defined as a "critical incident" (Miller, 1999; Mitchell & Everly, 1996).

As long as the nature and extent of any intervention is appropriate to the needs of the target population, it is probably reasonable to adopt a combination of these two definitions. That is, psychological support services should be activated both in response to highly stressful events and in response to significant distress or impaired functioning among officers.

Psychological Debriefing

Description

One of the most widely used primary prevention strategies in the aftermath of trauma is some kind of debriefing model. Psychological debriefing was designed as a response to individuals who have experienced psychological trauma, with the aim of establishing support and preparing individuals for recovery (Litz, Gray, Bryant, & Adler, 2002; Shalev, 2000). Unfortunately, the term is ill-defined and is used to cover a range of group and individual interventions that often include some combination of education, self-diagnosis, cognitive restructuring, and abreactions (or, at least, an opportunity to confront the traumatic memories).

Modern approaches to psychological debriefing were developed predominately by Raphael (1986) and Mitchell (1983) to help rescue workers deal with the stress associated with their employment. Initially, these debriefings were conducted in a group context. The work of Raphael and Mitchell has since been followed by alternative debriefing approaches, which employ a variety of techniques and

procedures, all of which have been essentially derived from these structures and adapted to suit various populations (Miller, 1999).

Critical Incident Stress Management (CISM) was developed in the 1980s to assist emergency services personnel after exposure to traumatic or "critical" incidents (Mitchell & Bray, 1990; Mitchell & Everly, 2000). CISM involves a range of crisis intervention and stress management services that may be offered to personnel at different time points following traumatic exposure. The best known component is debriefing, sometimes known as Psychological Debriefing (PD) (Devilly, Gist, & Cotton, in press; Litz et al., 2002) or Critical Incident Stress Debriefing (CISD) (Mitchell & Bray, 1990); however, proponents of CISM emphasise that CISD is only one part of CISM and that debriefing should occur conjunctly with other procedures as part of a comprehensive approach to the management of traumatic reactions. Although this makes reasonable sense clinically, this approach has been criticized on the grounds that the boundaries of CISM are so ill-defined that research to evaluate its effectiveness has become impossible (Devilly et al., in press).

The most widely used form of debriefing is often referred to as the "Mitchell Model" and usually comprises the following stages:

- Introduction and guidelines for participation
- Discussion of the relevant facts
- Discussion of thoughts
- Discussion of reactions and emotions
- Discussion of emergent symptoms
- Education about responses and coping strategies
- Re-entry (including summarization, discussion of available resources, etc.)

All personnel involved in the incident are generally encouraged (or, in some cases, forced) to attend the debriefing session regardless of their level of symptomatology, based on assumptions that all individuals will experience a reaction at some level and that having all personnel present is important in providing a complete picture of the event. Although the characteristics of those conducting the debriefing varies, with mental health, allied health, and peer support personnel being used in different settings, there is general agreement that those providing debriefing should be trained and that standard protocols should be implemented and carefully followed. (It should be noted, however, that there is no evidence at this stage to suggest that training increases efficacy). Since psychological debriefing has become popular among emergency services across the world, despite several cautionary opinions (Gist, 2002), it is appropriate to provide a brief overview of the available evidence. An important distinction should be made here between psychological debriefing, as discussed above, and operational debriefing. The latter is a purely factual review for the purpose of learning what actually happened for the historical record and improving future results in similar circumstances. The potential positive or negative psychological effects of operational debriefs have yet to be the subject of systematic study; although, it is reasonable to assume that they may confer some benefits for participants if the session is conducted well (e.g., in a balanced and constructive manner, without scapegoating and with adequate attention to the group dynamics).

Efficacy

Despite its widespread use, the effectiveness of debriefing is far from clear, with relatively few controlled studies available (Raphael, Meldrum, & McFarlane, 1995). Research in this area is notoriously difficult to conduct, and severe methodological problems limit the interpretability of most published studies (Deahl, 2000). The field is polarized, with strongly held views both for and against the process. Robinson and Mitchell and Everly (1995), for example, state that there is "overwhelming circumstantial and anecdotal evidence for the effectiveness of properly administered debriefings" (p. 6). They go further to state that the dramatic expansion of CISD through organizations around the world is testament to the fact that it meets important needs. On the other hand, neither a review conducted under the auspice of the Cochrane Foundation (Rose & Bisson, 1998), nor a meta-analysis of the available empirical literature (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002) found any evidence to support the use of one session psychological debriefing. As a result, those authors concluded that brief preventative interventions for trauma are inappropriate and that the current practice of routine psychological debriefing should cease.

In fact, the research evidence is inconclusive. Anecdotal reports and uncontrolled designs have often indicated some benefits from psychological debriefing (see Everly, Flannery, & Mitchell, 2000 for a review). Raphael, Singh, Bradbury, and Lambert (1983), for example, reported that rescue workers who underwent debriefing were able to assimilate their experiences more effectively, while Mitchell and Bray (1990) report that emergency services personnel who received CISD demonstrated less job turnover and fewer mental health problems. Some studies on adolescents (e.g., Stallard & Law, 1993) and children (e.g., Chemtob, Tomas, Law, & Cremniter, 1997) have reported reduced levels of symptomatology during debriefing intervention follow-up.

Several studies, on the other hand, have failed to demonstrate any beneficial effects from debriefing. For example, Carlier, Lamberts, van Uchelen, and Gersons (1998), in a study of police officers who had responded to a civilian plane crash, found no difference at 8 months between those who did and did not undergo a debriefing following the incident. Kenardy et al. (1996), in a quasi-controlled study of emergency services personnel following the Newcastle earthquake in Australia, and Rose, Brewin, Andrews, and Kirk (1999), in a randomized controlled trial with victims of violent crime, both failed to show a reduction in long-term psychopathology among individuals who received debriefing. Indeed, there is some evidence to suggest that debriefing may actually be iatrogenic, resulting in poorer subsequent adjustment. Some studies (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000) have found higher levels of post-traumatic problems at follow-up among individuals who were debriefed compared to individuals who were not. This was especially true for those with high initial symptoms (Mayou et al., 2000). Litz et al. (2002), however, note that effect sizes in those studies are small and suggest that it is premature to conclude that debriefing is actually countertherapeutic.

A major difficulty in the efficacy debate relates to the lack of consensus about the goals of debriefing. Proponents argue that the aim is not specifically to prevent long-term psychopathology but, rather, to "mitigate the impact of a critical incident

and to assist the personnel in recovering as quickly as possible from the stress associated with the event" (Mitchell & Everly, 1995, p. 8). Debriefing, it is argued, is not intended to be a form of psychotherapy and cannot realistically be expected to reduce all symptoms of stress among all individuals who receive it. On the other hand, it could reasonably be argued that an intervention that fails to improve longer term adjustment following traumatic exposure is of questionable value.

A final point worthy of note is the consistent finding that participants in debriefings usually report high satisfaction ratings with the experience, even when it does not reduce long-term symptoms (Robinson, 2000). Hytten and Hasle (1989), investigating the effects of debriefing on firefighters, for example, reported that 66% found the intervention worthwhile and helpful, despite the fact that there was no significant decline in their anxiety levels. It is interesting to note that this perception of benefit in the short term, as well as satisfaction with the opportunity to debrief, does not necessarily correlate with mental health outcomes (Solomon, Neria, & Witztum, 2000). Likewise, debriefing may be perceived as a desirable organizational response to traumatic exposure regardless of the necessity of the intervention. A recent retrospective study of 1,202 peacekeepers indicated that while two-thirds of respondents were in favour of debriefing on return to the UK, the majority did not require intervention, and highly distressed personnel were already accessing professional care (Greenberg et al., 2003). It would not be surprising if similar findings were apparent in law enforcement agencies around the world. At the very least, presumably, some kind of low-key early intervention provides an indication that the organization is concerned about the psychological well-being of its employees.

Summary and Recommendations

Although strong empirical evidence is lacking, there is a body of clinical and research data upon which to draw some conclusions about the effectiveness of debriefing, as well as tentative guidelines for the use of this approach under certain circumstances:

- There is considerable evidence to suggest that psychological debriefing is routinely perceived by participants as being beneficial.
- There is insufficient evidence to suggest that psychological debriefing applied indiscriminately to survivors of trauma facilitates recovery.
- There is preliminary evidence to suggest that individually administered debriefing, in the absence of screening for risk factors or suitability, may impede recovery in some individuals.
- There is preliminary evidence to suggest that those individuals with the highest initial distress are most likely to be adversely affected by participation in debriefing.
- It is reasonable to assume that the components of debriefing with the most potential for both benefit and harm are the detailed discussions of the event and personal reactions.
- It is no longer justifiable to conduct routine psychological debriefings following traumatic exposure; rather, decisions regarding whether to adopt this approach should be made on a case-by-case basis.

Clinical experience suggests that debriefing (notably the detailed review of the event) is more likely to be appropriate under the following circumstances:

- When it is provided within the context of a broader stress management program and ongoing organizational support (e.g., in occupational settings with strong employee support arrangements)
- When the participants are part of a pre-existing group that will continue to work together, rather than a group whose only shared experience is the traumatic event (Thus, a debriefing involving law enforcement officers from several areas or precincts would not normally be recommended, even if they all attended the same incident.)
- When the debriefing is group-based, with a strong emphasis on the benefits of ongoing peer support (There is a mounting body of evidence to suggest that single session individual debriefs are not recommended.)
- When the incident falls broadly within the range of events that those individuals may expect to encounter in the course of their work (That is, fundamental assumptions about the self and the world have not been severely disrupted by the experience. Debriefing models should be used with great caution following less expected events such as multiple shootings, terrorist attacks, and other incidents involving widespread loss of life.)
- When the emotional and behavioral reactions of individuals are contained and not overwhelming (Thus, some brief preliminary screening of individuals prior to conducting a debrief is strongly recommended; those with high symptom levels, including dissociative symptoms, such as feeling emotionally numb or excessive detachment, are the most likely to be adversely affected by a psychological debriefing process).

Finally, the level of confusion and emotive debate surrounding the term *debriefing* suggests that it should be dropped, reserving that term for operational debriefing. An alternative, such as "post-incident support," "psychological first aid," or "acute trauma management" should be found to describe a clearly defined group of interventions that may be used individually or in combination.

Potential Components of Early Intervention

Several components of a standard debriefing model are routinely adopted as part of a broader approach to disaster and trauma management. In view of the multiple uses to which the term *debriefing* is applied and the many components that may comprise a psychological debrief, it is recommended that the use of more specific descriptive terms be adopted for each aspect. It then becomes easier to develop specific intervention models that combine components to provide a "best fit" for any given situation (rather than adopting a "one size fits all" approach).

Education and Information

The provision of simple education about common psychological responses is routine practice in acute trauma management and disaster recovery (Creamer, 1996; Lystad, 1988), as well as in the treatment of more established disorders such as PTSD and ASD (Bryant, Harvey, Dang, Sackville, & Basten, 1998; Foa & Rothbaum, 1998). Such an intervention serves to allay fears of abnormal reactions ("I'm going crazy, losing my mind") and to reduce the emotional valence associated with acute

symptoms (i.e., getting anxious about feeling anxious). It is also assumed that a better understanding of normal trauma reactions may serve to reduce avoidance behavior and social withdrawal, prompt the use of adaptive coping strategies, and facilitate recovery. This may be particularly important among cultural groups in which acknowledgement of psychological distress is a sign of weakness. Although this information may be provided prior to the occurrence of a traumatic event as part of routine training, there is often a place for reinforcing such information again following the trauma. Equally, it is important that this information is presented in the context of an expectation of recovery in order to reduce the risk of "priming" the development of symptoms.

