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Outcomes of Mental Health Crises when Mental Health Professionals Partner with Mental Health Deputies

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ABSTRACT

Law enforcement has historically been on the frontlines of the mental health crisis. This expected role is difficult as police officers are not trained as mental health professionals. Collaboration between police officers, mental health professionals, and mental health authorities have produced integral models to assist with the mental health crisis. Crisis intervention teams (CIT), mobile crisis units, and street triage models are highlighted to gain understanding of the components of these models. This study desires to examine a collaborative, recently implemented mental health deputy grant program aimed at diverting mentally ill individuals in crisis from contact with the criminal justice system and connecting individuals in crisis to appropriate treatment services. This exploratory, descriptive design allowed for data to be categorized from a log containing synopses of each encounter over an eight-month span. The relationship between variables of cross-tabulated, nominal data was analyzed. Results show that mental health deputies are diverting mentally ill individuals from contact with the criminal justice system, connecting them to emergent treatment services and long-term community services.

Outcomes of Mental Health Crises when Mental Health Professionals Partner with Mental Health Deputies

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CHAPTER I

INTRODUCTION

Mental illness is becoming more prevalent as the number of people suffering with mental health issues increases. In 2016, the Substance Abuse Mental Health Administration (SAMHSA) measured nearly one in five American adults live with a mental illness (SAMHSA, 2017). These statistics divulge that mental illness is very prevalent in society today, and awareness of mental health crises has risen as a result.

Humanitarians have labored to provide the mental health population with appropriate diagnoses, effective treatments, and pharmaceutical therapies for the prevention of recidivism. However, multiple factors such as lack of social supports, substance use, environmental stressors, policy limitations, and gaps in mental health services can impact treatment efficacy. SAMHSA revealed that approximately 43.1% of the mental health population in 2016 received mental health treatment (SAMHSA, 2018). These statistics estimate that less than half of the mentally ill population received services, meaning that more than half did not receive services, thereby contributing to the likelihood of mentally ill persons to experience crises.

Since deinstitutionalization, law enforcement and people experiencing a mental health crisis have a long history of interactions. Law enforcement, often the first to respond to mental health crises, are required to make quick decisions. This can be a difficult task due to the fact that they are not trained as mental health professionals (Lord

& Bjerregard, 2014). In addition, it is common for untrained police officers to lack understanding and react more aggressively towards mentally ill persons, escalating the encounter towards unnecessary violence (Clayfield, Fletcher, & Grudzinskas, 2011). Community mental health services are limited in their capacity to manage violent behavior; therefore, law enforcement is called upon to provide safety. Each community is different and has varying needs; therefore, collaboration models can adjust according to the needs of the community and the level of cooperation between mental health entities and police departments.

Intervention models such as crisis intervention teams (CIT), mobile crisis units, and street triage models have been implemented in a variety of communities to de-escalate the immediate situation and connect people in crisis to appropriate treatment programs. They are also designed to help prevent mentally ill persons from entering into the criminal justice system without legal cause and to aid mentally ill offenders into appropriate treatment facilities such as rehab. Collaboration models and interventions are being evaluated to discover validity, effectiveness, and nature of implementation.

It is important to identify the scope of mental and emotional crises that can accompany the mental health population. Effective collaboration is needed between community mental health professionals and local law enforcement to address the mental health crisis. Intervention methods and models need to be examined for efficacy as it is critical to humanize people in crisis and respond appropriately to de-escalate the situation, ushering them to proper treatment facilities. Criminalization of the mentally ill does occur; therefore, it is necessary to identify the contributing factors as well as examine interventions for prevention.

A literature review was conducted to examine the relationship between law enforcement, clinicians, and persons with mental illness. The role of police officers engaging the mentally ill in crisis is also examined along with the use of force in a mental health crisis. The literature identifies different intervention models formed from collaboration between law enforcement and mental health professionals. Research aims to answer the following questions: Where do clients end up after contact with mental health deputies? Are clients connected to appropriate services and on-going treatment? Are clients diverted from contact with the criminal justice system? Are mental health deputies meeting client needs in the least restrictive method?

The purpose of this study is to explore the relationship between mental health, law enforcement, and mental health professionals in order to gain insight for future improvements. Research is limited in rural areas regarding mental health and effectiveness of intervention models. This study aims to bring insight to the Center for Life Resources, who is eager to determine the value of their recently implemented mental health deputy program. This study can also bring enlightenment to the importance of collaboration between law enforcement and mental health professionals in developing successful interventions for rural communities.

CHAPTER II

LITERATURE REVIEW

Mental Health

Mental health is important to the overall health of a human being. Mental health is thought of as the psychological, social, and emotional well-being of an individual who is able to successfully adapt to changes that occur in everyday life (MentalHealth.gov, 2017). Some have thought of good mental health as being mentally intact with the absence of a disorder, but it is more than that. Theorists such as Abraham Maslow believed that individuals can reach self-actualization, a state of having one's needs completely fulfilled to the point of being able to live up to one's full potential in life (Fradera, 2018). Mental health and wellness can be defined as the ability to realize one's full potential, cope with the stresses of life, work productively, and make meaningful contributions to others (MentalHealth.gov, 2017).

Mental Illness and Disorder

Awareness of mental illness is becoming more prominent through media advertisements, informational websites, and relational connections with someone who has mental illness. Mental illness can occur at any age, but typically symptoms begin either in childhood, adolescence, or in early adulthood. A mental illness is defined as "a mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment" (SAMHSA, 2017). It is

common for people to overlook the signs of mental illness and dismiss them as simply coping with the stressors of everyday life; however, mental illness can have a profound effect on physical health as well. According to The Department of Health and Human Services (DHHS), mental illness is the leading cause of disability and causes complications such as a weakened immune system, heart disease, and even death (MentalHealth.gov, 2017). It is vital that people with mental illness receive treatment, beginning with a diagnosis. A mental disorder can be diagnosed by a clinician through the use of The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). A mental disorder, as defined by the American Psychiatric Association (APA), "is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (*DSM-5*, p. 20). Physicians and psychiatrists have speculated that a variety of genetic and environmental factors have contributed to and possibility caused mental health disorders. These factors are identified as inherited traits, environmental exposures previous to birth, and brain chemistry (MayoClinic.org, 2018). If a mentally ill person is left undiagnosed and untreated, the chances of long-term recovery become slim, leading to more distress and worsening outcomes (MentalIllnessPolicy.org, 2017).

Mental Illness Facts

In 2017, The Substance Abuse Mental Health Administration (SAMHSA), estimated that nearly one in five American adults live with a mental illness, which is approximately 44.7 million people (SAMHSA, 2017). These figures reveal that mental illness is extremely common, affecting many individuals, families, and communities. In

2017, SAMHSA estimated that 20.2 million adults (8.4% of the population) have a serious mental disorder such as major depression, schizophrenia, or bipolar disorder. People with serious mental illness are more likely to be unemployed, arrested, and have inadequate housing compared to those without mental illness (SAMHSA, 2017). The Centers for Disease Control and Prevention (CDC) 2011 survey revealed that 6.4 million children ranging in ages from four to seven years have been diagnosed with attention deficit hyperactivity disorder (ADHD), and 13% to 20% have a mental disorder (SAMHSA.gov, 2017). Adults with substance use disorders came to 20.2 million in 2014 along with 7.9 million people diagnosed with a co-occurring mental health disorder and substance abuse disorder (SAMHSA.gov, 2017). Suicide is common for people suffering with a mental health disorder and happens more frequently in certain types of disorders. As of February 2018, suicide on average claims 112 American lives every day and is now the leading cause of death for people 15 to 24 years of age. More than 9.4 million adults in the United States had serious thoughts of suicide within the past year (MentalHealth.gov, 2018).