Similarly, it is common practice to provide information, where possible, about the incident and its consequences. Memories of the event are frequently confused, fragmented, and distorted, making it difficult to integrate and assimilate the experience (Foa & Rothbaum, 1998). Figley (1985) has noted that recovery from trauma is characterized by attempts to answer fundamental questions, such as "What happened?" and "Why did it happen?" The provision of accurate information facilitates understanding of the experience, helping to reduce negative appraisals of the event and feelings of vulnerability and increasing perceptions of control. Equally, of course, care should also be taken not to overwhelm the person, and information should be titrated according to need.

To date, strong empirical support for this intervention in isolation of other components is lacking. Indeed, the few studies that have attempted to evaluate the benefits of education following trauma have failed to demonstrate any effect (Ehlers et al., 2003; Turpin, Downs, & Mason, 2005). Nevertheless, the procedure is used so widely across settings and theoretical approaches that it probably justifies inclusion as a best practice.

Social Support

A strong evidence base exists regarding the benefits of social support in recovery from traumatic exposure (Creamer, Burgess, Buckingham, & Pattison, 1993; Gist & Lubin, 1999; Greenberg et al., 2003; Solomon, 1986; Ursano, Grieger, & McCarroll, 1996). Increased availability and use of naturally occurring social support networks is routinely associated with improved subsequent adjustment. Thus, a primary task in providing psychological first aid is to facilitate the development and use of naturally occurring support networks.

Presumably, pre-existing unit cohesion will be a major factor in the extent to which law enforcement personnel are able to support each other following exposure to trauma. There is increasing evidence to suggest that negative social support (e.g., having people around who are overly critical, demanding, hostile) is an important predictor of recovery, especially for females (Andrews, Brewin, & Rose, 2003). Thus, a thorough knowledge of the group dynamics and cohesion of the unit will comprise an essential part of the assessment in determining subsequent "best fit" interventions.

Management of Acute Symptoms

There is now a reasonable body of research evidence to suggest that two acute symptom presentations—(1) high arousal, which is characterized by increased heart rate and breathing, muscle tension, etc. (Bryant, Harvey, Guthrie, & Moulds, 2000; Shalev et al., 1998) and (2) peritraumatic dissociation, which is characterized by feelings of detachment and/or unreality, emotional numbing, etc. (Freedman, Brandes, Peri, & Shalev, 1999; Fullerton et al., 2000)—are associated with poorer adjustment.

The management of high arousal has long been a central component of treatment for both acute traumatic stress conditions (Bryant et al., 1998) and more chronic PTSD (Foa & Rothbaum, 1998). Simple arousal reduction strategies have also been commonly used in disaster recovery settings (Creamer, 1996). An evolutionarily developed "fight or flight" response is adaptive while the threat is present but becomes maladaptive if it continues too long after the danger has passed. High arousal disturbs the processing of information and serves to consolidate traumatic memories. These interventions (being relatively "nonpsychological" in nature) have high appeal to many populations such as law enforcement officers, emergency services workers, and the military. A reasonable body of strong empirical data has been accumulated to support the use of anxiety management in traumatic stress conditions (Foa, Keane, & Friedman, 2000). Thus, teaching simple arousal reduction strategies (such as simple breathing control, relaxation, reducing stimulants such as coffee and cigarettes, aerobic exercise, etc.) is a logical component of early intervention.

The management of acute dissociative states is slightly more problematic. It is assumed that dissociative symptoms develop as a protective strategy against intolerable stress, and caution should be exercised in attempting interventions targeted at reducing dissociation. No research has yet been attempted to determine the potential benefits of reducing acute dissociation on subsequent adjustment. Nevertheless, it is to be expected that, if other early intervention strategies are implemented effectively, dissociative states are likely to be reduced. At the very least, the presence of peritraumatic dissociation should be noted as a high risk factor, prompting the need for close monitoring of the individual.

As a final word on the subject of acute symptom management, it is worth noting that feelings of control (or lack thereof) are crucial for many survivors of trauma, even if they are not openly acknowledged. Thus, the provision of simple problem-solving strategies, assistance with planning and structuring time, encouragement to keep making smaller decisions (but to postpone major life decisions), and so on will assist the individual to gradually feel more in control.

Confronting the Traumatic Experience

There is no doubt that some kind of prolonged therapeutic exposure to the traumatic memories is the treatment of choice for established traumatic stress conditions such as PTSD (Foa et al., 2000). Less clear are the benefits of encouraging individuals to go through this process in the immediate aftermath of trauma and in the absence of effective screening for risk factors, acute symptom profile, and suitability. As noted above, this is one of the potential dangers of a debriefing approach.

Given the considerable body of evidence to support this approach (i.e., reviewing the traumatic experience in both formal and informal settings), as well as the apparent desire of many trauma survivors to talk about their experiences in the immediate aftermath, it may be best to consider this intervention as a possibility for some survivors after some incidents. A clinical decision will need to be made (perhaps based loosely on the criteria discussed under "Psychological Debriefing") regarding the suitability of this approach in each setting. At the very least, however, there should be no expectation that a detailed review of the experience and associated emotional reactions would be a routine procedure in every case. Making such a process compulsory would definitely not be recommended.

Chemoprophylaxis

Considerable interest has been generated in recent years about the possibility of chemoprophylaxis in traumatic stress; that is, a drug administered prior to, during, or immediately after exposure to an incident may protect the individual against the development of psychological adjustment problems. Clearly, the use of medication to modify emotional reactions during the incident raises serious ethical issues, as well as questions regarding potential impact on performance. The use of medication following the event, however, is perhaps less contentious since it is conceptually similar to strategies that are routinely adopted by groups and individuals to facilitate recovery, including moderate alcohol use.

As noted above, arousal at the time and immediately following the event seems to be an important factor in subsequent adjustment. In line with this proposal, two studies have provided preliminary evidence to suggest that drugs such as propranolol (a "beta-blocker" or, more accurately, a beta-adrenergic blocker), may facilitate recovery in emergency services workers (Pitman et al., 2002) and civilians (Vaiva et al., 2003). This research, however, is at a very early stage, and the field is a long way from making any recommendations in this domain.

Summary of Key Components

Although the empirical data to support the various components described above varies, all have some combination of strong research support, good theoretical rationale, or common usage as part of an accepted best practice approach in acute traumatic stress intervention. The following components, therefore, should be considered as possible interventions for law enforcement officers at various stages in the acute aftermath of trauma:

- Education about common responses to trauma
- Information about the incident
- Activation of, and encouragement to use, social support networks
- Simple symptom management strategies, especially directed at hyperarousal, combined with proactive problem solving
- Opportunities to discuss the experience (for those for whom it is appropriate)

Timing of Interventions

Although CISD is generally conducted within a few days of a traumatic event, there is little evidence to suggest that any particular timing is optimal. Debriefings are

routinely held between 24 and 72 hours after an incident (Dyregrov, 1989), and it is generally accepted that immediate debriefing is often neither possible nor desirable (Deahl, 2000). In many cases, individuals remain too distraught to process any type of intervention at this time; although the provision of simple information, including plans for follow-up the next day, is often a useful immediate strategy.

Perhaps more importantly, interventions should be timed according to the specific needs of the effected population and delivered in a "stepped" approach. It is reasonable to assume that the primary goal in the first 24 hours should be one of containment—establishing safety, addressing basic needs, and minimizing the escalation of overwhelming emotions. It is also an opportunity to conduct an assessment of the situation, screen for high-risk individuals, and begin to develop an appropriate "best fit" intervention. Subsequent acute interventions (24 to 72 hours after incident) will depend on the specific needs of the affected population and may comprise some or all of the components discussed above. This second phase is also an opportunity for more in-depth assessment of individual needs, triaging when appropriate for more intensive intervention. The importance of linking this phase with effective follow-up cannot be overemphasized.

Screening and Assessment

Given the uncertainties surrounding the benefits of early intervention, a strong emphasis on effective screening and assessment is essential. A considerable body of knowledge now exists to inform judgements about which emergency services personnel will, and will not, be at high risk of subsequent problems following traumatic exposure (Heinrichs et al., 2005; Hodgins, Creamer, & Bell, 2001). A range of pre-trauma factors (e.g., prior psychiatric functioning, prior trauma exposure), peri-trauma factors (e.g., level of exposure, predictability, controllability, acute responses), and post-trauma factors (e.g., social support) can predict subsequent adjustment. If the early intervention process does nothing else, it should identify those individuals who need to be targeted for more intensive follow-up.

Initial screening and assessment will be strengthened by the use of standardised assessment instruments. Such psychological tools assist in providing a conceptual structure to help individuals (and clinicians) understand traumatic responses. Such formal assessments also provide critical information for subsequent follow-up, allowing a reflection on past and present levels of symptomatology. Several good measures exist to assess acute symptom levels (Brewin, 2005). A promising approach with a broader focus has been taken by the Royal Marines within the British Defence Forces using a 10-item "Risk Assessment Checklist" (Jones, Roberts, & Greenberg, 2003).

CBT Interventions for ASD and PTSD

Thus far, this article has been devoted to the area of primary prevention—that is, interventions targeted at the whole population rather than only at those who are reporting problems. As noted previously, however, one of the primary goals of early intervention is to identify those in need of more intensive intervention (i.e., secondary prevention) and facilitate the transition to those more specialised services. It is beyond the scope of this article to provide a detailed review of specialist psychological and pharmacological interventions for ASD and PTSD. Suffice to

say, a strong body of research evidence now exists to support the use of structured cognitive behavioral interventions in the treatment of both acute (Ehlers & Clark, 2003) and chronic (Foa et al., 2000) conditions. Furthermore, preliminary evidence indicates that the treatment benefits of early CBT may be maintained at 4-year follow-up (Bryant, Moulds, & Nixon, 2003). Accordingly, it is of vital importance that psychological first aid protocols emphasise referral when appropriate for more intensive treatment and that those options are readily and easily accessible.

Conclusions

On the basis of the available research and clinical literature, as well as my clinical experience, the following recommendations are proposed:

- Acute interventions following trauma should be seen as part of a broader approach to mental health and psychological well-being in law enforcement agencies. Links with other levels of service available to officers should be clearly identified.
- The terms *debriefing*, *CISM*, and *CISD* are misleading and should be dropped in favour of more specific descriptions of individual components. Overarching terms such as *post-incident support*, *psychological first aid*, or *acute trauma management* should be adopted to cover the overall process.
- The type of event for which such "post-incident support" personnel are activated should be defined, both in terms of the objective nature of the incident to which the officers were exposed and the participants' responses.
- A single, standard intervention to cover all events ("one size fits all") is inappropriate. Rather, providers of post-incident support to law enforcement personnel should be capable of designing a "best fit" intervention comprising selections from a range of acceptable components.
- Interventions should be provided in a "stepped" fashion, beginning with a thorough assessment of the situation and ascending according to need. Immediate interventions (within less than 24 hours of the incident) should focus on containment and assessment, with subsequent interventions designed specifically according to the needs of the affected population.
- Detailed review of the event and associated reactions should not be a routine component but, rather, should be administered only on the basis of a careful assessment of "best fit." In particular, the decision should be made by the clinician at the scene and should take into account factors such as the opportunities for ongoing support, the nature of the incident, and the level of emotional and behavioral reactions among participants.
- Providers of post-incident support to law enforcement personnel should be skilled in the provision of a range of interventions including education about common responses to trauma, facilitating access to information about the incident, facilitating activation of social support networks and reducing levels of negative social support, simple symptom management strategies, and facilitating opportunities to discuss the experience (when appropriate).
- A brief, standardised instrument (or selection of instruments) should be adopted to assess risk and determine initial symptom levels.

Although there is now a mounting body of research evidence on which to base these recommendations regarding acute responses to trauma for law enforcement officers, there is still much that remains to be learned. It is incumbent upon those working in the field to constantly evaluate their work to generate systematic improvements.

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Alternatives to Debriefing: Utilizing Psychological First Aid After Hurricane Katrina

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It is well known that disasters can lead to negative psychological sequelae in those exposed. These include post-traumatic stress disorder (PTSD), major depression, suicide, alcohol abuse, and generalized anxiety. In addition, recent research has found a relationship between physical symptoms and exposure to multiple disasters (Fernandez et al., 2005). Of the plethora of possible psychological consequences of trauma, PTSD has been the most extensively studied.

The law enforcement community faces disasters as an occupational hazard, and therefore it may be at increased risk for these negative psychological outcomes compared to the general population. It has been estimated that between 7% and 30% of officers who have been exposed to traumatic events subsequently develop post-traumatic stress symptoms or PTSD, which can be disabling if left untreated (Carlier, Lamberts, & Gersons, 1997). Within the law enforcement community, the higher the level of exposure to trauma, the greater the risk of developing traumatic stress symptoms (Hodgins, Creamer, & Bell, 2001). Furthermore, law enforcement may also face the financial burden of depression, increased alcohol abuse, and possibly suicide after exposure to a disaster.

Studies have identified an increased risk of depression in law enforcement officers after a disaster. One such study found that 16% of police officers screened positive for depression and that 35% of them scored in the moderate to high range on a PTSD measure (Violanti et al., 2006). This indicates that not only do many officers face PTSD-inducing traumatic events, but there may also be a relationship between trauma and depression in this population (Violanti et al., 2006). The relationship between perceived stress and depression is even stronger among law enforcement officers over age 50. Overall, those officers who reported high stress were significantly more likely to report depression than those who reported low stress (Multivariate Odds Ratio – 10.14 95% Confidence Interval – 3.88-26.54) (Gershon, Lin, & Li, 2002).

The emotional and financial consequences of mental illness are enormous. In the most comprehensive study to date, depression/sadness/mental illness constituted the third most expensive illness for any employer, costing $348 per employee per calendar year (Goetzel et al., 2004). Only hypertension and heart disease accounted for higher expenditures by employers. Loss of productivity by employees can have a significant impact on the morale of the overall workforce in dangerous professions. Unfortunately, the most irreversible consequence of depression/sadness/mental illness is suicide.

Suicide is the eighth leading cause of death in the United States, and several studies have found that factors such as depressive symptoms and psychiatric disorders contributed to the increased suicide risk (Haste, Charlton, & Jenkins, 1998; Kung,

Pearson, & Liu, 2003; Qin, Agerbo, & Mortensen, 2003). Suicidal crises are most commonly seen in law enforcement officers who have recently faced debilitating stressors or who have prior histories of depression (Miller, Hemenway, & Azrael, 2004). Although there is serious debate as to whether suicide in the law enforcement community is elevated compared to the general population (Boxer, Burnett, & Swanson, 1995; Mohandie & Hatcher, 1999), it is clear that premature death by suicide is a legitimate concern for the law enforcement community. Factors that are involved in completed suicides include use of a firearm (Miller et al., 2004) and acute alcohol intoxication (perhaps leading to decreased inhibition) (Sher, 2006). Given that it is an occupational requirement to carry a firearm and that there are elevated rates of alcohol misuse by law enforcement (Davey, Obst, & Sheehan, 2000), the concerns about increased suicide risk are clearly warranted. There has been recent evidence suggesting that even natural disasters may increase the risk of suicide among highly exposed individuals (Yang, Xirasagar, Chung, Huang, & Lin, 2005). Therefore, it is critical to develop and implement mental health interventions to mitigate these unfortunate consequences for law enforcement officers in the post-disaster context.

Early mental health intervention after disaster has been a topic of study since the early part of the last century, with the objective being to mitigate the impact of trauma on mental health (Blain, Hoch, & Ryan, 1945). In the case of law enforcement officers, several different approaches have been attempted, including peer support interventions, critical incident stress debriefing (CISD), brief eclectic psychotherapy, and psychological first aid (Castellano, 2003; Gersons, Carlier, Lamberts, & van der Kolk, 2000; Levenson & Acosta, 2001; Mitchell, 1983; Orner et al., 2003). After the terrorist attacks of September 11, 2001, the Patrolman's Benevolent Association of the New York Police Department (NYPD) dispatched its Police Organization Providing Peer Assistance (POPPA) to Ground Zero and provided one-on-one peer support to those working at the site (Levenson & Acosta, 2001). Anecdotally, these services were well received, and POPPA fulfilled its mission of educational outreach, peer support, and providing information for additional support services. They reportedly handed out thousands of POPPA pamphlets and found only one pamphlet on the ground (Levenson & Acosta, 2001). One year later, POPPA performed outreach and screening of the NYPD for stress symptoms still present from the disaster (Dowling, Moynihan, Genet, & Lewis, 2006). Of the 28,232 officers who were screened, 17% endorsed symptoms of anger/irritability, 5% complained of chronic agitation, and 9.2% still had difficulty concentrating (Dowling et al., 2006). Overall, 68% of officers had at least one disaster-related stress symptom still present 15 to 27 months after the attack (Dowling et al., 2006).

The Port Authority Police Department (PAPD) suffered the largest loss of life of police officers in the terrorist attacks of September 11, 2001 (Castellano, 2003). They implemented group Cop 2 Cop interventions for over 1,200 PAPD officers. It was assumed that such a group format would not only be logistically efficient but would also be more effective in normalizing responses and teaching practical coping skills. In this program, officers were mandated to attend a 2-day session if they had more than 30 days of exposure to one of the recovery sites (Castellano, 2003). The Critical Incident Stress Management (CISM) model was utilized (Everly, 2000). Although implemented quite extensively among the PAPD officers, no outcome measures were reported for this intervention. Another intervention strategy employed extensively by first responders is group debriefing (an aspect of CISM). Despite its continued

use, group debriefing has little empirical evidence supporting its effectiveness. One study found that despite high levels of satisfaction expressed by those debriefed, the psychological outcomes were not different for officers who had been debriefed from those who were not (Carlier, Voerman, & Gersons, 2000). Furthermore, among the experienced emergency services personnel surveyed, only 6% endorsed the group debriefing model (Orner et al., 2003).

Psychological first aid (PFA) is an alternative to the group debriefing model. The premise of PFA is that early intervention should reduce the initial distress caused by traumatic events and should foster short- and long-term adaptive functioning (NCTSN & NCPTSD, 2005). According to Tucker and Ng (2004), it is designed to be provided by mental health specialists and currently encompasses four basic areas of focus: (1) stabilize emotionally overwhelmed survivors, (2) assess for maladaptive psychological patterns or illness (including suicide risk), (3) connect the survivor with his or her own natural support system, and (4) communicate information regarding adaptive coping and how to seek further assistance. In approach, there is no need for rigorous adherence to a prescribed script or steps, and there is flexibility regarding the implementation of PFA, perhaps providing for a more natural interaction.

On August 29, 2005, Hurricane Katrina made landfall along the Central Gulf Coast. The storm surge caused multiple breeches in the New Orleans levees, ultimately flooding 80% of that city, all of the St. Bernard's parish, and portions of St. Tammany and Plaquemines parishes. The ensuing chaos led to riots, looting, and over 1,400 storm-related deaths. There were also two police officer suicides (AP, 2005). Being both emergency responders as well as disaster victims, law enforcement officers were exposed to trauma in an unprecedented way. Approximately 80% of New Orleans Police Department (NOPD) was displaced by the storm. All NOPD officers were told to evacuate their families prior to the storm, and a significant percentage of them are still living apart because of storm-related issues. Furthermore, due to ineffective planning, officers did not have stable sleep accommodations.

The National Center for PTSD lists nine factors that place first responders at greatest risk for severe post-traumatic stress symptoms (Young, Ford, & Watson, 2005):

- Life-threatening danger or physical harm (especially to children)
- Exposure to gruesome death, bodily injury, or dead or maimed bodies
- Extreme environmental or human violence or destruction
- Loss of home, valued possessions, neighborhood, or community
- Loss of communication with or support from close relations
- Intense emotional demands (e.g., searching for possibly dying survivors or interacting with bereaved family members)
- Extreme fatigue, weather exposure, hunger, or sleep deprivation
- Extended exposure to danger, loss, emotional/physical strain
- Exposure to toxic contamination (e.g., gas or fumes, chemicals, radioactivity)

Unfortunately in the aftermath of Hurricane Katrina, law enforcement officers were most often exposed to all nine factors. Due to sniper attacks and general storm-related chaos, most officers had periods where their lives were in danger. Most had to search for possibly dying survivors or saw dead bodies floating in the street. Approximately 80% of first responders had lost their homes or valued possessions.

The communications problems during the first several weeks after the storm are well documented both within the organization and the outside world (Fordahl & Meyerson, 2005). Most officers subsisted on MREs (Meals Ready to Eat) and slept anywhere they could. They were even exposed to toxic contamination in the form of contaminated floodwater, which necessitated post-exposure vaccinations. Thus, they are at what is arguably the highest risk for severe post-traumatic stress symptoms that any officer has ever faced on U.S. soil. The need for early mental health intervention was clear from the outset. Due to the high level of traumatic exposure and logistical issues for peers, a decision was made to allow only mental health professionals to provide this intervention. In the first few days after the storm, a medical clinic was set up in a hotel in Baton Rouge, Louisiana, which had escaped major storm damage. Officers were rotated out of New Orleans to check on family members, apply for their own disaster assistance, and recuperate before returning to duty. The following is a description of the mental health intervention provided to the New Orleans Police Department in the New Orleans first responders' clinic.

The clinic was a required first stop after leaving New Orleans and was designed as "one-stop shopping" for New Orleans first responders. It housed the post-exposure vaccination station, triage nursing station, medical station (with pharmaceutical supplies), and the mental health station. In addition, it housed a Federal Emergency Management Agency (FEMA) assistance center, feeding center, travel assistance center, computer stations, and a sleeping area. Phone banks were also set up to check on the safety of missing family members.

The mental health and medical stations were located in the same ballroom. Consequently, mental health was completely integrated into the medical model, and members of the mental health team felt that this decreased stigma surrounding receiving mental health. They also felt that the mandatory nature of making stops at all stations (including mental health) ultimately allowed first responders to benefit from the education provided without having to specifically seek it out. Initially, the U.S. Public Health Service (USPHS) had mental health specialists deployed to the clinic and operated the clinic until September 10, 2005, at which time Catholic Charities took over. The intervention provided by the USPHS was PFA, and the Catholic Charities therapists continued this intervention. The medical director of the clinic was a psychiatrist from New Orleans who had extensive experience in state department crisis intervention and was ideally situated to handle the logistical difficulties of operating a clinic solely with rotating volunteers. Along one wall of the ballroom, therapists lined up two rows of chairs that faced each other. Therapists used those chairs facing into the ballroom and those facing the therapist (and wall) were used by the New Orleans police officers. Since the decision had been made to integrate the mental health services fully, this was the only privacy measure employed at the clinic. After the USPHS left, there were a core group of five licensed therapists, two chaplains, and two psychiatrists on-site during clinic hours. With the abundance of mental health specialists, all first responders received individual PFA without lengthy waits. The therapists' primary responsibility was to provide PFA and assess for problematic reactions. They also provided educational materials on normal and abnormal reactions after disaster and healthy coping strategies. The two psychiatrists' primary responsibility was to see any persons about whom the therapists had concerns. Since the medical director encouraged using a low threshold for referral, the therapists felt very comfortable asking for a second opinion. Again, the feeling of the staff was that this was another way of reducing stigma, since many

people ultimately had psychiatric consults that were brief and seen as another routine stop. The psychiatrists wanted more privacy and improvised by using a low traffic hallway to see first responders. They also provided PFA directly when time permitted. Although all therapists had their own style in implementing PFA, I would like to share my template, which operationalized PFA in the clinic.