Mental Health Treatment

Mentally ill persons often do not receive the care they need (Shah & Beinecke, 2009; Theriault, Coleman, & Theriault, 2017). DHHS statistics reveal that only half of the mental health population received treatment in 2016 (MentalHealth.gov, 2017; Mental Illness Policy.org, 2017; NIMH, 2017). This treatment gap significantly limits the impact that interventions could have on the mentally ill population (Theriault et al., 2017). There are many contributing factors to neglecting treatment once signs and symptoms are recognized. Fear of stigmatization, perceived social standards, and family

expectations are a few reasons why people do not seek out treatment (Theriault et al., 2017). Shah and Beinecke (2009) identified key barriers in treating mental health such as insufficient funding for services, lack of services in rural areas, limited numbers of mental health professionals, and complexities integrating mental health with primary care entities. Limitations and barriers to treatment for the mentally ill increase the chances for a mental health crisis. Hensen et al. (2016) described a study conducted in Groningen where half of the mentally ill encountered by police intervention teams were disconnected from mental health services approximately one year before experiencing a crisis.

Crisis in Mental Health

Gullslett, Kim, Anderson, and Borg (2016) refer to Cullberg's definition of crisis as "a person's reaction to external stress that has overwhelmed him or her, in which there is a breakdown of coping mechanisms; therefore, requiring professional help" (p.162). When the mentally ill are under less amounts of stress, they typically have identified some coping skills useful for lowering intense emotions. However, when they become overwhelmed with stress, they cannot cope, thus contributing to a personal crisis. An individual experiencing a mental health crisis can also exhibit disturbing behaviors, placing themselves and/or others in danger (Mojitabai et al., 2015). Researchers have studied what is needed in the midst of a crisis to ease a person's distress. A 2009 survey administered by Agar-Jacomb and Read identified the needs of individuals in crises, such as feeling emotionally supported, treated with compassion, and having their viewpoints taken seriously (Burns-Lynch, Murphy, Gill, & Brice, 2014). Numerous emergency mental health services are available for people in crisis, such as psychiatric hospitals and

emergency rooms. Many professionals engage with individuals in crises; however, law enforcement plays a crucial role.

Law Enforcement and the Mental Health Crisis

Police officers and people with mental illness have a long history of encounters since deinstitutionalization. The deinstitutionalization movement was intended to be a positive, humanizing transition of the mentally ill to their families and communities. Popple and Leighninger (1999) explained the United States government had high hopes of significantly improving their lives, though it has been stated by scholars that communities were not equipped at that time with resources and social services to properly treat and care for large numbers of mentally ill. In the 1960s, Judge Bazel fought for mental health treatment to be centralized in the community and offered in the least restrictive setting (Slate, 2017). Despite the efforts of many, the deinstitutionalization movement continued to neglect the mentally ill and leave them vulnerable to homelessness and exploitation (Popple & Leigninger, 1999). Another negative consequence of deinstitutionalization is the rising numbers of mentally ill jailed due to limited psychiatric hospital beds and crisis services (Popple & Leigninger, 1999). In addition, many individuals do not remain in community mental health services, creating numerous gaps in treatment that have been noted to cause mental health crises (van den Brink et al., 2012).

Police Officers' Encounters with the Mentally Ill

Police officers often serve on the front lines in a mental health emergency (Kisely, et al., 2010; Lord & Bjerregaard, 2014; Munetz, Fitgerald, &Woody, 2006; Steadman, Deane, Borum, & Morrissey, 2000; van den Brink, et al., 2012; Wood & Beierschmitt,

2014). Studies show that between 7% and 10% of all police calls involve people with mental illness (Lord & Bjerregaard, 2014; Wood, Watson, & Fulambarker, 2017). Police officers must make quick decisions to assess the individual for mental illness and manage the situation swiftly. These decisions can be very difficult for officers not trained as mental health professionals (Kisely, et al., 2010; Lord & Bjerregaard, 2014). A 2014 study found that the majority of interactions occurred between police and mentally ill homeless persons with 77% to 80% presenting with severe psychosis (Girard et al., 2014). When police officers encounter the mentally ill in crisis, they are most likely coming in contact those who are more volatile. Lord and Bjerregaard (2014) discovered that people with serious mental illness are "twice as likely to become violent, intoxicated, psychotic, mood-disorder diagnosed, and in emergent need of care" (p.470). Police officers are encountering the seriously mentally ill and suicidal/homicidal persons daily, raising the question: Are police officers solely responsible for managing mental health crises?

Police Officers' Role and Mental Health Training

Police officers are trained to enforce the law and protect people in communities by keeping them safe from individuals who threaten harm and break the law. Police officers often find themselves functioning as "accidental interventionists" and "peacekeepers" during crises involving the mental health population (Wood & Beierschmitt, 2014; Wood et al., 2017). This automatic role expectation leads police to experience confusion, questioning their responsibilities. Meehan (1995) further describes their role confusion as to whether they are law enforcement or social services.

Controversial questions have arisen pertaining to police officers' role in managing mental health crises since tragic fatal shootings have occurred (Wood et al., 2017).

Police officers often receive very little training when it comes to engaging the mentally ill (Clayfield, Flectcher, & Grudzinskas, 2011; Meehan, 1995). However, police officers are still the first responders to emergencies, even mental health emergencies. It is illogical to believe that police officers can solitarily manage mental health crises (Young, Fuller, & Riley, 2008). A 1999 survey showed that 55% of 195 police departments located in large cities across the United States did not have any specialized response training for the mentally ill (Young et al., 2008). In addition to a lack of training, police officers may not know how to connect mentally ill persons to appropriate treatment facilities and emergent care. Lee et al. (2015) state that police officers without sufficient training will "often immediately transport the mentally ill in crisis to a hospital instead of assessing and treating them in the community" (p.538). Meehan (1995) attributes officers' decisions to a lack of confidence in making treatment decisions for mentally ill persons. However, Olivero and Hansen (1994) found police officers to be one of the primary sources of referral to community mental health treatment facilities.

Perceptions and Attitudes of Police Officers

Law enforcement has a variety of perceptions and attitudes when it comes to mental illness. Many police departments across the United States are leading with solutions to aid the mental health crisis, while others respond out of duty. Some law enforcement officers perceive interactions with the mentally ill as distasteful, feeling as if they lack control over the process. Other officers are not convinced that mental health

treatments are successful, leaving them with a deficient feeling when aiding the mentally ill instead of a rewarding one (Meehan, 1995). Negative attitudes may be seen in police officers, but the culprit appears to stem from society as a whole. Clayfield et al. (2011) perceived negative attitudes towards the mentally ill "may be the result of inaccurate information and little contact with these individuals" (p.742). Clayfield et al. (2011) explained that police officers' lack of understanding and training could result in making inappropriate decisions when responding to calls involving emotionally disturbed persons. In 2008, police officers' attitudes toward mentally ill persons were measured by the Mental Health Attitude Survey for Police (MHASP). Four hundred and twelve officers from major city police departments participated voluntarily in this study. The results showed that female officers, nonwhite officers, and officers with more experience had more positive attitudes towards emotionally disturbed persons (Clayfield et al., 2011). Even though attitudes of police officers vary, use of appropriate force towards mentally ill persons is still a concern.

Use of Force

Police officers using force to maintain safety in a mental health crisis is an extremely important issue, as tragedies have occurred. In 2003, the Treatment Advocacy Center reported that 52 mentally ill persons were killed by law enforcement officers, and seven police officers were killed by people with mental illness that same year (Munetz et al., 2006). Many police departments are searching for interventions and alternatives to minimize force. An Ohio police department decided to utilize tasers instead of service weapons when encountering a mental health crisis. A study conducted by the Akron Police Department in 2000 revealed that they discharged their Tasers 61 times in the first

18 months of implementation without physical injury or further harm. Of the 61 times the Tasers were deployed, 27 individuals were thought to have a mental illness, 16 expressed suicidal/homicidal ideation, 10 possessed weapons, and eight individuals presented with serious psychosis (Munetz et al., 2006). Another study in New Zealand revealed the use of Tasers were twice as likely to be deployed at mental health emergencies versus criminal arrests (O'Brien, McKeena, Thom, Deisfield, & Simpson, 2011). The use of Tasers is controversial and raises questions of risk and appropriateness of use on mentally ill people in crisis, since they are already distressed. Munetz et al. (2006) state that advocates argue tasers are used to frighten and manipulate. O'Brien et. al. (2011) recommend that clear policies be implemented to regulate the use of Tasers during a mental health emergency so as not to overuse force.

Criminalization of the Mentally Ill

Criminalization of the mentally ill is an ongoing issue. The term was coined by Abramson (1972) who discovered that people with mental illness were being inappropriately placed in the criminal justice system due to a lack of community resources (Lord & Bjerregard, 2014; Olivero & Hansen, 1994). In 1981, Bonovitz and Bonovitz referenced the deinstitutionalization movement as the culprit of the "transinstitutionalization" movement of the mentally ill into local jails and prisons (Olivero & Hansen, 1994). In 2009, statistics show 14.5% of all males and 31% of all females jailed in the United States were severely mentally ill, leading to the conclusion that officers arrest a substantial amount of mentally ill persons (Watson & Fulmbarker, 2012). However, some have argued that the number of people incarcerated is increasing regardless of mental status and that the numerical increase of incarcerated mentally ill

persons is merely reflection upon proportions (Lord & Bjerregard, 2014). Awareness of criminalization has increased since the 1970s and 1980s. Advocates for fair and dignifying treatment of mentally ill persons have increased as well. Law enforcement and mental health professionals are aware of this issue, which has contributed to more training, collaboration, and solution finding (Lord & Bjerregard, 2014).

Crisis Interventions

Gelman and Mirabito (2005) described crisis intervention as an approach to "restoring client systems to their previous level of functioning by capitalization on the heightening motivation, capacity, and opportunity engendered by crisis" (p.480). This definition basically describes crisis intervention as engaging the client in their current state of mind, allowing them to express what they are feeling, and attempting to return them to homeostasis (Gelman & Mirabito, 2005). Young et al. (2008) describe crisis intervention to lessen the "impact of stress on the victim" (p. 346).

Crisis Intervention Team Model (CIT)

Numerous models and approaches to crisis intervention have developed over the years as the need for effective interventions continues. Numerous tragedies have brought to light the need for crisis interventions, such as a tragedy that occurred in 1987 in Memphis where a police officer shot and killed a mentally ill man (Steadman et al., 2000). Another tragedy occurred in 2012 in Atlantic City where a woman suffering from schizophrenia and homelessness stabbed two tourists to death (Wood & Beierschmitt, 2014). In addition, mentally ill persons often relapse and exhibit disturbing behaviors that require police assistance. Mental health professionals also call on law enforcement

when a client presents with a significant history of risk, pointing to the need for a collaboration of skills for both entities (Hollander et al., 2012).

Crisis intervention team model (CIT) was developed in the 1980s by the Memphis police department. They began by setting a safety goal to improve encounters between officers and mentally ill persons (Watson & Wood, 2017). The CIT model is a collaborative, multi-faceted strategy improving encounters between police officers and mentally ill persons in crisis (Watson, Compton, & Draine, 2017). This model allows police officers to volunteer for the program, which requires substantial mental health training and stresses the importance of collaboration with community social services and emergent entities such as psychiatric hospitals and emergency rooms. The training given to select officers provides them the knowledge, skills, and ability to link distressed persons to psychiatric care (Watson et. al., 2017). Scholars have raised questions as to whether this model is an evidence-based practice (EBP). Watson et al. (2017) stated that CIT can be considered an EBP when defining EBP as the use of "best available evidence to guide policy and practice" (p.435).

Mobile Crisis Intervention Model (MCI)

Integrated mobile crisis teams can consist of community mental health professionals, police officers, and emergent care facilities. Depending upon the collaboration agreement, some clinicians are on staff with the police department and others would receive calls from dispatch alerting them to respond to a crisis call. One particular MCI model was assembled in Nova Scotia after hearing of this type of integration in the United States. Their mobile crisis team was comprised of clinicians from a community behavioral health center along with the police department and an

ambulance service as needed. When a mental health crisis arose, dispatch would alert a clinician who arrived at the scene of a crisis accompanied by a police officer casually dressed in street clothes (Kisely et al., 2010).

Street Triage Model (STM)

The street triage model (STM) is similar to both CIT and MCI in that integration occurs between the local police department and mental health professionals during a mental health emergency. This model differs from other models as it encompasses various approaches to crisis response. In the first integration approach, police officers will attempt to contain the crisis without mental professionals' input; however, if the situation escalates, the officer is to call a clinician for guidance. In the second approach, clinicians are the primary source alerted to respond to the crisis, and police are notified to meet them at the scene (Horspool et al., 2016).

Outcomes of Crisis Interventions

Police officers assigned to CIT in Philadelphia in 2009 had at least 40 hours of mental health training including mental health first aid (MHFA) which is a 12-hour training program on how to identify and manage behavioral health crisis situations (Wood & Beierschmitt, 2014). A mixed method study was conducted on the encounters officers had with mentally ill persons while on foot patrol in areas commonly populated by the homeless. The CIT commonly encountered people with co-occurring mental health issues, anti-social behaviors, and who were often inebriated (Wood & Beierschmitt, 2014). The study also revealed that they had 50,570 transports to psychiatric emergent facilities after a crisis and took note that some had become regulars to this service. Also discovered was the frequency of non-violent misdemeanors that

would leave officers no choice but to arrest them. Wood and Beierschmitt (2014) discussed that judges commonly assign mentally ill offenders community service or rehab since the majority are charged with misdemeanors.

Mobile Crisis Intervention (MCI)

MCI teams interacted with mentally ill persons who were in crisis, and some were even homeless. Girard et al. (2014) reported on a study where the interactions were mainly with people who had psychosis (77%) and acute psychosis (80%). Also, they discovered that life on the streets was very violent in nature, and a high percentage of ethnic minorities was represented among mentally ill interactions. Due to the coercive practices of some clinicians, the mentally ill persons were more afraid of the psychiatrists than the police officers (Girard et al., 2014). Kisely et al. (2010) analyzed that MCI services increased significantly from 464 contacts with mentally ill persons previous to MCI implementation to 1666 after two years of the program, and the time on scene was reduced from 165 minutes previously to 136 minutes. In addition, mentally ill persons who were contacted by MCI showed improved engagement compared to before MCI services (Kisely et al, 2016).