After visiting the medical station, the law enforcement officer would take a seat in the mental health section. Following introductions, the officer would give the mental health specialist the medical sheet, which gave basic demographic information, medical symptoms, treatment, and occupation. To attempt to succinctly triage people, I asked how long they were in law enforcement. Then, I asked both their marital status and whether they had children. Following this, I specifically inquired about the whereabouts of their families and whether their immediate family was safe. In the event that they did not know the whereabouts, I would stop the questioning and physically usher them to the assistance area where they could get help in locating family members. Any psychological intervention that occurred while the safety of their family was in doubt would clearly be ineffective. Most people responded that their families were safely evacuated to Houston, Atlanta, or somewhere in Louisiana and that they had made contact.

I asked what the officer did during the storm. I did not attempt to get the officer to provide more details than he or she was comfortable. The phrasing of this question was purposely ambiguous enough that officers could give a lot of information or almost no information, whichever they chose. Ultimately, I think the officers shared what they thought was important to them, whether it was their experiences, their reactions, or their general feelings about the situation. The tenants of PFA explicitly state that one should not try to force people to open up if they are not ready, and this was a way that one could give officers the opportunity to talk and leave it up to them as to whether they wanted to discuss their feelings or not. After this, I asked about whether their homes were intact. Most said "no," and most officers were living on a cruise ship that had docked in New Orleans. Next, I inquired about their faith and whether their faith had been shaken as a result of the storm. Most officers were either Catholic or Baptist, and very few officers expressed doubts about their faith. In fact, most were relying on their faith as a coping strategy.

On a practical note, I asked about where the officers were going after they left the clinic. Most officers were going to check on their families, and then they were scheduled to return to New Orleans for duty. As triage, I asked about the officer's sleep, energy, appetite, and general spirits. Finally, I inquired about usual coping strategies and whether these were effective now (if they were healthy) or they had thought about others (if they were drinking or other unhealthy strategies). Sometimes, if I had concerns, I asked whether the officer had ever seen a counselor in the past to try to gently assess prior psychiatric history.

Discussing common reactions to trauma and healthy coping strategies would conclude the intervention. Since I did not expect any officer to retain the verbal information in this environment, written pamphlets were provided to them to peruse at their convenience. I pointed out that they should employ strategies that have helped in the past except increasing alcohol use. I informed them of the kinds of symptoms that, if they did not decrease with time, or actually became worse over time, would be problematic enough to warrant an appointment with a

counselor. Since the infrastructure of the entire healthcare system in New Orleans was destroyed, it was not feasible to provide clear information on referral sources. We decided to remind them of the NOPD's Employee Assistance Program (EAP) that we hoped would be functional shortly and encouraged them to access that for further assistance. In the event of an emergency, we gave the number of our medical director who was a New Orleans psychiatrist. If no problems were suspected, the entire intervention would take 15 minutes. If there were concerns in the process, I would try to assess the situation more fully, and this would take additional time. The officers responded positively to the intervention and expressed appreciation for the information we were able to provide.

Conclusion

Given the inordinately acute and chronic stressors faced by the New Orleans Police Department, no single mental health intervention would be expected to fully mitigate the risk for negative psychological sequelae. It was hoped that giving additional education and resources on stress and coping strategies in the immediate aftermath of Hurricane Katrina would assist officers in identifying maladaptive coping in themselves and others. Ultimately, PFA must be followed by long-term screening to detect negative psychological symptoms early and interventions, which must be designed to aggressively treat symptoms that are problematic. PFA must also be rigorously evaluated to ensure that the intervention is helpful for law enforcement before endorsing its widespread use.

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Emergency Responder Exhaustion Syndrome (ERES): A Perspective on Stress, Coping, and Treatment in the Emergency Responder Milieu

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Introduction

Inherent in the emergency services profession[1] is the potential for exposure to critical incident stress with the accompanying post-trauma reactions. Traumatic events can cause reactions that affect jobs, relationships, and quality of life. Although most responders are able to recover and continue working with the help of friends, debriefings, and professional counseling, some responders develop debilitating symptoms and need additional assistance. Police officers reporting high levels of stress have three times greater health problems, three times greater levels of domestic violence, five times higher rates of alcoholism, and are ten times more likely to suffer from depression than other officers (National Institute of Justice, 1999). Sadly, more law enforcement officers kill themselves than are killed by felons or die in on-duty-related accidents (Hackett & Violanti, 2003). The purpose of this article is to discuss the Emergency Responder Exhaustion Syndrome (ERES), a culture-based theoretical orientation, and to provide a treatment plan for clinicians working with emergency responders.

Background

Emergency responders risk their lives daily and must respond to trauma with care, judgment, and professionalism. "Stress arises from ordinary work pressures on the individual and the police family as well as from critical incidents that cause the officer to confront his or her own mortality" (Scrivner & Kurke, 1995, p. 15). Over time, this continual exposure to stress may affect their health, work, family, and spirit. This article will provide information on the nature of critical incident stress as it relates to emergency responders, describe and explain the ERES, and discuss treatment utilizing the ERES concept. Our experience with this population comes from a combined 100 years of emergency responder experience, working as sworn officers with various law enforcement agencies and as psychologists specializing

[1] For the purpose of this article, we are defining an *Emergency Responder* as a civilian public safety employee, specifically, police, fire, emergency medical services and corrections.

in treatment of emergency responders. Data has been obtained through our work as clinicians and peers at the West Coast Posttrauma Retreat (WCPR) (see www.WCPR2001.org for more information), a 6-day residential treatment program for emergency responders suffering from critical incident stress, sponsored by the First Responder Support Network, Inc.

At the time this article was written, staff at WCPR had treated 99 first responders. Over 60% were law enforcement; 21% were either fire or EMS; and the remainder was comprised of corrections, military, probation, and other service personnel. At the time of their attendance, 52% of the clients were still working but experiencing emotional, psychological, and vocational difficulties. The majority of attendees were diagnosed with posttraumatic stress disorder, and all attendees were experiencing significant symptomology. Thirty four percent were not working and were pending the result of their disability claims, and 13% had already retired. Approximately one year later, 92% of the attendees who were working at the time of their attendance at the program were still working. Six percent of the attendees who were not working were able to return to work, and the remainder retired or their disability claims were still pending.

Emergency responder work is stressful and unpredictable. Emergency responders must have the emotional resources to perform multiple tasks without losing control in the face of physical threats. The complexity of their work requires them to . . .

> exercise considerable skill, make delicate decisions with fateful consequences, and solve a wide range of interpersonal problems, with no hard-and-fast criteria about the correctness or incorrectness of solutions. [They] must therefore live with doubts and uncertainty about some of what they have done, which can make them question their own adequacy or competence and undermine their self-esteem. (Toch, 2002, pp. 55-56)

They need to exhibit leadership, control, and assertiveness; think clearly under pressure; and adhere to norms of the police subculture (Anderson, Swenson, & Clay, 1995). Simultaneously, they must deal with distorted or offensive press reports that detract from their public image; communicate well with the public; and exhibit restraint and empathy (Brown & Campbell, 1994). "Officers are being called on to make complex, high-risk judgments on the spur of the moment in response to a fluid situation" (Anderson et al., 1995, p. 117). They must be able to complete their tasks despite provocation, ambiguity, and the ever-present threat of psychological or physical injury (Shusman, Inwald, & Knatz, 1987; Silva, 1990).

Common sequelae of police stress include emotional detachment, agitation, alcohol/substance abuse, heart attacks, ulcers, suicide, cynicism, suspiciousness, decreased efficiency, absenteeism, early retirement, marital problems, and symptoms associated with posttraumatic stress disorder (PTSD) (Bohl, 1995; Toch, 2002). Personal and environmental factors combine with traumatic events to create stress reactions such as PTSD. Risk factors include isolation, anhedonia, lack of opportunities for expression of feelings, and failure to develop interests outside of the workplace. Symptoms immediately following a critical incident may include shock, nightmares, irritability, difficulty concentrating, emotional instability, and somatic complaints. Recovery may take weeks to months (Carlier, 1999). In addition to PTSD, possible diagnoses include acute stress reaction and chronic stress reaction (American

Psychiatric Association, 2000). Acute stress reaction involves symptoms of panic, freezing, disorientation, and agitation; whereas, chronic stress reaction typically involves exhaustion, lack of humor, lack of direction, paranoia, and isolation (U. S. Department of Defense, 2005). Several criteria from clusters including avoidance, arousal, and reexperiencing must be met to qualify for a diagnosis of PTSD (American Psychiatric Association, 2000).

Emergency responders respond to and immerse themselves daily into the chaos and confusion of other people's lives, and by doing so, they put themselves at risk of becoming victims of traumatic incidents. One needs only to stand back and watch officers responding to a call of a "man with a gun" or firefighters responding to and entering a structure fire to appreciate their coping abilities. Responders comfort trauma victims and operate in the wake of negative events. Responders need not directly experience the exposure to trauma to be affected. Rather, constant vicarious or secondary exposure (i.e., behaviors and emotions resulting from knowledge about a traumatizing event that was experienced by another person and the desire to help that person) can also create stress (Comille & Meyers, 1999; Harris, 1995; McCunn & Pearlman, 1990) or compassion fatigue (i.e., cumulative stress resulting from heightened caring about victims of criminal acts) (Figley, 1999). For example, in a study of child protective service workers, Comille and Meyers (1999) found that up to 37% experienced significant levels of vicarious emotional distress.

In the emergency services occupations, stressful or traumatic events are often referred to as critical incidents. Traumatic stress symptoms will be experienced by over 86% of officers involved in a critical incident (White & Honig, 1995). Because of the varying effects an incident has on different responders, it is important to keep the definition of a critical incident flexible (FBI, 1996). A critical incident is any situation faced by a responder that causes unusually strong emotional or physical reactions. These reactions may have the potential to interfere with the responder's ability to function either at the scene or later in life (Mitchell, 1983, as cited in Clark & Friedman, 1992).

Kirschman (1997) believes that 85% of emergency responders experience symptoms of critical incident stress, which may include impaired job performance, difficulty concentrating, short-term memory loss, tardiness, loss of interest in work and/or pleasurable activities, loss of motivation, absenteeism, and physical health problems (see also Brown & Campbell, 1994). However, as a result of emergency responders' training, beliefs, experience, and culture, they may believe the opposite to be true (that a minority experience such symptoms). It is important to point out and explain to responders the differences between normal job-related stress and critical incident stress because responders may experience inappropriate guilt if they are unable to handle what they believe is typical job stress (Davis, 2002).

Mitchell and Bray (1990) initially developed a list of critical incidents that affect the emergency responder. This list was later modified and expanded as follows (H. Duggan, personal communciation, 2003):

1. Line-of-duty death
2. Serious injury in the line of duty
3. Suicide of a working partner
4. Injury to or death of a child

5. Prolonged exposure to a victim who dies
6. Multiple injury/fatality accident
7. Victim known to the responder
8. Any incident in which one's personal safety is in peril, including deep undercover work
9. Exposure to infectious diseases
10. Unusual media attention
11. Administrative and/or coworker betrayal

Self-Concept and Culture

An individual's self-concept, which is developed through childhood and is informed by subsequent adult experiences, is comprised of the beliefs people have about themselves and their world. A self-concept template is developed through cultural consensus and allows individuals to interpret their environment and establish expectations about the future (Eidelson & Eidelson, 2003). When people are involved in critical incidents, three basic assumptions or beliefs about the self and the world are challenged: (1) the belief in personal invulnerability, (2) the belief that one is a good person, and (3) the belief in a meaningful and orderly world (Janoff-Bullman, 1985). When a person faces a loss, as in the loss of the feeling of invulnerability, there must be some adjustment in order to continue functioning effectively. The interval between the recognition of the loss and the adjustment can be problematic.

Critical incidents may give rise to psychological crises that violate or contradict the beliefs people have about the world and their place in the world. For example, police officers may develop a distorted view of the world (e.g., loss of a belief in a just world) because of their exposure to crime and violence (Brown & Campbell, 1994). Exposure to critical incidents may challenge the evaluation of one's competency, contribute to self-doubt (Everly, 1995), or shatter the responder's assumptions regarding the world as a safe place. During a critical incident, responders' expectations about their ability to handle stressful situations are called into question (Mitchell, 1990; Ryan & Brewster, 1994).

An emergency responder's self-concept is informed by cultural beliefs and enables him or her to perform on the job. In this article, *culture* refers to the underlying beliefs, values, practices, norms, or expectations of the emergency responder subculture (Anderson et al., 1995). Responders are action-oriented problem-solvers who can be depended upon by peers to control themselves and the environment. Responders value honesty, morality, bravery, compassion, clarity, and effectiveness under stress. They expect positive outcomes regardless of the circumstances. Retired NYPD Sergeant Daniel Rudoffosi refers to this process as "Adaptive Dissociation" (personal communication, 2003). The responder self-concept is both necessary and unrealistic and can prove to be a psychological trap. For example, police officers responding to a call of a robbery in progress or firefighters entering a burning structure have to assume that they will be successful. When success is not achieved, the responders may blame themselves. Some of the beliefs held in this subculture are influenced by socially constructed expectations of the public. For example, the public would question a firefighter or paramedic who cries at the scene of a traffic accident.

To treat responders effectively, one must understand the cultural factors at work in the emergency services. Generally speaking, the emergency service worker has

a strong need for the acceptance, respect, and approval of peers (Benner, 2000; Finn & Tomz, 1998). Police peers reinforce psychological toughness, the failure to show emotions, independence, self-reliance, aggression, and quick reactions to danger; on the other hand, qualities such as warmth, compassion, and sensitive child rearing are shunned. Expressions of fear might be viewed as weakness. These characteristics that are reinforced on the job can result in negative consequences if taken home (Wester & Lyubelsky, 2005). Even when physically alone, behavior and decisions are strongly influenced by the expectations of peers. The very reasons that a responder may go into danger are "peer-driven." A belief that the responder failed to meet culturally derived expectations may cause him or her to second-guess job performance, despite all evidence to the contrary.

The emergency responder is taught to reject, deny, and/or suppress "normal reactions" to abnormal events (Lowery & Stokes, 2005; Pulley, 2005; Toch, 2002; Wastel, 2002; Wester & Lyubelsky, 2005). The cultural belief is that the reactions are not appropriate for someone in the emergency professions (Kopel & Friedman, 1997). The distressed emergency responder may project a facade of competence while harboring a feeling of insecurity and shame. Failure to acknowledge feelings such as sadness and anger may result in poor job performance (Anderson et al., 1995) or may simply allow the job at hand to be completed (Toch, 2002).

Traditional approaches dealing with traumatic incidents tend to either pathologize the responder or encourage the responder to ignore the event and his or her reactions (Regehr & Hill, 2002). Such denial of emotions and appearance of the need to be *tough* (Stephens, Long, & Miller, 1997), however, leads to significantly related higher levels of psychological distress in police officers (Progrebin & Poole, 1991) and firefighters (McFarlane, 1988) and is likely unrelated to the responder's gender. The responder may look to peers to see whether they are experiencing similar emotions and effects. When peers also hide their normal psychological and physical reactions, the responder feels shame and believes he or she is alone in this experience, leading to further isolation (Garrison, 1990).

Early life experience, such as childhood trauma, may influence a career choice in emergency services. In such a case, a responder's same personal history, in conjunction with a treatment-averse subculture, may reduce his or her willingness to access appropriate treatment when needed. "It is a paradox that those early life experiences that may lead a person to choose police work as a career might be the very elements that undermine it" (Kirschman, 1997, p. 89). Instead of getting the professional help that is needed, the responder may seek out a peer group that relies on stimulation (e.g., work harder, faster, better) and avoidance of emotional expression, which in turn further predisposes the responder to traumatic events and the consequences of problematic coping (e.g., alcohol, affairs, and social withdrawal). Furthermore, responders who have been involved in critical incidents may not have access to their current or early traumatic memories, thus preventing the body's natural healing process from occurring.

Memory, Meaning, and Narrative

Research has demonstrated that traumatic memories may be stored in the brain differently from nontraumatic memories (van der Kolk, 1988, 1994; van der Kolk & van der Hart, 1991). Support for this phenomenon is found in neurological and

trauma research. Trauma is believed to cause the autonomic nervous system and neurological functioning in the hippocampus and medial thalamus to malfunction. Though encoding of memories occurs, some believe that correct verbal encoding of long-term memories is inhibited (Everly, 1993a, 1993b; Terr, 1994; van der Kolk, 1988).

Not all memories are verbal. Body memories of trauma have been cited as examples of memories that have been repressed and stored on a somatosensory level (Erdelyi, 1990; Horowitz, 1994; Howe, Courage, & Peterson, 1994; Terr, 1988, 1991; van der Kolk & van der Hart, 1991). Empirical evidence supporting the phenomenon has been difficult to obtain; however, there are many theories that support the existence of body memories. It has been suggested that traumatic events may be encoded on a sensorimotor level without orientation to time and space (thus, they are not easily translated to language and are not easily retrieved) and that memories may be demonstrated by gestures (Horowitz, 1994; van der Kolk & van der Hart, 1991). In order for these traumatic body memories to be integrated with existing schemes, the images need to be repeatedly revisited to construct a linguistic narrative of the event (van der Kolk & van der Hart, 1991).

Foa, Steketee, and Olasov-Rothbaum (1989) developed a theory about how fear information is stored in the memory (as cited in Litz & Weathers, 1994). They suggest that information about the event is stored in a "trauma network." This information consists of the responder's physical, emotional, and psychological reactions to the event. Also stored in this network is the meaning a person ascribes to the event. An emergency responder, who originally felt competent in his or her performance, may now believe, "I am helpless, I have no control over what happens to me, I am vulnerable" (Litz & Weathers, 1994, p. 24). The trauma is compounded through repeated similar events that continue to chip away at the emergency responder's belief of being a competent human being.

The meaning a responder attributes to an event is shaped by the responder's history and commonly held ideas about the correct way to respond. For example, McFarlane's (1989) study of firefighters in Australia found that those with premorbid psychological problems were at greater risk for problems following exposure to trauma. Beliefs about responding *correctly* are constructed within the dominant societal and responder cultures. It is the meaning ascribed to an event that determines the responder's behaviors and reactions after the event (Everly, 1994; White & Epston, 1990).

Wedded to responders' incident memories is a self-imposed report card in which they evaluate themselves and often impose low performance grades, regardless of objective reality. If responders are unable to focus on positive outcomes, global negative self-appraisals may develop; these must be challenged through the creation of alternative narratives before the negative stories become the dominant narratives (Bohanek, Fivush, & Walker, 2005; Brown, 2003).

Narrative theory postulates that responders develop a story about themselves and their reactions to critical incidents. Responders may see themselves as heroes or cowards, depending on the meaning they attribute to their experiences. They construct narratives to make sense of all experiences, including those that do not

make sense (Freedman & Combs, 1996). They may overlook aspects of the critical incident that do not conform to their dominant problematic story.

Narrative approaches allow the externalization of symptoms (White & Epston, 1990). The ERES approach encourages the responder to decide that a symptom *belonged* to an incident and not to the responder. It engages the responder's natural and trained tendencies to take a stand against problems. The narrative restorying provides an opportunity for the responder to make new meaning and develop a sense of control over problematic symptoms (Amir, Stafford, Freshman, & Foa, 1998). The narrative externalization process helps identify the ways in which the symptoms affect the responder's life and what he or she might do to counter those effects. Sample questions and further explanation are included in the "Treatment" section later in the article.

Emergency Responder Exhaustion Syndrome (ERES)

Emergency responders who attend the West Coast Posttrauma Retreat (WCPR) consistently present clinical symptoms that include depression, posttraumatic stress disorder, anxiety, sleep disorders, and substance abuse disorders. ERES may include physical, emotional, spiritual, mental, or relational symptoms of any or all of these diagnoses (Anderson et al., 1995). Although emergency responders tend to reject the notion of a formal diagnosis (Levenson & Dwyer, 2003), regardless of its appropriateness, they can accept the concept of ERES. ERES provides a framework for clinicians to understand a variety of symptoms displayed by emergency responders. The ERES framework permits the symptoms to be placed into a culturally acceptable format, which increases the likelihood that an appropriate and effective treatment program can be constructed.

Emergency responders are often reluctant to seek and remain in treatment. In a study of U.S. combat soldiers in Iraq and Afghanistan, Hoge et al. (2004) found that concern about stigma and how soldiers would be perceived by peers and superiors was related to resistance to seeking mental health interventions. The most significant barriers to seeking mental health services were being seen as weak (65%), feeling that their superiors would treat them differently (63%), feeling that their peers might have less confidence in them (59%), and the perception that it might harm their career (50%). Aversion to treatment may stem from the desire to avoid that which would remind the responder of the traumatic event, the need to be accepted within the emergency services culture, and the fear of confidentiality violations (Cameron, 2004; Meyer, 2001). Hackett and Violanti (2003) note that the stigma associated with help-seeking behaviors involves not only the possibility of negative impact on the responder's career but also the possibility of fitness for duty evaluations, mistrust by peers, and a view of oneself as being weak or inferior. Additionally, Wester and Lyubelsky (2005) found that police officers are reluctant to seek psychological help, largely due to their relative distrust of those outside their culture (see also Jones, 1995) and fear of being labeled. This resistance may, in fact, be a further example of the use of avoidance and may be a simple maladaptive coping mechanism (Davis, 2002).

Teaching responders about ERES helps them understand how their career contributes to their current distress. It normalizes reactions in a culturally acceptable way. It allows responders to recognize that the symptoms are honorable. This shift away

from pathology allows responders to address current issues without shame and seek treatment. The core ERES elements are depression, isolation, and physical and emotional exhaustion. Separating and externalizing the problem as depression, isolation, and exhaustion can help reduce the difficulties responders experience by making the symptoms manageable. ERES is a model by which responders can reevaluate their beliefs, consider the impact of family-of-origin and subculture issues, and then plan how to recover.

It is important to maintain adaptive coping strategies while examining those that may not be serving the responders well. One way this is accomplished is through group therapy. Groups at WCPR allow the responders to challenge negative beliefs when delivering their individual narratives and to receive other members' nonjudgmental perspectives. An advantage of utilizing groups is that they allow participants to join with others who share similar experiences and who are otherwise isolated, alienated, and emotionally restricted (Foy et al., 2000). The goals of group therapy are to normalize the responders' experiences, reduce isolation and symptoms, increase a feeling of community and support, and allow for the responders to feel understood (Talbot, Manton, & Dunn, 1992). Groups are able to "challenge members to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation" (Foy et al., 2000, p. 159). They also allow responders to make a connection between their critical incidents and important relationships and past experiences. Candidates for groups are emergency responders who have the ability to establish trust with peers and staff, willingness to maintain confidentiality, the ability to tolerate high levels of arousal, and little likelihood of being retraumatized by other group members' critical incidents. Contraindications for group therapy include those who are actively suicidal, homicidal, psychotic, or abusing substances or those who have secondary gains such as malingering, fraud, or pending litigation (Foy et al., 2000).

Discussion of ERES, whether through didactic education, one-on-one, or group therapy allows for both insight and normalization. As one responder stated, "I learned more about myself and my reactions in those two hours (ERES class) than I did during my previous year in therapy." Despite the responder's favorable relationship with his private therapist, the therapist had not presented the responder with an understanding of his symptoms that fit with his subjective reality. ERES provided a culturally acceptable explanation of his situation and for the first time allowed him to develop an equally culturally acceptable plan to counter its effects.

Key Characteristics of ERES

The key characteristics of ERES are depression, isolation, and physical and emotional exhaustion.