Street Triage Model (STM)

Mentally ill persons who had encountered the street triage team saw them as compassionate and motivated. They also had good use of knowledge, skills, and expertise along with positive attitudes because they felt like they were actually helping the mentally ill by connecting them to services (Horspool, et al., 2016).

Perceptions of Mental Health Professionals and Police Officers

Crisis intervention models that require collaboration between police officers and clinicians are hailed as overall positive and helping solve the national mental health crisis. However, with any collaboration, mutual expectations and role comprehension can become hazy along with real or misinterpreted perceptions. According to Hollander et al (2012), clinicians reported some officers had limited understanding about mental health policies, misinterpreting them, causing disagreements as to whether a case was considered urgent and thus declining to transport. In other circumstances, police officers felt disrespected and unappreciated by clinicians (Hollander et al., 2012). A questionnaire completed by clients who engaged in various forms of crisis intervention models revealed they felt supported and listened to during their crisis and the teamwork de-escalated the situation; however, further training for police officers on how to properly engage clients and not harass them is needed (Evangelista et el., 2016).

Limitations of Crisis Intervention Models

Many limitations to crisis intervention models exist, raising questions to their efficacy. Interventionists such as clinicians and police officers experience difficulty linking mentally ill persons to services unless they are in a crisis (Hollander et al., 2012; Wood & Beierschmitt, 2016). Clinicians also encountered challenges using dispatch to request a policeman's response and obtaining situational client information previous to appearing on the scene (Wood & Beierschmitt, 2016). Crisis intervention teams cannot be everywhere at once, thus presenting significant limitations when there is a simultaneous crisis call (Hollander et al., 2012). Likewise, Horspool et al. (2016) explain

that demands for appropriate staff for joint intervention teams could cause a staffing shortage from existing mental health entities.

Conclusion

The literature describes both the nature and prevalence of mental illness as well as defining what constitutes as a mental health crisis. The deinstitutionalization movement involuntarily placed police officers as first responders to mental health crises. The literature revealed that law enforcement historically possessed a lack of knowledge and expertise in identifying and properly managing crises. Tragic interactions between law enforcement and the mentally ill ending in death have occurred, which demands the need for appropriate, safe interventions.

This research examines the efficacy of a variety of crisis intervention programs as well as limitations, perceptions, and outcomes. Crisis intervention team (CIT) is a model sought after by many police departments. It is a unit comprised of police officers trained specifically in responding to mental health crises including de-escalation approaches and techniques.

Mobile crisis teams are an integration of law enforcement, mental health professionals, and ambulance services. These entities partner together and rely upon one another to fulfill their specific duties. Mobile crisis teams strive to be supportive to persons in crisis and to connect them to emergency services such as psychiatric hospitals. The street triage model strives to do the same, focusing primarily on serving the homeless mentally ill population.

Since the implementation of these services, studies have revealed an increase in usage by mentally ill persons, reduction of time officers spent at the scene, and improved

engagement between mentally ill persons and officers. Recipients of crisis interventions had feelings of being supported while others experienced scrutiny. Limitations include difficulties linking persons to mental illness services outside of an emergency and challenges within the model such as incomplete or no information before arrival on the scene of a crisis.

CHAPTER III

METHODOLOGY

Purpose

The purpose of this study is to examine outcomes of the mental health deputy program to determine its validity. Outcomes will present useful to the future precedence of this integrated program and inform the Center for Life Resources (CFLR) of the benefit of the Brown County Mental Health Deputy Program, which was implemented through a grant in April of 2018. The grant allowed CFLR to hire two mental health deputies to assist in response to crisis calls during daytime hours, Monday through Friday. This research could also inform city government in rural areas seeking to implement an intervention team consisting of mental health professionals and mental health deputies. To determine validity of the mental health deputy program, this study sought to answer following research questions: Where do mental health crisis clients end up after contact with mental health deputies? Are clients connected to appropriate emergent services and ongoing treatment services? Are clients diverted from contact with the criminal justice system? Are the mental health deputies meeting client needs in the least restrictive method possible?

Research Design

The design for this project was exploratory, descriptive research. The researcher examined the mental health deputy grant program, as an intervention model. The grant

required both mental health deputies to be licensed as peace officers by the Texas Commission on Law Enforcement Standards and Education. They are required to have at least 40 hours of mental health training in order to obtain their peace officer license. Also, both mental health deputies receive ongoing mental health training as employees of the CFLR and additional continuing mental health education as required for maintaining peace officer certification. The reason for collecting qualitative data is to study the outcome of services rendered by trained mental health deputies in response to individuals in crisis. The rationale behind the particular research design was to give the researcher freedom to explore variables within the data.

Data Collection

The secondary data was gathered using the mental health deputy log completed by two mental health deputies following a crisis call. The data contained criteria of a few identifying variables such as name and address of clients along with a brief synopsis of the outcome of each crisis call. All identifiers that could reveal or connect a situation to a particular person were deidentified by the crisis department supervisor before the primary investigator analyzed the data. The synopsis contained a brief description of services rendered by mental health deputies categorized as screening, transporting, engaging, or ensuring safety of client or others.

Sample

The data contained information and synopses of people in crisis from Brown County, which is a mainly rural area. Persons having a crisis could account for a percentage of current clients receiving services from a CFLR. The median age in this study was 40 years old. Sixty-seven (49%) were males, and 70 (51%) were females.

Race, ethnicity, or cultural affiliation was not documented in the demographics of this study.

Instrument

The secondary data was measured quantitively. The mental health deputy's log is located at the CFLR in the crisis department, secured in personal computers assigned to each deputy. The data was secured, only updated by the deputies who access their computer by password. The crisis department supervisor has access to the log as part of his job requirements to monitor the services and decisions of the deputies. Data entries began in April of 2018 and ended on December 31, 2018. Data collected for this research project is documented in the mental health deputy log located at the CFLR in Brownwood, Texas. Following the resolution of a crisis call, two mental health deputies enter information into a log. The information recorded in the log contains: date, age of client, name of client, client address, name of the responding officer, the name of the mental health crisis professional, the nature of the call (such as screening, transport, engagement, or safety), and a brief synopsis of the events that transpired, including outcome. All identifiers were removed by supervisor, Stephanie Miller, LMSW, as to maintain anonymity and was given to the principal investigator to analyze the data. Permission to analyze data has been granted by the CFLR in Brownwood, Texas. Limitations and biases include mental health deputies' perceptions of the situations and not based on any additional viewpoints of persons involved in the crises. Data is solely based on mental health deputies account of the actions that transpired in that particular incident.

Analysis

The data was organized and categorized for reoccurring themes and outcomes. The yearly totals were categorized by the frequency of services provided by deputies and number of individuals connected to specific treatment services. The reason for the crisis call was categorized by suicidal tendencies, homicidal tendencies, mental distress/psychosis, and medication difficulties. Suicidal tendencies were categorized from "not suicidal" to "suicide attempt." The interventions deputies utilized were categorized from least restrictive to most restrictive methods such as engagement, screening, emergency detention order (EDO), and arrest. Likewise, outcomes were categorized in the same manner from safety plan to jail. Suicidal tendencies were ranked based on severity and given a number from one to five, one representing "not suicidal" and five representing "suicide attempt." Interventions and outcomes were ranked the same using the same numerical values from most restrictive to most restrictive. Chi-Square ($\chi 2$) analysis was used to test the significance of mental health deputies' service frequencies. Cross tabulation and Chi-Square ($\chi 2$) analysis were used to examine association between the nominal variables while Cramer's *V* analysis was utilized as a posttest to examine the correlation between the nominal variables.