Depression

Although the level of depression varies for each responder (Breslau, 2002), it is not uncommon for responders to report suicidal ideation, planning, and suicide attempts. Situational events, critical incidents, and life stressors are not responsible for police officer suicide; however, the depression stemming from them is (Hackett & Violanti, 2003). It is important for a responder to understand that depression is a chemical imbalance that can create feelings of helplessness and hopelessness

and when combined with poor judgment, difficulty concentrating and making decisions, poor impulse control, and substance abuse, suicide may appear to be a viable option (Hackett & Violanti, 2003). Responders who are influenced by depression utilize selective perception to "prove" their insufficiency (Furr & Funder, 1998; Moffitt, 1994). Depression frequently blocks a responder's ability to perceive positive outcomes (e.g., "I survived") and fosters a negative belief (e.g., "I failed to save that person; therefore, I am a bad person"). This cycle of depression, negative self-appraisal, and a reluctance to accept positive outcomes further isolates and exhausts the responder.

Isolation

There is a strong need to conform and be a part of the team in the emergency services. Emergency responders rely on each other for emotional and physical survival, and peers motivate one another to confront and handle danger. Responders may also develop a sense of separation, isolation, secrecy, and resistance to outside criticism (Brown & Campbell, 1994). At times, responders may believe that they are not worthy of the respect and trust of fellow peers. Simply leaving the job will not alleviate symptoms. In fact, separation from police duties increases vulnerability to symptoms (Paton, Violanti, & Schmuckler, 1999). Yet, they may isolate from the very people who could help them recover out of fear of being discovered as *frauds*. As an example, one responder experienced an intense negative reaction after receiving an award recognizing her investigative abilities. She explained, "No one knew how badly I felt inside (as a result of my experience investigating the case), and receiving that award just proved that I was a fraud."

Social support from colleagues may reduce the effects of critical incidents; however, when peer support does not enhance coping skills, a reverse effect can occur which may be retraumatizing (Lowery & Stokes, 2005) and cause responders to avoid certain thoughts or feelings and to further isolate themselves. Avoidance involves attempts to escape or minimize heightened emotionality (Asmundson, Stapleton, & Taylor, 2004). Emotional distancing by emergency responders makes it unlikely that they will receive the help needed. For example, student paramedics had significantly greater trauma-related symptomology when they expressed negative attitudes regarding emotional expression (Lowery & Stokes, 2005). Thus, emotional distancing is a maladaptive coping strategy.

Exhaustion

Exhaustion, as used here, means a depletion of the ability to cope. As a responder exhausts these coping abilities, symptoms such as insomnia, suspiciousness, hypervigilance, chronic fear, panic attacks, disengagement, emotional constriction, depersonalization, derealization, memory disturbance, exaggerated startle response, agoraphobia, and others may appear (Briere, Weathers, & Runtz, 2005). As coping resources are depleted, failed attempts at recovery (e.g., insufficient psychotherapy, excessive overtime, etc.) reinforce a sense of personal failure, which enhances depression and isolation. As a result, adaptive coping (e.g., physical exercise, peer support, hobbies, spirituality, relaxation, and family support) decreases, while maladaptive coping (e.g., engaging in high-risk activities, substance abuse, and multiple sexual relationships) increases. While the responder's capacity to recover

is slipping away and while support is dwindling, families and bosses become more demanding.

Stress from the job can carry over to the home, making it difficult to recover from the demands of the job at home (Peeters, Montgomery, Bakker, & Schaufeli, 2005). Increasing stress at both home and work may lead to burnout. *Burnout* has been defined as stress arising from the interaction between the responder and recipient (e.g., distressed citizen) (Alexander, 1999) with the failure to find meaning and growth in life (Van Dierendonck, Gaarssen, & Visser, 2005) and has exhaustion and cynicism as its core issues (Peeters et al., 2005). Exhaustion is also closely associated with core maladaptive assumptions, negative beliefs, demands, and unmet expectations (Van Dierendonck et al., 2005).

A typical presentation is as follows:

> Officer Smith was raised by an alcoholic, abusive father. Although shaken by his childhood experiences, Smith coped by being involved with many ego-enhancing activities outside the family. In his 20s, Smith enthusiastically entered law enforcement and was well respected as an assertive and responsible officer. During his career, Smith experienced a number of events that either reinforced or challenged his belief of himself as competent and in control. When Smith encountered a negative event, he would redevote himself to his work, often at the expense of his family, until he once again felt a sense of competence. At some point, Smith experienced an event that caused the collapse of his coping abilities, violated a number of the core assumptions he had about himself, and led to new negative beliefs (i.e., "I'm vulnerable, less than capable, and flawed"). This event not only challenged his self-concept but also connected with his core unresolved beliefs. Instead of believing that the incident was bad, Smith came to believe "I am bad." Smith attempted to cope with these new beliefs, but for the first time in his life, his usual coping mechanisms were ineffective. Smith had difficulty sleeping, was anxious, and used alcohol as a way to gain temporary control of his symptoms. As Smith's depression and anxiety symptoms increased, he saw himself as a fraud and lived in fear of his "true-self" being discovered by other officers. To prevent his secret from being discovered, Smith began to emotionally isolate himself from work and his family. The resulting lack of support "verified" for Smith that he was indeed a flawed human being.

Smith's story is typical of the responders who attend WCPR. Many have experienced a stress debriefing, attended therapy, and may be on psychotropic medications. Many report significant childhood trauma including emotional, physical, and sexual abuse; suicide of parents; or parents who were emotionally unavailable (Davis, 2002; Dietrich, 2002). Unresolved prior traumatic events may amplify symptoms associated with current critical incidents and reduce one's ability to recover (Kirschman, 1997). In one WCPR session, four out of seven responders reported being sexually abused as children, and all seven reported emotionally detached parents. The literature concerning the well-documented effects of childhood abuse is covered in other publications (Albeck, 1994; Briere, 1992).

Although many responders are able to experience critical incidents without the development of an acute stress reaction, research demonstrates that the risk increases

when a career in emergency services is combined with ineffective coping strategies and an abusive/neglectful family history (Briere, 1992; Yehuda & McFarlane, 1995). It is vital to explore childhood history with a responder who is experiencing intense distress from a current event. For example, a responder who grew up in an abusive family may have internalized the belief that she deserved the abuse. As an adult responder, when she experiences a traumatic incident, the old internalized self-abusing belief enhances the current traumatic reaction and interferes with her ability to recover. Additionally, Kirschman (1997) stated that PTSD "is produced by exposure to severe, usually life-threatening trauma, and amplified by unresolved prior trauma, the organizational response, media events, and community reaction" (p. 77). If symptoms are left untreated, there may be lasting effects (Bohl, 1995).

Treatment

A comprehensive diagnostic evaluation should precede treatment. As treatment begins, establishment of trust and a therapeutic alliance is primary. The clinician should demonstrate a concern for the responder's physical safety, provide education about trauma, monitor symptoms, identify and address coexisting diagnoses, and offer support for any ongoing crises (Foa, Keane, & Friedman, 2000). Current research has demonstrated that police officers prefer to utilize problem-focused and direct-action strategies to deal with occupational stress (Evans, Coman, Stanley, & Burrows, 1993; see also, Rothbaum, Meadows, Resick, & Foy, 2000). Treatment helps responders understand the ways in which they have isolated themselves and depleted internal and external coping resources. When responders use avoidance, the therapist points it out and encourages them to stay with feelings of caring and trust, along with the feelings that were being avoided (Roemer, Harrington & Riggs, 2002).

Responders should be encouraged to develop an alternative narrative with associated countertactics to be utilized against the incidents' negative effects. The goal is to develop habituation of the emotional response, construction of a narrative that includes examination of the event and its consequences, and subsequent reduction of symptoms. Ultimately, treatment should help the responders connect maladaptive beliefs and responses to current symptoms with the goal of empowering them to take the necessary steps to recover.

In addition to recognized treatment factors of empathy, warmth, congruence, and the therapeutic alliance (Lambert & Barley, 2001), there are specific WCPR interventions that target subculture issues. For example, subcultural issues are discussed utilizing the overlaying template of depression, isolation, and exhaustion and encouraging the responder to identify problematic beliefs and behaviors, develop alternative strategies, and take steps to put those strategies into action. These specific steps are as follows:

1. Challenging the *Myth of Uniqueness*
2. ERES education/externalization of the problem
3. Modified debriefing process
4. Education on psychophysiology of stress, responder personalities, and other relevant topics
5. Substance abuse treatment/education
6. Addressing earlier traumatic/unresolved issues
7. Goal setting

8. Family/work reintegration
9. Administrative/personal betrayal
10. Eye movement desensitization and reprocessing (EMDR)

Treatment helps responders understand the ways in which they have isolated themselves and depleted internal and external coping resources. At WCPR, it is assumed that responders have internal resources to deal with normal work-related stress but that they may benefit from additional help in dealing with critical incidents (Regehr & Hill, 2002). For example, narrative exposure therapy involves repeated, detailed discussion of the worst traumatic event while reexperiencing the effect associated with that event.

It is often difficult for responders to determine the *worst* event; therefore, responders may be asked to tell a narrative story of their lives, from birth to present, focusing on their traumatic experiences. The therapist asks about emotional, physiological, cognitive, and behavioral reactions experienced during the telling of the narrative. The responder is encouraged to feel these reactions, and the process continues until habituation occurs (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Once these tenets are in place, the specific interventions detailed below may be employed.

Challenging the *Myth of Uniqueness*

The first intervention to treat emergency responders at WCPR is to challenge the *myth of uniqueness*. To process traumatic information, the clinician must help the responder move beyond emotional and cognitive defenses that interfere with treatment (Briere, 1992). In Solomon's (1988) discussion of officer-involved shootings, he stated that approximately one-third of officers will have few or no symptoms; about one-third will have mild symptoms and will be able to work through them without intervention; and about one-third will have serious symptoms, which will require professional intervention. At the core of the distressed responder's defense is the often unspoken belief, "I am not worthy" with its attached problem-saturated narrative.

One of the most common fears of the responders is that they alone are experiencing the negative symptoms. Thus, the myth of uniqueness evolves. This belief paralyzes a responder's natural resiliency because it is closely associated with shame. *"Since I am the only one feeling this bad, I must be a bad person."* Control over the traumatic event is achieved by actively restructuring cognitive schema to develop meaning. "A sense of coherence expresses the belief that life, or the situation at hand, is comprehensible, manageable, and meaningful" (Loo, 1999, p. 278). In a group setting, such as WCPR, residents interview each other in a semistructured format to challenge this belief. Some of the questions are as follows:

- Why are you here and why now?
- What will be the first sign that will tell you that you are getting better?
- What will other people notice?
- Who will be the first to notice and why?
- Can you tell me about a time in your life when you were able to overcome a difficult situation? What skills, traits, and abilities did you use?

Residents return from this interview and often report relief in knowing that other responders are experiencing distress similar to their own. It is often the first step in challenging the isolation. For individualized treatment, when a group may not be available, we recommend that the clinician conduct the interview, normalize symptoms, and address the *Myth of Uniqueness.*

We recognize that it is often difficult to have responders attend a group therapy session in the private practice setting. An option is to seek a qualified responder trained in peer support and encourage a meeting between the two responders. Departments in which peer counselors are made available have greater productivity, less absenteeism, lower levels of grievances filed, fewer disciplinary actions, and improved employee morale (Anderson et al., 1995). Initial meetings could be facilitated by the clinician within the context of a psychotherapy session. This connection with an experienced responder is a vital step in the healing and normalization process. Lehman, Ellard, and Wortman (1982) recommend that talking with someone who has had a similar experience (e.g., their study involved the death of a peer) is the most useful intervention that can be made. In cases in which the responder has lost a sense of invulnerability, they recommend that treatment be provided by a professional who is culturally sensitive. Police officers in crisis may see clinicians as mercenaries; whereas, peers are more likely to be viewed as competent, caring, and helpful (Davis, 2002; Hackett & Violanti, 2003).

Many responder agencies have peer support teams staffed by peers who have recovered from significant trauma-related symptoms. Peer counseling is conducted by responders who are psychologically healthy and altruistic and are capable of dealing with countertransference and validating others' experiences while maintaining confidentiality (Loo, 1999). These peers have the potential to act as a model of hope for the responder who is currently experiencing significant distress. For example, police officers may not be the best judge of their own reactions to stress. Peers, however, may be more objective and able to see symptoms (Toch, 2002). "Peer support programs seem to work well for suicide interventions" (Hackett & Violanti, 2003, p. 10). Peer counselors make initial interventions and recommendations for professional treatment when warranted.

ERES Education/Externalization of the Problem

As part of the education process, we encourage clinicians to discuss the ERES concept and help responders separate themselves from their problems. At WCPR, during the ERES education portion, responders are asked to answer the following (or similar) questions to begin the externalization process:

- How was depression (isolation, exhaustion) first introduced into your life?
- What tactics does depression (isolation, exhaustion) utilize to control and stay in your life?
- What does depression (isolation, exhaustion) want you to think, believe, and feel about yourself (your career, family, etc.)?
- What would your life look like if depression (isolation, exhaustion) were to succeed?
- What tactics have been useful in countering these negative effects?
- What percentage of your life does the problem control?

Modified Debriefing

Debriefings are often used to provide psychoeducation, mutual support, emotional expression, and release and for the department to demonstrate acceptance of responders' reactions (Bisson, McFarlane, & Rose, 2000; Brown & Campbell, 1994). "There appears to be little doubt that giving traumatized individuals a psychological map to understand their reactions does much to contain their distress and to allow them to institute a series of self-regulatory processes" (Bisson et al., 2000, p. 42). Although Bisson et al. (2000) caution against the use of debriefings because of the lack of empirical support and theoretical framework, they state that if debriefings are used as part of a comprehensive management program, then they may be beneficial.

Trauma work involves an in-depth revisiting of the indexed critical incident. "It is important to confront traumatic memories directly instead of trying to avoid them" (Cardena, Maldonado, van der Hart, & Spiegel, 2000, p. 259). For example, fear memories may be reconsolidated and rebuilt in the amygdala every time they are retrieved. Therapy offers the opportunity to retranscribe these memories via reactivation of the emotions experienced at the time of the trauma. Every time a memory is retrieved, it is synthesized and rebuilt with kinder and gentler associations made with the safety established via the therapeutic relationship (Kaplan-Solms & Solms, 2002).

WCPR attendees often report multiple critical incidents and are asked to debrief the one that is currently bothering them the most (Bisson et al., 2000). This serves as a model for debriefing other critical incidents in the future. We have found that utilizing a modification of the International Critical Incident Stress Foundation's seven-step debriefing model (Mitchell & Everly, 1997) provides a culturally acceptable framework to begin the discussions. In typical critical incident debriefings, responders are told that it is not group therapy and that the following treatment assumptions are made: (1) The responder has an adequate premorbid level of functioning, (2) Symptoms are normal and not signs of a serious disturbance, and (3) Symptoms are temporary (Bohl, 1995). Although we often make these treatment assumptions at WCPR, the modified debriefings *are*, in fact, group therapy. During this modified debriefing, we utilize the *Fact, Thought* and Reaction phases to engage the responder. However, the distinction among these three phases is somewhat arbitrary; for example, a responder who starts emoting during the fact phase would not be told to wait until the reaction phase. There is a need to remain flexible (Bohl, 1995).

Debriefings allow the responders an opportunity to review their experiences and gain mastery (Talbot et al., 1992). We have also found that the use of certain aspects of dialectical behavior therapy (Linehan, 1993) is helpful. For example, development of coping skills such as distress tolerance, mindfulness, emotional regulation, and improved communication may allow the responders to tolerate painful reactions and reduce the use of avoidance (Linehan, 1993). Responders are taught how to observe and discuss their critical incident, their thoughts and interpretations, their sensory and somatic responses, their emotional reactions, their desires and fantasies (including magical thinking that may produce inappropriate guilt), their heightened sense of vulnerability, and their actions following the incident (Goldfarb, 1998; Marra, 2005). Having the responder talk, stand, and walk through a reenactment

of the incident "frame by frame" has been beneficial, as many responders will gloss over important facts or emotionally difficult moments. This allows the clinician to obtain important information that may be needed to respond helpfully (Marra, 2005). Clinicians are encouraged to ask questions to further develop the responder's story of the incident. Also, reframing allows for development of adaptive behaviors, such as strengthening bonds with family members, coworkers, and friends (Wester & Lyubelsky, 2005). As a general rule responders prefer an active, interactive clinical style. Sample questions are as follows:

- At that moment (during the incident), what were you thinking (feeling, sensing)?
- How did the incident (or specific moment) affect the way you conduct your life?
- Complete this sentence: "Because of the incident (moment), I now/fear that/hope that . . . "
- What belief did you develop about yourself as a result of your involvement in this incident? Is this a positive belief?
- If the belief remains, how might if affect your life?
- Is there anything about this incident that reminds you of something that occurred in the past?

Havassy (1991) (as cited in Bohl, 1995) hypothesized that the ritualistic aspect of critical incident debriefings contributes to their perceived success. That is, there is comfort to be gained in social rituals, similar to the start of healing that occurs with a funeral.

Psychoeducation

Psychoeducation can be utilized to reduce concern about treatment and prognosis, reduce self-blame over symptom development, enhance the credibility of the therapist, and provide a framework for recovery (Bisson et al., 2000; Carlier, 1999; Creamer & Forbes, 2004; Flack, Litz, & Keane, 1998; Hackett & Violanti, 2003). Education on the psychophysiology of trauma, emergency responder personalities, use of medication, and other topics is provided at WCPR.

Substance Abuse

Many responders utilize alcohol or demonstrate increased vulnerability to alcohol abuse as a means to manage their emotions (Beutler, Nussbaum, & Meredith, 1988; Breslau, 2002; Briere, 1992; Tucker et al., 2002). In a recent study of U.S. combat military soldiers stationed in Afghanistan and Iraq by Hoge et al. (2004), they found that rates of PTSD, major depression, and misuse of alcohol were correlated with the number of firefights in which they were involved. We have also observed an increasing number of responders who utilize sex (affairs, Internet chat rooms, pornography) as an emotional regulator. These maladaptive coping techniques need to be identified and addressed.

Addressing Earlier Traumatic/Unresolved Issues

Many responders who experience intense distress after an event have a history of childhood traumatic experiences, which is consistent with research on stress

disorders (Briere, 1992; Ford, 1999; Yehuda & McFarlane, 1995). In addition to helping a responder reveal and discuss early traumatic experiences, it is beneficial to help the responder understand how those early experiences affect current responses to stress. Some useful questions include the following:

- Where and when have you felt this way (reaction or symptoms) before?
- As a result of my early experience . . .
  - "I believed that I . . . "
  - "I continue to feel like I . . . " or "I am afraid that I . . . "
- What do you know about yourself as an adult (e.g., beliefs, skills, traits) that would challenge earlier beliefs?
- How would your life be different if you were able to reject the old beliefs?

Goal Setting

Responders are excellent at identifying a problem and working toward a resolution. This trait, if not already a part of their personality, is instilled in them in the academy and throughout their career. Treatment goals are stated explicitly: To process memories, to learn to use adaptive skills, and to develop alternative beliefs (Roemer et al., 2002). Goal setting includes specific steps a responder will take to improve his or her current situation. Attendees are encouraged to utilize steps that are both concrete and measurable (e.g., "I'm going to work out three days a week" vs. "I am going to improve my health"). Another goal is to empower responders to overcome and learn from their critical incidents so that they might be better prepared in the future (Violanti, 1999).

The goals address all aspects of the responder's life, including work, family, physical and mental health, and spiritual wellness (when appropriate) and include specific steps the responder will take to counter the effects of depression, isolation, and exhaustion. Ideally, the goal-setting plan is put into a semiformal contract and signed by the client and the therapist, which can then be utilized as a tool in subsequent therapy sessions or to monitor progress, compliance with treatment, and success.

Emergency responders are often resilient; that is, they may focus on positive outcomes of having survived a critical incident. They may engage in a process of self-enhancement and growth (Higgins, 1994) and exhibit qualities of altruism, forgiveness, strength gained from surviving, and self-knowledge (Carlier, 1999). As a result, they may share their experience with others by becoming peer counselors themselves. For example, at WCPR, attendees often return as peer counselors, which enables them to continue the recovery process while helping others. As one peer counselor stated, "The first time I came back, I was half client and half peer counselor; the next time I returned I felt more like a peer counselor than a client."

Family/Work Reintegration

Family discord is common among trauma survivors and requires evaluation on initial assessment (Riggs, 2000). Divorce rate estimates among emergency responders range from 35% to 75% (Wester & Lyubelsky, 2005). This is likely due to job stress that is taken home (Toch, 2002). Diane Wetendorf, a domestic violence advocate and counselor, states that "there are no statistics that tell us what percent of officers and firefighters emotionally abuse and physically batter their intimate partners. All we

know is that there are many of them." It is known that rates of domestic violence are significantly higher in veterans with PTSD (Riggs, 2000).

Responders will have likely distanced themselves from their families as they struggle to maintain emotional composure. Officers may share more of their emotional issues with their work partner than their significant other, which has the potential of generating envy or jealousy in a spouse (White & Honig, 1995).

Interactions with family members may trigger recollections and reliving of past traumatic events. These cause either rage or withdrawal, which eliminates communication and triggers feelings of fear, hopelessness, and anger/rage in family members, which, in turn, perpetuates the conflict (Riggs, 2000). Going home and announcing, "I'm back" can create relationship difficulties with a spouse who has assumed many additional roles (chief financial person, decision maker, etc.) within the family (Paton et al., 1999). Although an effective way of dealing with stress is to discuss critical incidents with one's spouse or significant other, a risk exists that the partner and other family members will develop vicarious traumatization (White & Honig, 1995).

Vicarious traumatization, coupled with personality changes experienced by the responder, exacerbate family dysfunction. Family members may experience physical illness, increased anxiety, lowered frustration tolerance, depression, and symptoms associated with PTSD as a result of vicarious traumatization (White & Honig, 1995). Failure to resolve family issues may result in "permanent, and often maladaptive, adaptations" (Paton et al., 1999, p. 84). This is where the clinician can help with a renegotiation of the relationship contract. The goal is to improve family functioning, measured by reduction in conflict and increased communication (Riggs, 2000).

Additionally, responders may face stigma when they return to work after a stress leave. It may be necessary for the clinician to predict this and to discuss issues of shame, fear, and worry. Alternatively, simply leaving the job will not alleviate symptoms. In fact, separation from police duties increases vulnerability to PTSD (Paton et al., 1999).

Administrative/Personal Betrayal

Although there are many events that can be the cause of the responders' current psychological distress, there are often times that responder's symptoms are charged by previous issues of abandonment and rejection. The earlier, unresolved issues can be activated by current events including administrative/personal betrayal. The damage caused by this phenomenon cannot be overemphasized. Gilmartin (2002) observed that "minor dissatisfaction with the organization or agency can become all-consuming anger, hostility, and open hatred toward" management (p. 5). It is important for the clinician to not focus solely on the critical incident but to provide time for the responder to discuss issues of administrative or personal betrayal and to look for ways that current issues connect to previous ones.