CHAPTER IV

FINDINGS

Table 1

Distribution of Outcomes from Contact with MHD

Location:	# of calls
Contracted for Safety	213
Transported to Medical Clinic at CFLR	45
Transported to Private Psychiatric Hospitals	42
Transported to Respite Care Facility	40
Transported to the ER	12
Transported to State Psychiatric Hospitals	6
Transported to CFLR for Clinical Services	5
Transported to Jail	1
Transported to the ARK (Domestic Violence Shelter)	1

Table 1 indicates that the vast majority of mental health deputy contacts ended up contracting for safety. As the table also shows smaller numbers were transported to various facilities for care. The majority of destinations were places where the person the deputy was called to assist could receive mental health care. Similarly, Table 2 shows that the majority of individuals who were subjects of an intervention were connected with ongoing treatment and a majority were diverted from contact with the criminal justice system and from the emergency room. Further, Table 2 shows that several of those who may have been taken to jail, to a psychiatric hospital, or to the emergency room instead received other services designed to help those persons function.

Table 2

Mental Health Deputy Log - Data Totals from 2018

Specific Data	Total #s
Number of staff trained in military-informed care	2
Number of indiv. connected to housing services	4
Number of indiv. connected to employment services	8
Number of indiv. in crisis diverted from ER	17
Number of indiv. in crisis diverted from psychiatric hospitals	30
Number of indiv's diverted from contact with the criminal justice system	44
Number of indiv's identified and connected with ongoing treatment	54
Number of clinical/therapeutic interventions completed	55

Figure 1 displays mental health deputy calls, by month, for 2018. As the figure indicates, total number of assists spiked during the summer months of June and July. Interestingly, a rise in the total number of assists occurred in October and in November. Mental health deputies responded to more calls to assist from the Brownwood Sheriff's Office (BWD SO) than they did from the Brownwood Police Department (BWD PO) or the Early Police Department (Early PD).

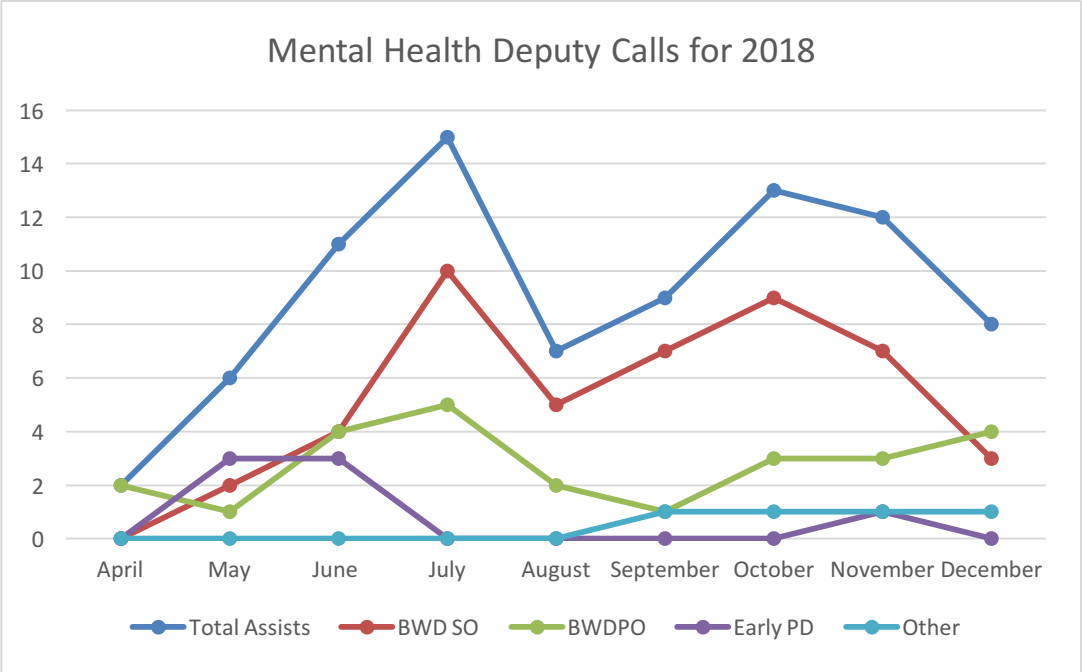

Figure 1: Total Mental Health Deputy Calls for 2018

Like Figure 1, Table 3 shows that June and July were the busiest months in terms of provision of services. Figure 2 helps determine that, in June and July, engagement was highest; closely followed by transport. In October and November, screening was the most frequent service provided. Safety plans were the least utilized service across the year. A χ^2 test (see Table 4) indicated that the distribution of total services is significantly different ($\chi^2 = 68.5$, df = 8, $p < .0001$) than what would be expected from a random (normally distributed) set of values. Stated differently, it is extremely unlikely that the observed frequencies by month are due to chance; and a systematic difference, by month, in total services provided exists. Similarly, the distribution of values for engagement deviated significantly from expected values, $\chi^2(8, N = 149) = 53.9$, $p < .0001$, indicating a high probability of a true difference in engagement services by month. The same was true for Screening and Transport. Safety was the only variable that, with a high level of confidence, did not appear to vary significantly from normal.

Table 3

Deputy Log Totals

Month	Total Services	Engagement	Screening	Safety	Transport
April	12	0	6	2	4
May	33	6	13	5	9
June	77	30	22	7	18
July	80	34	10	6	30
August	58	19	19	8	12
September	56	16	13	15	12
October	65	16	23	11	15
November	51	15	22	3	11
December	45	13	16	5	13
Total	477	149	144	62	124

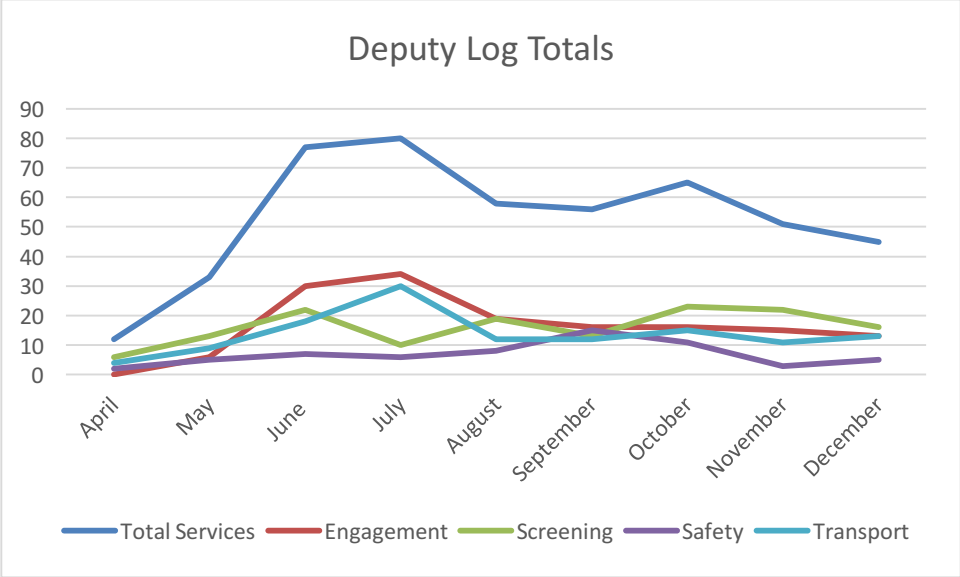

Figure 2: Deputy Log Totals

Table 4

Chi-Square (χ2) Test Results for Deputy Log Totals

Services	χ2	df	*p*	Corrected *p*
Total Services	68.5	8	0.000	0.000
Engagement	53.9	8	0.000	0.000
Screening	17.8	8	0.023	0.000
Safety	19	8	0.015	0.074
Transport	30.2	8	0.000	0.001

Table 5 presents the results of a crosstabulation of restrictiveness of outcomes by suicidality ranking. Cramer's *V* indicated a significant, $V(137) = .29$, $p = .000$, correlation between the two rankings. Stated differently, there was a significant tendency for restrictiveness of outcome to increase as risk of suicidality increased. For example, 60% ($n = 9$) of those who were transported to a psychiatric hospital had a plan, possessed the means to suicide, or had made a suicide attempt. However, the one person transported to jail (most restrictive) was not suicidal. The majority of those who completed a safety plan only (77%; $n = 59$) were rated as either non-suicidal or suicidal ideation without a plan or means.

Table 5

Outcomes Ranked from Least to Most Restrictive by Suicidal Risk Scale Crosstabulation

Outcomes		Not Suicidal	Ideation No Plan	Suicidal With Plan	Suicidal With a Weapon or Drugs	Suicide Attempt
Safety Plan	Count	28	31	11	3	3
	% within Safety Plan	36.80%	40.80%	14.50%	3.90%	3.90%
ER or Med Clinic	Count	23	1	1	0	1
	% within ER or Med Clinic	88.50%	3.80%	3.80%	0.00%	3.80%
Respite Care	Count	9	4	5	1	0
	% within Respite Care	47.40%	21.10%	26.30%	5.30%	0.00%
Psychiatric Hospital	Count	3	3	3	4	2
	% within Psychiatric Hospital	20.00%	20.00%	20.00%	26.70%	13.30%
Jail	Count	1	0	0	0	0
	% within Jail	100.00%	0.00%	0.00%	0.00%	0.00%
Total	Count	64	39	20	8	6
	% within Total	46.70%	28.50%	14.60%	5.80%	4.40%

Figure 3 shows the information presented in Table 5 and graphically portrays that the vast majority of 2018 crisis clients received the least restrictive intervention (i.e., only a safety plan). In addition, the majority of crisis team clients were either not suicidal, or had suicidal thoughts (i.e., suicidal ideation) but had no plan nor means to suicide. The figure also highlights the low number of clients who were sent to jail (n = 1).

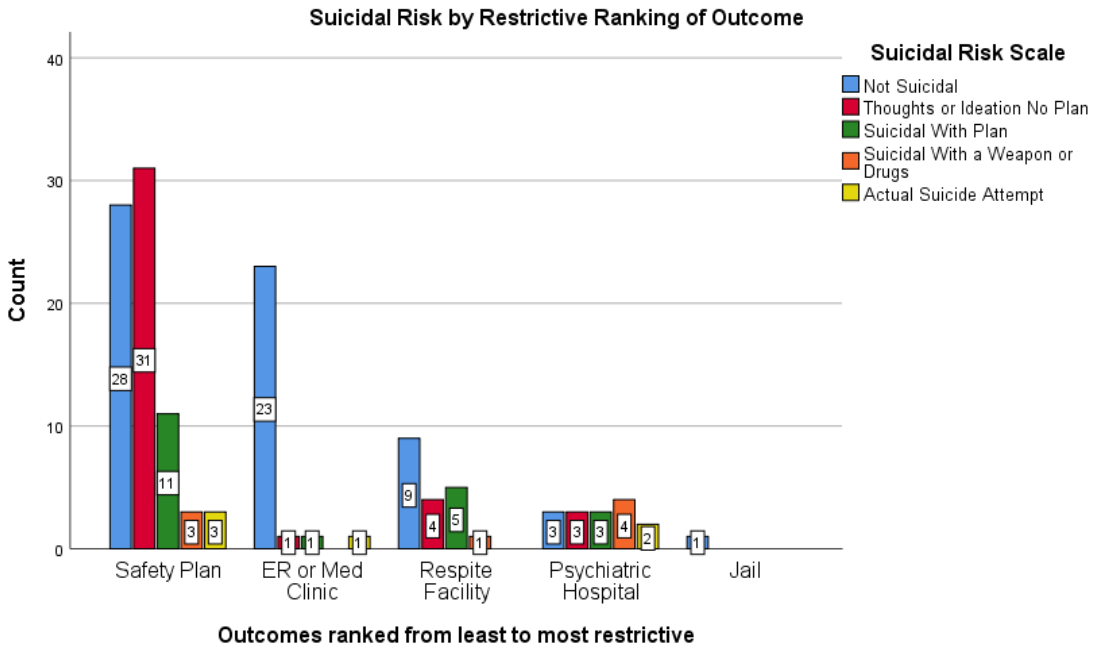

Figure 3: Suicide Risk by Restrictiveness of Outcome

Table 5

Outcomes Ranked from Least to Most Restrictive by Reason for Call Crosstabulation

	Medication Difficulties	Mental Distress or Psychosis	Suicidal Tendencies	Homicidal Tendencies	Total
Count	9	26	37	4	76
% within Safety Plan	11.80%	34.20%	48.70%	5.30%	100.00%
Count	20	4	2	0	26
% within ER or Med Clinic	76.90%	15.40%	7.70%	0.00%	100.00%
Count	8	2	9	0	19
% within Respite Facility	42.10%	10.50%	47.40%	0.00%	100.00%
Count	1	5	8	1	15
% within Psychiatric Hospital	6.70%	33.30%	53.30%	6.70%	100.00%
Count	1	0	0	0	1
% within Jail	100.00%	0.00%	0.00%	0.00%	100.00%
Count	39	37	56	5	137
% within Total	28.50%	27.00%	40.90%	3.60%	100.00%

Table 6 presents the ranked outcomes by the reason for the call. Again, this crosstabulation resulted in a statistically significant, V (137) = .354, p = .000, nominal by nominal association. The reason for the contact with the mental health deputy for nearly all (92%, n = 24) who were transported to the emergency room or an outpatient medical clinic was either medication or non-suicidal mental illness-related. Sixty percent (n = 9) of those who were transported to a psychiatric hospital made contact with a mental health deputy because of either suicidal (53.3%, n = 8) or homicidal (6.7%, n = 1) tendencies.