Many responders believe the oft-spoken phrase, "We are a police (or fire) family." As in an idealized family, responders expect to be treated with care when they experience distress. For example, a study of New Zealand emergency responders revealed that organizational stressors predicted levels of job satisfaction more than

levels of trauma did (Brough, 2004). At times, however, responders' experiences do not meet this expectation. Obsessing about administrative or personal betrayal relinquishes personal control, focusing on a situation over which the responder has no control. This can result in the responder thinking of himself or herself as a victim, which, in turn, leads to a sense of entitlement and further relinquishes control. "The victim, however, forgets loyalty and integrity and begins viewing the world as loyalty versus integrity" (Gilmartin, 2002, p. 109).

Failure to identify the earlier traumatic incident may inhibit recovery from the current event. As an example, one WCPR attendee presented a highly traumatic event, which he successfully debriefed; however, he did not experience significant symptom reduction until he was able to connect his current symptoms to an event that occurred when he was a teenager: As he was about to leave for college, his father told him, "Well, I hope this makes a man out of you; heaven knows I've tried and failed."

Examples of some questions utilized at WCPR are as follows:

- Have you ever felt (somatic and emotional) this way before?
- Is it possible the way you are reacting today is connected to something from your past?
- What strategies did you use to cope with the previous event?
- Would these strategies work for you today?
  - If yes, . . .
    - What keeps you from utilizing them today?
  - If no, . . .
    - Why wouldn't they work?

Eye Movement Desensitization and Reprocessing (EMDR)

Research on the use of Eye Movement Desensitization and Reprocessing (EMDR) to treat individuals who have been involved in traumatic incidents has been significant, and its efficacy has been widely recognized (Parnell, 1997). EMDR is a therapeutic technique that quickly uncovers critical information. This information enables the responder to replace negative beliefs with more realistic perspectives (Figley, 1999; Shapiro, 2001). Although some researchers have found that exposure therapy may be superior or as effective as EMDR (Asmundson et al., 2004), other studies have shown both short-term and long-term benefits (Davidson & Parker, 2001). For example, Wilson, Becker and Tinker (1995, 1997) found that initial benefits from using EMDR were sustained over a 15-month period.

Studies show that both those diagnosed with PTSD and those without the diagnosis received initial and long-term benefits from EMDR treatment. A relatively small number of EMDR sessions resulted in substantial benefits that were maintained over 6 months (Marcus, Marquis, & Sakai, 2004). Even stronger evidence involving benefits received from EMDR was found for people who have had single traumatic events, people who have not benefited from traditional psychotherapy, inpatient veterans, and substance abusers (Chemtob, Tolin, van der Kolk, & Pitman, 2000).

In the final stages of the WCPR program, attendees meet individually with psychotherapists. Over 90% of the time, EMDR is used as a treatment tool. We

have had considerable success using this technique, due largely to the work that the responder completed in the debriefing and through other psychoeducational components. Responders are asked to imagine scenes in the future in which they are functioning effectively and are proud of their performance (Davis, 2002). Research is currently being conducted that will detail the treatment effects that have been observed anecdotally.

Countertransference and Parallel Process

Clinicians who work with emergency responders may encounter personal or countertransference issues. The nature of the work may evoke violent fantasies; thoughts of death; feelings of abandonment; helplessness or degradation; or other symptoms such as exhaustion, increased use of alcohol, headaches, feeling tense, difficulty concentrating, stomach aches, changes in sleep patterns, nightmares, and increased demands on family and friends (Talbot et al., 1992). It is important not to deal with these issues with the responder or at the group level; rather, the therapist may need to obtain outside resources to help resolve these issues. Clinicians work in pairs to be able to debrief and support each other (Talbot et al., 1992); however, even psychologists with years of experience have found that the stress was significant. Wester and Lyubelsky (2005) recommend that "psychologists need to develop and implement methods of overcoming professional as well as socialized barriers to the provision of psychological services" (p. 56).

Parallel process is a dynamic that may occur when clinicians supervise other therapists or act as group leaders/facilitators. *Parallel process* is typically defined as the replication of treatment obstacles and challenges (that occur between the therapist and the patient in clinical sessions) in supervision (between the therapist and the supervisor). For example, groups that have not achieved cohesion may leave the leader feeling isolated and increase the probability that a parallel process will occur. Staff at WCPR's modified debriefing process include clinicians, peer counselors, and a chaplain. On occasion, staff meetings may generate issues that are similar to the issues being enacted in group sessions. We have found it very important to discuss parallel process issues with peer counselors throughout the retreat. All WCPR staff (peers, clinicians, and chaplains) participate in a "debrief the debriefiers" meeting after each session to help identify countertranference and discuss parallel process issues.

Discussion

ERES is a cluster of symptoms that we have observed in our work with emergency responders. Presenting a framework to understand their symptoms in a culturally acceptable context is a first step toward engaging the responder in treatment. Additional resources may be needed to address the unique issues presented by emergency responders (for listings of organizations, websites, books, and videos, see Gilmartin, 2002; Kates, 1999; Kirschman, 1997; Kirschman, 2004). Responders involved in critical incidents are required to make extraordinary adjustments (Bohl, 1995); however, the number and severity of symptoms that develop should not be defined in terms of the event itself but rather by the degree to which the individual personalizes the event that makes it significant.

It is hoped that clinicians will find this article useful in their work and that it will enable them to recognize the signs and symptoms of work-related stress in their clients. We also hope that the interventions described here will help responders return to work better prepared to deal with such incidents.

Administrators need to be educated regarding the cost of traumatic stress. For example, in addition to the personal toll that is taken, there may be increased rates of accidents, absenteeism, stress-related worker's compensation claims, premature retirement, and decreased rates of productivity (White & Honig, 1995). "The agency can significantly impact the law enforcement family by creating family-friendly policies and by offering psychological assistance such as critical incident debriefings that take spouses into consideration. [As a result,] the department can have a real and measurable impact on peace officer work performance" (White & Honig, 1995, p. 204).

Conclusion

Additional research is needed to further develop effective treatments for emergency responders who have been involved in a critical incident. Specifically, additional confirmation and statistical support of the WCPR treatment model would be helpful. Factor analysis of each program element would provide useful information, as would development of the theoretical underpinnings of ERES. Although gains may be immediately realized in terms of symptom reduction, they may not be permanent. Analysis of long-term gains, maintenance of progress made, and relapse prevention should be completed. Lastly, it will also be important to measure changes in relationships and quality of life.

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Ann Buscho, PhD, Ann is a licensed clinical psychologist in San Rafael, California. She works at Marin County Community Mental Health and has a private practice. Her areas of specialty include family issues, anxiety, depression, and PTSD. She is a designated stress manager for the Marin County Office of Emergency Services and is experienced in critical incident stress debriefing and EMDR. She is also married to a police officer.

Dave Nagle is a 30-year sheriff's deputy and a now retired sergeant with the Sonoma County Sheriff's Department in California. Dave's law enforcement experience includes patrol, canine, dive team, cliff and ocean rescue, helicopter, narcotics, and CISM. Dave supervised the Sheriff's Department Marine Safety & Enforcement Unit and coordinated the department Peer Support Program, which serves 700 members and participates with a regional CISM team as a debriefing facilitator. Dave is a founding member of WCPR.

Book Review

Chicago Police: An Inside View – The Story of Superintendent Terry G. Hillard
Thomas J. Jurkanin with Terry G. Hillard. (2006). Springfield, IL: Charles C. Thomas Publishing. ISBN 0-398-07611-1.

The first sentence of the book's Introduction reads, "In macro-style, this book examines crime, criminal activity, and police response. More specifically, the book focuses on the City of Chicago, which has a long history of and association with crime." The focus of the book is indeed upon the City of Chicago, and recently retired superintendent Terry G. Hillard, but the book is really about urban policing in America. It integrates seamlessly three stories—the biography of a superintendent who by all accounts was both effective and beloved, the Chicago Police Department, and police response to the changing face of crime.

American policing is more decentralized (some would say fragmented) and hence more variant in structure and style than any other national system. It is difficult to write about "policing in America" without stretching generalizations to the breaking point. Think for a moment about the diversity of image of the three largest metropolitan departments—New York City, Chicago, and Los Angeles. Each has its heritage, traditions, styles, and images. Each has generated its own television genre. One cannot claim to understand American policing without understanding the independent character of America's dominant agencies. *Chicago Police* provides that insight into the Heartland's police agency of record.

Chapter One is a snapshot of the City of Chicago itself. One must understand the jurisdictional context to understand any police department. The city of 3 million is the core of a sprawling metropolitan area, ChicagoLand, which includes 8.2 million. Chicago is rich in history, culture, and folklore—from the Gold Coast to Cabrini Green. Chapter Two captures part of that folklore, crime in Chicago from Prohibition's Al Capone to the cult gangsters of the 1930s, Pretty Boy Floyd and John Dillinger, to the more contemporary, and more repugnant, Richard Speck and John Wayne Gacy.

Chapters Three through Five trace the life of Terry G. Hillard, from his truly humble beginnings in South Fulton, Tennessee, to Superintendent of one of the world's largest police departments. The writing style of the book is captured by the opening sentence of Chapter Three: "In his popular book, *Everything I Needed to Know I Learned in Kindergarten*, author Robert Fulghum postulates in a simple, straightforward manner that lessons we learn early in life need to be remembered . . . 'Play fair'; 'Hold hands and stick together'; 'Clean up your own mess'; 'Share everything'; . . . " The linkage to *Everything I Needed to Know* is then used to describe the influence of Hillard's childhood on his career. The biographical description thus never gets tedious. It is linked to the larger story of being a police officer in America—in this case, of course, a most admired police officer.

Chapters Six through Ten describe policing in Chicago today. The Chicago Police Department under current Superintendent Philip Cline continues to focus its crime reduction effort upon the infamous trio, "gangs, guns, and drugs," the title of Chapter Seven. Taken together, they represent the "new organized crime"—poignantly in

Chicago but in every major American city, as well. The documentation in this section is superb. The book skillfully mixes sources as diverse as academic sociological analysis and news stories from the *Chicago Tribune*. Here, the book transcends being either a biography or an organizational history and offers broader insight on the issue of "the police and crime control." The analysis is just as insightful regarding police crime control strategy as the series of books describing Compstat in New York (*The Compstat Paradigm, NYPD Battles Crime, Turnaround*). Chapter Eight describes the evolution and increasing sophistication of Chicago's crime reduction strategy, from the Chicago Alternative Police Strategy (CAPS) to its current Violence Initiative Strategy and Evaluation (VISE) effort. Chapter Nine makes a social statement about the tragic effect of crime in the inner city, contrasting the national media fixation upon a few "glamour" murders to the killing of innumerable forgotten victims, such as an 11-year-old girl, Ryan Harris, murdered by a sexual predator in Chicago's Englewood neighborhood. In Chapter Ten, the challenge to a police chief created by shootings of citizens that generate hostile public reaction is chronicled in the form of the "Night from Hell" experienced by Superintendent Hillard on June 5, 1999. The focus of the book upon one night involving two police shootings provides insight into the daily challenge of police citizen confrontation.

Chapter Eleven samples the occupational milieu of policing in a major city. From recruitment to the role of the union, that milieu is a critical part of law enforcement. The chapter includes a synopsis of the circumstances surrounding the deaths of officers killed in the line of duty during Hillard's tenure as superintendent. One suspects that Hillard personally asked that the chronicle of each be included.

Chicago Police makes an important contribution to the literature base on American policing. It combines biography, organizational history, and analysis of police operations. The book is richly referenced and includes a comprehensive bibliography and author/subject index. It stands as an academic contribution as well as a story with human interest.

Larry T. Hoover, PhD
Director, Police Research Center
Sam Houston State University

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Chicago Police: An Inside View – The Story of Superintendent Terry Hillard

Authors: Thomas J. Jurkanin, PhD, with Terry G. Hillard

In macro-style, this book examines crime, criminal activity, and police response in the city of Chicago, which has a long history of and association with crime. This book will give the reader an inside view of the Chicago Police Department so that a better understanding might be gained of police operations not only in Chicago but in other major city police agencies.

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