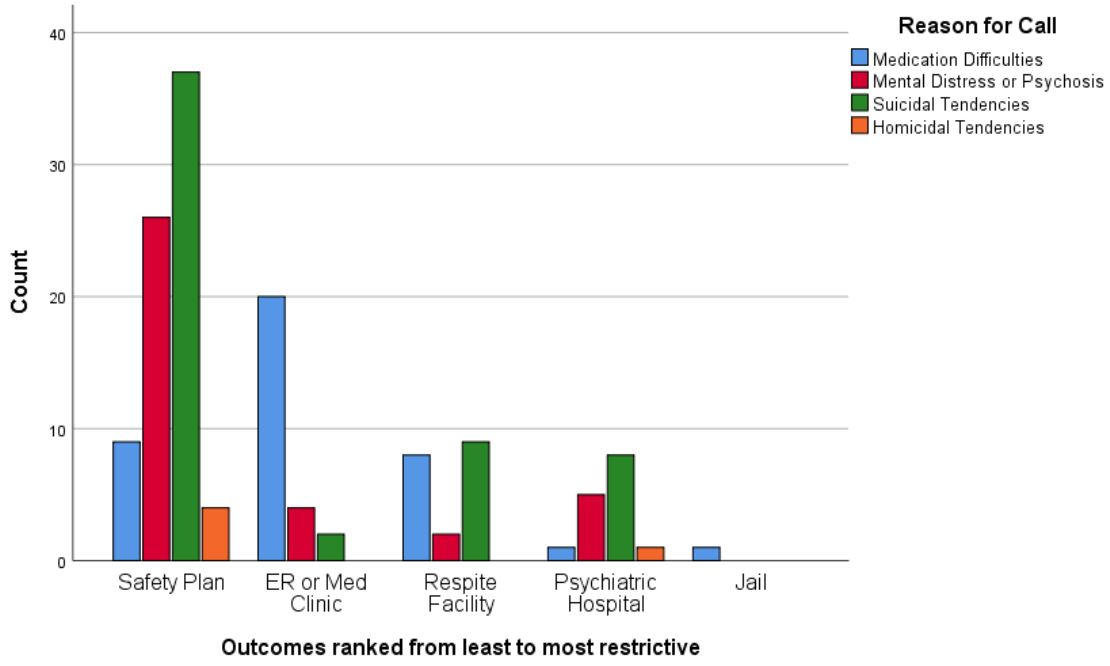

*Figure 4:*Outcomes Ranked from Least to Most Restrictive by Reason for Call

Table 7 and Figure 5 show results of a crosstabulation of the reason for the crisis call and the intervention. Again, Cramer's V was statistically significant, V(105) = .348, p = .000 indicating an overall moderate association between the two variables. The table shows that a higher percentage (i.e., 72%) of those with the reason for call rated as less

severe (i.e., medication difficulties and mental distress) received engagement (de-escalation skills). A large proportion of those received screening (Columbia Suicide Severity Rating Scale) were rated (i.e., the reason for the call was rated) as having suicidal tendencies (77%). Seventy percent of those receiving an emergency detention order (EDO) had either suicidal or homicidal tendencies (i.e., the urgency of the call was rated higher). Figure 5 clearly illustrates that most calling with suicidal tendencies were screened for suicidality and the majority with mental distress or psychosis received de-escalation skills training (i.e., engagement).

Table 7

Reason for Call by Intervention

		Medication Difficulties	Mental Distress or Psychosis	Suicidal Tendencies	Homicidal Tendencies	Total
Engagement	Count	9	25	10	3	47
	Percent	19.10%	53.20%	21.30%	6.40%	100.00%
Screening	Count	3	7	36	1	47
	Percent	6.40%	14.90%	76.60%	2.10%	100.00%
EDO	Count	0	3	6	1	10
	Percent	0.00%	30.00%	60.00%	10.00%	100.00%
Arrested	Count	1	0	0	0	1
	Percent	100.00%	0.00%	0.00%	0.00%	100.00%
Total	Count	13	35	52	5	105
	Percent	12.40%	33.30%	49.50%	4.80%	100.00%

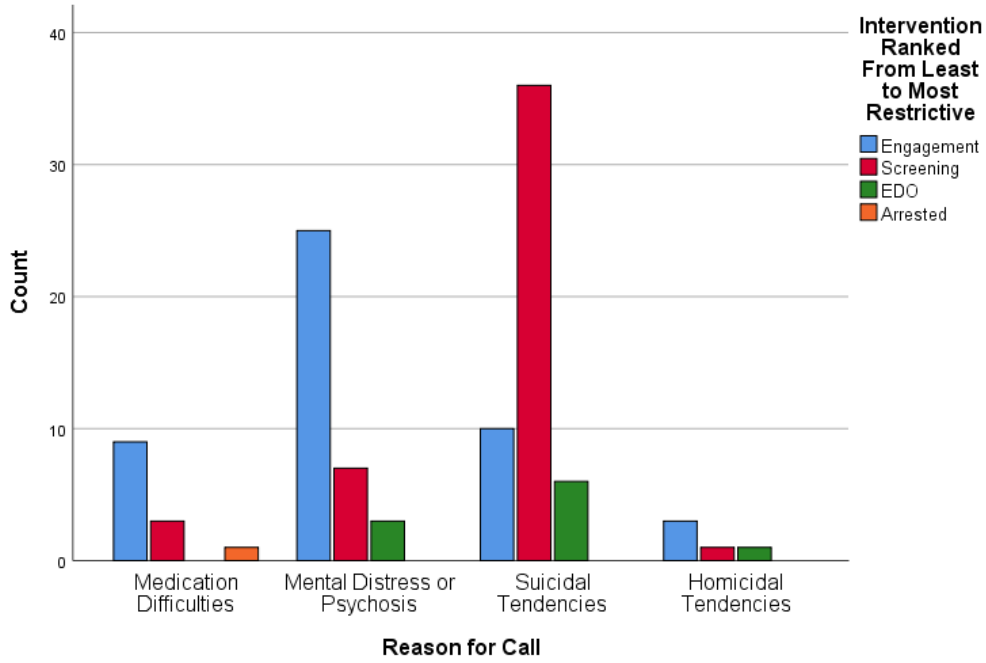

Figure 5: Intervention by Reason for Call

CHAPTER V

DISCUSSION

Various models of collaboration have been implemented into police departments and mental health authorities to aid the mental health crisis. This study examines the outcomes of individuals experiencing a mental health crisis after contact with mental health deputies. Secondary data was utilized to determine reasons why mental health deputies were called to the scene, interventions used to determine services, and outcomes of the crisis calls. In addition, secondary data also yielded results as to the number of individuals connected to additional needed services including long-term treatment programs. Four research questions were asked to determine the benefit of the mental health deputy grant program in collaboration with the local mental health authority, CFLR.

According to Table 3, the deputies provided more services in the summer months (June and July) than in other times of the year. This could be due to the extreme heat in central Texas during those months causing more irritability than in cooler months. Additional stress on the families could be another possible factor, as children need to be occupied while school is out for the summer. Another plausible explanation is that people are more active in the summer, increasing the chance for incident.

Mental health deputies assisted Brownwood Sheriff's Office (BWD SO) more than other local police departments as displayed in Figure 2. The higher assists could be

suggestive of knowledge of the deputies training and skill or because their jurisdiction covers more area.

Where Do the Clients End up after Contact with Mental Health Deputies?

Literature suggests that police officers have historically misinterpreted encounters with the mentally ill due to a lack of knowledge and training (Clayfield et al., 2010). As previously stated, mental health deputies have sufficient training as peace officers, which includes CIT. Results from the data, particularly in Table 1, shows that the highest number of outcomes were "safety plans" or contracting for safety, meaning that the individual and the mental health deputy agreed upon goals for remaining safe while staying in the community. The other encounters resulted in connection to treatment services, such as psychiatric facilities and medical clinics. Fewer encounters were connected to ongoing treatment at a CFLR such as case management and counseling services. The remaining encounters were taken to jail or to the local domestic violence shelter.

Are Clients Connected to Appropriate Services and Ongoing Treatment?

The literature argues that police officers without sufficient training will "often immediately transport the mentally ill in crisis to a hospital instead of assessing and treating them in the community" (Lee et al., 2015, p.538). The data testifies to the outcomes corresponding to the reason for the call, as seen in Figure 4. Persons with suicidal tendencies and mental distress/psychosis were the majority to safety plan. Furthermore, suicidal tendencies were categorized by severity from suicidal thoughts without a plan to an actual suicide attempt. Figure 3 displays suicidal thoughts as the majority to safety plan and persons who were suicidal with a weapon or drugs were

transported to a psychiatric facility. Findings from Table 2 show that 17 individuals were diverted from the emergency room and 30 individuals from psychiatric hospitals. In addition, Table 2 also reveals that 109 individuals were connected to long-term treatment services such as case management or clinical/therapeutic services including medication management and/or counseling. It is unknown how the mental deputies are diverted individuals from emergency room or psychiatric hospitals, but it can be concluded that mental health deputies are assessing these individuals and making decisions based on their training.

Are Clients Diverted from Contact with the Criminal Justice System?

Lord and Bjerregard (2014) discussed the ongoing issue of criminalization of the mentally ill emphasizing that "without appropriate and immediate mental health interventions, law enforcement officers might have to resort to physical restraint and arrest" (p.471). Findings reveal that only one individual out of the 365 contacts made by mental health deputies was arrested and taken to jail on account of a warrant. Mental illness and the reason for the warrant might be connected because the individual was a current client of CFLR, but no definitive link could be found. In addition, results from Table 2 show that 44 individuals were diverted from the criminal justice system as a direct result from contact with mental health deputies. It is unclear how they were diverted, but Figure 1 displays the total number of mental health deputy's assistance given to local police that could have otherwise ended in arrest. Another likely assumption to jail diversion according to Table 3, is the high utilization of engagement (de-escalation techniques).

Are Mental Health Deputies Meeting Client Needs in the Least Restrictive Method?

Mental health deputies utilized the least restrictive interventions and outcomes proportionally to the reason for call and treatment needed. Figure 5 and Table 8 reveal that individuals who had difficulties taking medications were engaged by mental health deputies, and the individuals who displayed suicidal tendencies were administered the Columbia Severity Suicide Rating Scale (C-SSRS), which is a screening to determine the risk of suicide. Figure 4 and Table 6 show the majority of individuals refusing medications or needing medication management were transported to the emergency room or to the med clinic at a CFLR. Likewise, individuals who were suicidal either contracted for safety, were transported to the respite care facility in the community, or to a psychiatric hospital depending upon severity. According to the study, the majority of clients that the mental health deputies contacted received the least restrictive interventions. The individuals receiving more restrictive outcomes such as psychiatric hospitalization originated from calls more serious in nature, such as individuals threatening suicide with a weapon or pills.

Mental Health Deputy Program

The study begs to answer the question, "Is the mental health deputy grant program working?" The mental health deputies were consistently utilizing appropriateness of intervention by placing clients in treatment services in portion to the reason for the call. Overall, the mental health deputy grant program appears to be accomplishing the intended goals for jail diversion, connection with emergent services, and connection to long-term services. The use of force was not a goal in this study; therefore, it was not analyzed. However, according to the data, the use of force was not utilized.

Implications for Policy and Practice

Implications for policy include collaboration of both law enforcement and mental health authorities to produce higher quality data. Additional tracking data is needed to measure long-term mental health treatment and criminal justice system outcomes. This data could be utilized to improve engagement, assessment, and treatment options for mentally ill offenders. This data could also inform policymakers of preventive programs for jail diversion and better conditions for incarcerated mentally ill persons. Data could aid in the design of future evidence-based models of engaging and assessing the mentally ill as well as more effective training and engagement approaches for both entities.

The literature suggested more partnerships between police and mental health systems as well as improvements in training and more specifically in crisis intervention. Implications to improve practice include sharing data between entities for the purpose of treating mentally ill persons and avoidance of gaps. Beierschmitt and Wood (2014) suggest development of data-driven approaches to areas of high crime and co-occurring disorders is needed. Continual positive collaboration between mental health authorities and law enforcement is recommended as well as additional tracking data to measure long-term outcomes in the context of the mental health deputy program. In addition, mental health authorities would benefit from collecting data from the local police departments to track arrests of mentally ill persons for future improvements. Recommendations for the mental health deputy grant program includes data tracking of race, time per contact, and if possible, linking the mental health diagnosis with client in

crisis. Depending upon grant resources, recommendations for a deputy to be on call during irregular hours would be beneficial.

Limitations

The most significant limitation to this study is the age of the mental health deputy program as it was one of the newest implemented grant programs at CFLR totaling eight months in operation since April of 2018. The grant only allocated for two mental health deputies adding to the limited number of contacts. Throughout the course of this study, significant limitations and complications were present in collecting and analyzing data.

The sample size was not a full representation of the data. Difficulties occurred gathering the data upon request of release to the researcher. A portion of the data was already aggregated from the full sample. Another portion of the data analyzed was not the full sample size. Another significant limitation was that the data does not allow for inferential data as it was already aggregated. In addition, the data did not allow for a breakdown of components for more powerful statistical tests.

CHAPTER VI

CONCLUSION

Communities have struggled for solutions to properly meet the needs of mentally ill persons since deinstitutionalization. Various models have been implemented into local police departments and mental health authorities as means of regaining control.

The mental health crisis is not the sole responsibility of one entity or another. While police officers are often found on the frontlines of the mental health crisis, it should not be their expected role. Collaboration is of utmost importance in solving the crisis. Teamwork between mental health authorities, mental health professionals, and law enforcement is of critical importance to ensure mentally ill persons are connected to treatment services while engaged with empathy and professionalism.

Connecting the mentally ill to appropriate emergent services as well as long-term treatment services is key, if possible, utilizing least restrictive measures to treat them in their own community. As this study reveals, police officers who receive appropriate training regarding mentally ill persons are able to assess the individual and connect them with appropriate services. As stated before, many factors contribute to the mental health crisis in America; however, collaboration of community mental health authorities and local law enforcement is shown to aid the crisis.

Continued efforts of collaboration in rural areas is also needed and recommended from this study as resources are limited. Sharing data between law enforcement and local

mental health authorities is also needed for future improvements and collaborative efforts.

The literature suggests that more research is needed for long-term sustainability of community-based treatments in a least restrictive manner for people with mental illness. Costs are high for state psychiatric hospitals to remain in operation and often have few openings with a long waiting list. Private psychiatric hospitals are more accessible; however, the treatment periods are short in nature.

More research is needed for collaborative models to ensure ongoing necessary improvements coincide with evidence-based practices and current community data. Although not highlighted in this study, future recommendation of culturally knowledgeable and sensitive approaches is needed in diverse communities as mental illness can be taboo in some cultures.

Future research should aim to understand perceptions of mentally ill persons when engaged by police officers and mental health professionals. Surveys and other research instruments should be utilized not only to measure treatment efficacy and client improvement but also to improve upon compassionate encounters.

Throughout the course of this study, the prevalence of teen suicide appears to be on the rise. Although the data did not reveal any significant information in regard to this population, further research is needed to determine preventative measures to ensure mental and emotional well-being for teens.

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APPENDIX A

Institutional Review Board Approval

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

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325-674-2885

Dear Melissa,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled

(IRB# 16-086)is exempt from review under Federal Policy for the Protection of Human Subjects as:
☐ Non-research, and
☑ Non-human research
Based on:

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs