Local Law Enforcement within a Collapsing Mental Health System: A Qualitative Analysis on Crisis Intervention Team Programs in Virginia

by

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Abstract

The Crisis Intervention Team (CIT) model is a globally recognized and implemented jail diversion program that improves local law enforcement response to individuals with mental illness or substance use disorder (MISUD). Despite the decentralized nature of the model, several states have implemented statewide CIT programs. Virginia was the first state to mandate every locality to participate in a CIT program through state law. This study examines the mechanisms, characteristics, and effects of CIT programs on law enforcement using interview data from local law enforcement officers (n = 24) and CIT Coordinators (n = 3) throughout the Commonwealth. The results suggest that officers strongly endorse the application and benefits thereof despite CIT's practical limitations, such as substantial resource and staffing shortages and inefficient policy constraints. Officers welcome this evolution of law enforcement as CIT programs normalize the use of de-escalation and communication during encounters involving people with MISUD. Officers find that severe shortages in behavioral health services resulting from chronic disinvestment cannot be resolved or managed using CIT alone. Dramatically expanding Virginia's behavioral health systems and establishing mental health providers as the primary first responders for behavioral health crises will reduce the growing demand and strain on law enforcement. The policy implications of these findings are discussed in relation to enhancing public safety and health outcomes.

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Chapter 1: Introduction

"It's not illegal to be crazy" is a crude but common reminder today in local law enforcement agencies (LEA).[1] Law enforcement officers (LEO) are the primary responders for crises involving mental health and substance use issues. Their actions determine whether someone with mental illness[2] or substance use disorder (MISUD) are directed to behavioral health services or the criminal justice system. Police discretion is further complicated when enforcing criminal policies that may inadvertently target MISUDs, such as the possession, use, or distribution of substances or dysfunctional or impaired social behaviors. For example, public intoxication is a misdemeanor in Virginia.[3] Despite complicated overlap between signs of MISUD and criminal policy, LEOs historically receive minimal behavioral health training and are subject to widespread stigma surrounding behavioral health conditions. They are traditionally trained to interpret behaviors and signs associated with MISUD as criminal, threatening, deceptive, or non-compliant.[4] The rates of arrest and incarceration for people with MISUD multiplied after punitive drug and crime policies were implemented and strictly enforced.

The capacity and authority of local law enforcement agencies expanded while behavioral health services shrank, and law enforcement inadvertently became the de facto first responders for behavioral health crises.[5] During the War on Crime and War on Drugs, federal and state

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[1] Repeated quote from CIT Training Instructors during live CIT Training in Virginia in November 2021

[2] Mental illness refers to mental health conditions and disorders as identified and defined by the Diagnostic and Statistical Manual of Mental Disorders IV and V (DSM-4, DSM-5). It includes any mental illness (AMI) and serious mental illness (SMI) as defined by the National Institute of Mental Health.

[3] Va. Code Ann. § 18.2-388

[4] Markowitz, F. E. (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behavior, 16*(1), p. 36-44, https://doi.org/10.1016/j.avb.2010.10.003

[5] Grob, G. N. (1991). From Asylum to Community. Princeton University Press. https://doi.org/10.1515/9781400862306; Kelly, T. A. (2009). *Healing the Broken Mind: Transforming America's Failed Mental Health System* (New York: New York University Press); Markowitz, 2011; Erickson, B. (2021). Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. *American Journal of Psychiatry Residents' Journal, 16*(4), 6-7. https://doi.org/10.1176/appi.ajp-rj.2021.160404

governments invested heavily into police officer recruitment and crime control initiatives, and they broadened law enforcements' authority through the implementation of strict criminal legislation. Meanwhile, federal and state governments cut funding to state psychiatric facilities to eliminate patients abuse and negligence.[6] Approximately 95 percent of state psychiatric hospitals across the nation shut down, yet policymakers did not properly fund the development of alternative community-based treatment and support services.[7]

Due to the nature of law enforcement, LEOs routinely get involved in situations involving MISUD by the time people are already experiencing severe levels of dysfunction and psychological distress.[8] Symptom management, recovery, and remission for MISUD requires equitable access to comprehensive health care services, supportive communities, and secure housing options.[9] Without proper treatment and support, symptoms worsen in severity, and remission becomes more challenging to reach. As the consequences resulting from inappropriate health care services over the past six decades accumulate, LEOs more frequently encounter people with MISUD.[10] This increase has contributed to the overrepresentation of MISUD among jail populations and disproportionately high rates of arrest, injury, use of force, and deaths of people with MISUD during officer encounters.[11]

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[6] Erickson, "Deinstitutionalization Through Optimism"
[7] Fisher, W. H., Geller, J. L., & Pandiani, J. A. (2009). The Changing Role Of The State Psychiatric Hospital. *Health Affairs, 28*(3). https://wr.perma-archives.org/public/z3ss-zka7/20190926211206mp_/https://doi.org/10.1377/hlthaff.28.3.676; Fuller, D. A., Sinclair, E., Geller, J., Quanbeck, C., Snook, J. (2016). Going, going, gone: Trends and consequences of eliminating state psychiatric beds, 2016. Arlington, VA: Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/going-going-gone
[8] Markowitz, 2011; Kelly, 2009; Fuller, D. A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). Overlooked in the Undercounted: The The Role of Mental Illness in Fatal Law Enforcement Encounters. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf
[9] Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). SAMHSA's Working Definition of Recovery. https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf
[10] Fuller et al., "Overlooked in the Undercounted"
[11] Markowitz, 2011; Saleh, A. Z., Appelbaum, P. S., Liu, X., Stroup, T. S., & Wall, M. (2018). Deaths of people with mental illness during interactions with law enforcement. *International journal of law and psychiatry, 58*, 110–116. https://doi.org/10.1016/j.ijlp.2018.03.003; Rohrer, A. J. (2021). Law Enforcement and Persons with Mental

Traditional policing methods tend to rely on physical coercion and paramilitary tactics to ensure compliance. Force techniques may include the use of a physical strike, baton, pepper spray, taser, or firearm.[12] The "Ask, Tell, Make" model was originally designed for situations that demanded immediate physical action or intervention to quickly control a situation; however, it became an unofficial standard policing procedure.[13] Even when only minor crimes and misdemeanors have occurred, LEOs are more likely to use arrest and coercive force using this method.[14] The "Ask, Tell, Make" procedure generally adheres to the following steps:

1. An officer asks the person to do something.
2. If the person does not voluntary comply with the officer's request, the officer instructs them to do it.
3. If the person does not comply with the officer's command, the officer forces the person to comply by applying physical strength and placing the individual under arrest.

Local police departments and sheriff's offices experienced substantial financial, psychological, and physical costs after consistently applying traditional policing practices to situations involving MISUD. LEOs escalating involvement with MISUD inspired the

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Illness: Responding Responsibly. *Journal of Police and Criminal Psychology, 36*, 342-349. https://doi.org/10.1007/s11896-021-09441-2; Hassell, Kimberly D. "The Impact of Crisis Intervention Team Training for Police." *International Journal of Police Science & Management 22*, no. 2 (June 2020): 159–70. https://doi.org/10.1177/1461355720909404

[12] Rohrer, A. J. (2021). Law Enforcement and Persons with Mental Illness: Responding Responsibly. Journal of Police and Criminal Psychology, 36(2), 342–349. https://doi.org/10.1007/s11896-021-09441-2

[13] Albrecht, Steve. (2018). Two Tools for Field Communications. POLICE Magazine. https://www.policemag.com/486674/two-tools-for-field-communications?page=2; Doyle, Mike. (2018). ASK, TELL, MAKE: STILL WORKS. Tactical Transients. https://www.tacticaltangents.com/bulletin/asktellmake/; Willis, Brian. (2016). Rethinking Ask, Tell, Make. Winning Mind Training. https://winningmindtraining.com/rethinking-ask-tell-make/; Wolfe, Dune. (2019). The 'Ask, Tell, Make' mistake. Police1. https://www.police1.com/police-training/articles/the-ask-tell-make-mistake-fz633oUFKu8G82nO/;

[14] Markowitz, 2011; Franz, S. & Borum, R. (2010) Crisis Intervention Teams may prevent arrests of people with mental illnesses. *Police Practice and Research, 12*(3), 265-272. http://dx.doi.org/10.1080/15614263.2010.497664

development and promotion of police-based jail diversion programs. One prominent such solution has been the Crisis Intervention Team (CIT) model developed in 1988 from Memphis, Tennessee. The CIT model emerged as the most prominent jail diversion[15] and crisis intervention framework across the world and a "best practice" model for law enforcement.[16] The aim of CIT is to promote public safety and health by reducing the rates of arrest, civilian and officer injuries, and fatalities among individuals with MISUD and connecting more people to community-based treatment options.[17]

The program model incorporates a 40-hour, week-long intensive training for LEOs. The CIT training equips LEOs with the skills, knowledge, and options to appropriately de-escalate and connect individuals with MISUD to community services. By deconstructing officers' stigmatized perceptions of MISUD, LEOs are more likely to recognize signs of MISUD and implement de-escalation and diversion options instead of following traditional decision-making procedures, such as "Ask, Tell, Make."[18]

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[15] In previous literature, CIT has also been categorized as an intervention pathway, intervention deflection, pre-arrest diversion, pre-booking diversion, and law enforcement diversion. CIT seems to primarily target people with mental illness or mental health issues; however, it varies by program. Previous studies have indicated the CIT programs they studies investigate outcomes on people with behavioral health needs, mentally ill person, person with mental illness, person with mental health or substance use issues, mental health consumers, behavioral health consumers, and other variations.

[16] CIT International. (n.d.). What is CIT. https://www.citinternational.org/What-is-CIT; Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf; Rohrer, 2021.

[17] Hassell, "The Impact of Crisis Intervention Team Training for Police;" Rohrer, A. J. (2021). Law Enforcement and Persons with Mental Illness: Responding Responsibly. Journal of Police and Criminal Psychology, 36(2), 342–349. https://doi.org/10.1007/s11896-021-09441-2; Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, D. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services, 65*(4), 523-529. https://doi.org/10.1176/appi.ps.201300108; Saleh et al., 2018

[18] Hassell, "The Impact of Crisis Intervention Team Training for Police"

As the prevalence of MISUD and incarceration rates in Virginia worsened, a small group of LEOs and mental health providers traveled to Memphis, TN to complete the CIT training and develop Virginia's first CIT programs through their affiliated LEAs. In 2009, the Virginia General Assembly officially instituted the CIT model by mandating all localities to develop or join a CIT program.[19] The Virginia Department of Behavioral Health and Developmental Services (DBHDS) continues to support Community Service Boards (CSB) and LEAs in developing and administering local and regional CIT programs. CSBs offer community-based behavioral health services, included comprehensive crisis services, and they coordinate with and oversee their assigned CIT program. As of 2022, the DBHDS reported 38 operational local and regional CIT programs in Virginia with 95% coverage of state residents.[20] They form the Virginia CIT Coalition, a statewide decentralized network of CIT programs. While DBHDS advises LEAs to train at least 25% of their patrol force, medium- and large-sized agencies with sufficient financial and staffing resources aim to train their entire force, including their dispatchers and emergency first-responders.[21]

LEOs and policymakers in Virginia recognized the Memphis CIT framework as successful and effective for improving safety and diversion outcomes, but the lack of statewide data measurements prevents reliable, valid data collection and analysis. To measure the effects of CIT programs over time and among programs throughout the state, standard definitions measuring program characteristics (i.e., descriptive data) and specific outcome variables (e.g., arrest and diversion rates) are needed to conduct comparable assessments on CIT outcomes. Currently, programs independently select, define, and collect their measurements, so comparing

[19] Schein, C., Davis, S., Craver, S., & Hall, A. (2021). Virginia's CIT Assessment Sites: FY2020 Annual Report. Virginia Department of Behavioral Health & Developmental Services.
[20] Schein et al., "Virginia's CIT Assessment Sites: FY2020 Annual Report"
[21] Ibid

data between programs is difficult. This indicates that assessments tend to reflect localized findings for their program, and their results cannot be generalized to CIT programs on the state or policy level.[22]

Statement of Purpose

The purpose of this study is to investigate how CIT programs in Virginia have transformed local law enforcement response. CIT is a community-oriented, police-based jail diversion program that aims to use law enforcement as an interception point to connect citizens to proper health services as an alternative to arrest. Since the model emerged in 1980s, law enforcement, mental health care providers, and policymakers all over the world have praised its success in promoting a more appropriate mental health response. CIT focuses on police discretion as the key point in determining mental health and diversion outcomes, so the mechanisms and effects of CIT must be understood to measure its success and impact on law enforcement.

Quantitative and quantitative data collection and evaluation are essential for program implementation and improvement. However, data collection is challenging for local and regional CIT programs because each CIT program is designed according to the distinct characteristics of each agency and the communities they serve. Their decentralized, community-oriented nature inhibits the creation of standard definitions and procedures for data collection and analysis. Without standardized performance metrics and data collection practices, statewide analysis cannot be conducted to accurately estimate CIT's overall impact on law enforcement.

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[22] Virginia Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Criminal Justice Services, Virginia CIT Coalition Leadersihp Committee, and Virginia CIT Stakeholders. (2011). Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs (CIT). DBHDS. https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/dcjs/essential-elements-commonwealth-virginias-crisis-intervention-team-programs-cit.pdf

In this study, semi-structured interviews are conducted with local sworn LEOs in Virginia, one of the only states where every locality is required to develop or join a CIT program, to discuss law enforcement and crisis response before and after CIT programs were implemented. Interview data is used to identify CIT's mechanisms, advantages, disadvantages, and ecological impact on law enforcement (i.e., officer, agency, community, and policy levels). If CIT programs train officers to recognize and divert individuals with MISUD, their experiences expressed in interviews will reflect changes in law enforcement practices and characteristics that are more likely to promote diversion.

Previous studies that measure the impact of CIT on law enforcement tend to focus on officer-level outcomes, and their participant samples typically represent large, urban police departments. There is limited research that explores the impact of CIT beyond officer-level outcomes. Since Virginia is one of the few states to mandate the creation of CIT programs, previous studies also do not normally investigate CIT programs developed by state law or compare the characteristics of CIT programs. This study collects qualitative data representing various LEOs and LEAs across the state to provide an overarching and nuanced understanding of CIT programs and their distinct characteristics. A theorical framework will identify and map key factors and mechanisms that contribute to favorable outcomes or evolution of policing within and beyond the individual level. Findings and recommendations regarding Virginia's CIT programs and policies are then offered.

Chapter 2: Literature Review

Individual, organizational, cultural, and institutional factors each influence how officer and agency respond to situations involving individuals with mental health and substance use issues. The main purpose of this literature review is to explain the historical, social, and policy

context that initiated and shaped the development of CIT and explain key concepts for how CIT impacts law enforcement. After describing how police became involved in mental health matters, I summarize theories of policing and a mental health diversion model to explain the mechanisms influencing police discretion in the CIT model. By training officers to accurately recognize signs of MISUD, de-escalate, communicate, and refer to community resources, CIT should enable officers to make more informed, appropriate decisions. They are less likely to see MISUD signs as threatening or suspicious, so they are less likely to arrest individuals with MISUD and choose to use alternatives to arrest. This review will close with an in-depth look at research on CIT programs and law enforcement in Virginia.

National Crime and Mental Health Policy

Federal crime legislation significantly expanded and shifted local police response across the nation in 1965 to enforce law and order more strictly. At the same time, the federal government cut all funding to psychiatric facilities with the intention of replacing them with community-based mental health services. In consequence, thousands of state asylums closed, and people under their care were abandoned on the streets without any professional or family support. The deinstitutionalization movement accompanied the massive surge in arrests as police became the de facto response for mental illness and substance use disorder.[23]

Deinstitutionalization Movement

In the mid-twentieth century, the federal government was the primary contributor to mental health programming. The federal government established the National Institute on Mental Health (NIMH) in 1946 to establish a national mental health care program (See Table 2.1).

[23] Markowitz, 2011; Patch, P. C. & Arrigo, B. A. (1999). Police Officer Attitudes and Use of Discretion in Situations Involving the Mentally Ill: The Need to Narrow the Focus. *International Journal of Law and Psychiatry, 22*(1), 23–35. https://doi.org/10.1016/S0160-2527(98)00014-4

NIMH received limited executive and financial power. In 1948, Congress allocated the $4.5 million to the NIHM to cover total operating costs, research grants, state aid, and training grants. By 1962, funding increased to $106 million[24] although NIMH was not authorized to provide, pay, or regulate mental health services. State and local governments were responsible for providing and paying for mental health services. A major constraint on such programs was a severe shortage of mental health professionals (psychiatrists in particular) across the nation from the 1940s to 1960s.[25]

[24] Weiss, J. A. (1990). Ideas and Inducements in Mental Health Policy. Journal of Policy Analysis and Management, 9(2), 178–200. https://doi.org/10.2307/3325411
[25] Weiss, 1990; Grob, 1991

Table 2.1 *Key Mental Health care and Deinstitutionalization Legislation*

Legislation Title	Enacted	Scope
National Mental Health Act (P.L. 79-487)	1946	Surgeon General was authorized to research the causes, diagnosis, and treatment of mental illnesses. NIMH was created. (Total of $2.5 million in 1945; ($4.5 million in 1948; $106 million in 1962).[26]
Mental Health Study Act (P.L. 84-182)	1955	Joint Commission on Mental Illness and Health published the *Action for Mental Health,* a report on human and economic programs of mental health.[27]
Mental Retardation Facilities and Community Mental Health Construction Act (CMHA)	1963	NIMH grants authorized $150 million to construct community mental health centers (CMHC) to decrease institutionalization. [28]
CMHA Amendment (P.L. 92-211)	1970	Grant funds authorized for the construction and staffing of centers for 3 more years, with priority on poverty areas.
CMHC Extension Act (P.L. 95-622)	1978	CMHA revised and extended. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research is established.

[26] Weiss, J. A. (1990). Ideas and Inducements in Mental Health Policy. *Journal of Policy Analysis and Management, 9*(2), 178–200. https://doi.org/10.2307/3325411
[27] NIMH. (n.d.). NIMH: Important Events in History. NIHM. https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh#:~:text=1949%E2%80%94On%20April%2015%2C%20NIMH,Institutes%20of%20Health%20(NIH).
[28] Weiss, 1990, p. 181-182; Blake Erickson. Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. 2021. *American Journal of Psychiatry Residents' Journal 2021 16*:4, 6-7. https://doi.org/10.1176/appi.ajp-rj.2021.160404

PHS Act (P.L. 99-550)	1991	Congress passes requirement that each states develop a Comprehensive Mental Health Services Plan.
Americans with Disabilities Act (ADA)	1990	Equal opportunity for employment, public services and accommodations, commercial facilities, transportation, and telecommunications is required for citizens with disabilities (includes mental illness and addiction). [29]
Garrett Lee Smith Memorial Act (PDF)	2004	For the first time, funding is specifically appropriated for youth suicide prevention programs.
Mental Health Parity and Addiction Equity Act (PDF)	2008	Insurance groups are required to offer coverage benefits for mental health or substance use disorders coverage that are no more restrictive that requirements or benefits offered for other medical care.
Comprehensive Addiction and Recovery Act (CARA)	2016	Congress is required to authorize $181 million annually for opioid abuse epidemic response by increasing initiatives for research, public education, treatment, and intervention programs.
21st Century Cures Act	2016	The Assistant Secretary for Mental Health and Substance Use role and Chief Medical Officer role, and Center for Behavioral Health Statistics and Quality (CBHSQ) are codified. Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) was created to promote health care coordination. National Mental Health and Substance Use Policy Laboratory

[29] Weiss, 1990, p. 181-182; Blake Erickson. Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. 2021. *American Journal of Psychiatry Residents' Journal 2021 16*:4, 6-7. https://doi.org/10.1176/appi.ajp-rj.2021.160404

		(Policy Lab) was created to promote evidence-based practices and service delivery models for serious mental illnesses and substance use disorder.[30]
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act	2018	Programs are established for first responders and recovery housing to enhance best practices. The Comprehensive Opioid Recovery Centers grant program was established to develop and maintain comprehensive opioid recovery centers that will provide individuals with opioid use disorder (OUD) holistic care, including all FDA-approved MAT, counseling, recovery housing, job training, and more.[31]

[30] Substance Abuse and Mental Health Services (SAMHSA). (n.d.). Laws and Regulations: Federal Laws Related to SAMHSA. https://www.samhsa.gov/about-us/who-we-are/laws-regulations
[31] SAMHSA, n.d.

Deinstitutionalization began in the 1960s when abhorrent conditions and treatment of mentally ill patients shocked the nation. The Joint Commission on Mental Illness and Health released the "Action for Mental Health" report in 1961. They listed several goals. First, they planned to publish the first comprehensive report on the state of mental health services in the United States. Second, they wanted to develop a financially accessible national program that would meet minimum standards of care for people with mental illnesses. The report revealed shocking inadequacies in national mental health services and provided policy recommendations for both state mental hospitals and community mental health care.[32]

While the employment numbers and amount of funding in local law enforcement began to grow, the federal and state governments cut most of the funding to state psychiatric hospitals in 1963 (See Table 2.1). Mental hospitals were notorious for appalling living conditions and medical care. State mental health hospitals lost nearly half-a-million beds from 1955 to 2000.[33] When adjusting for U.S. population growth during the same time period, the number of state hospital psychiatric beds decreased from 339 beds per 100,000 individuals to 22 beds per 100,000 individuals.[34] The Community Mental Health Act (CMHA) of 1963 aimed to completely reform the mental health care system and liberate institutionalized patients.[35] Deinstitutionalization was designed to eliminate long-term care, state-run, residential psychiatric facilities and expand community mental health centers. The new centers were supposed to treat those who were receiving care from the state hospitals.[36] The federal government invested $150

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[32] Brody, S. J. (1961). ACTION FOR MENTAL HEALTH. Final Report of the Joint Commission on Mental Illness and Health.
[33] Lamb, H. R., & Weinberger, L. E. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry and the Law, 33*(4), 529–534.
[34] Kelly, *Healing the Broken Mind*; Lamb & Weinberger, "Shift of psychiatric inpatient care;" Erickson, B. (2021). Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. *American Journal of Psychiatry Residents' Journal, 16*(4), 6-7. https://doi.org/10.1176/appi.ajp-rj.2021.160404
[35] Kelly, *Healing the Broken Mind*; Erickson, "Deinstitutionalization Through Optimism"
[36] Erickson, "Deinstitutionalization Through Optimism"

million in federal grant aid over the course of 3 years to develop and staff 1,500 community-based services.

Regardless of optimistic intentions to strengthen community mental health care, states constructed approximately half of the new centers, and these facilities did not accept patients requiring long-term, intensive care.[37] Instead, they disproportionately treated people with less severe conditions with no prior involvement with psychiatric hospitals.[38] Although the government intended to provide sustained care to previously hospitalized individuals, the decentralized nature of community mental health centers made them difficult to assess and regulate.[39] Without support from loved ones, formerly hospitalized individuals with the most severe, debilitating conditions commonly entered the "institutional circuit of acute care hospitals, jails, prisons, and forensic facilities" due to the limited availability of psychiatric beds, lack of access to community mental health services, and increased contact with law enforcement.[40]

Community services limited access and delivery of mental health services for the most severe and difficult cases. Despite all the problems, psychiatric hospitals still provided food, housing, health care, transportation, and other types of support. Any treatment is better than no treatment. As asylums were not properly replaced, the number of people who needed treatment drastically grew.[41] This also increased rates of mental illness and substance use disorder among the growing population of those without housing. Furthermore, most mental health consumers

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[37] Kelly, *Healing the Broken Mind*; Erickson, "Deinstitutionalization Through Optimism;" Grob, 1991.
[38] Erickson, "Deinstitutionalization Through Optimism"
[39] Kelly, *Healing the Broken Mind*; Erickson, "Deinstitutionalization Through Optimism"
[40] Erickson, "Deinstitutionalization Through Optimism;" Lamb & Weinberger, "Shift of psychiatric inpatient care"
[41] Erickson, "Deinstitutionalization Through Optimism;" Patch, P. C. & Arrigo, B. A. (1999). Police Officer Attitudes and Use of Discretion in Situations Involving the Mentally Ill: The Need to Narrow the Focus. *International Journal of Law and Psychiatry, 22*(1), p. 23-35. https://doi.org/10.1016/S0160-2527(98)00014-4

receiving treatment from state hospitals did not qualify for Medicaid or Medicare after hospitals were shut down.[42]

Expansion of Local Law Enforcement

Local law enforcement agencies across the nation experienced drastic growth in size and power during the War on Crime and Poverty and War on Drugs. National and state policies proposed to end poverty, violent crime, and addiction by enlarging the authority, workforce, infrastructure, and resources of law enforcement. Police would launch an "all-out attack on crime" and poverty in the "slums of cities."[43] The militant principles aiming to eliminate "enemies" of society paradoxically creates and exacerbate the conditions (e.g., economic stability, primary health care access and quality, prevention services, substance use treatment and recovery services, social and community support) causing them to initially occur.[44] The beliefs and policies of the War on Crime and Poverty and War on Drugs are still imbedded in present-day health care and law enforcement systems.

The federal government authorized massive investments to state and local law enforcement expansion and controversial policing procedures, such as "no-knock" search and seizures.[45] For example, Congress approved appropriations of more than $4 billion dollars

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[42] Erickson, 2021

[43] "Further Steps Taken on Anticrime Legislation." In CQ Almanac 1966, 22nd ed., 567-70. Washington, DC: Congressional Quarterly, 1967. http://library.cqpress.com/cqalmanac/cqal66-1302054.

[44] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 11 May 2022 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

[45] "No Knock" Search and Seizure and the District of Columbia Crime Act: A Constitutional Analysis. (1971). The *Journal of Criminal Law, Criminology, and Police Science, 62*(3), 350–362. https://doi.org/10.2307/1142174; Alfonseca, Kiara. (2022). What to know about no-knock warrants, following Amir Locke's fatal shooting. ABC News. https://abcnews.go.com/US/knock-warrants-amir-lockes-fatal-shooting/story?id=82725760 (As of February 2022, Florida, Oregon, and Virginia prohibit no-knock entries, and more than 34 states restrict its use); Office of Public Affairs. (2021, September 14). Department of Justice Announces Department-Wide Policy on Chokeholds and 'No-Knock' Entries. [Press Release]. Department of Justice. https://www.justice.gov/opa/pr/department-justice-announces-department-wide-policy-chokeholds-and-no-knock-entries (After the global protests against police brutality in 2020, the U.S. Department of Justice limited the use of "no knock" entries in September 2021.)

towards local law enforcement to enhance their crime control and prevention efforts from 1968 to 1970.[46] The government also enacted harsh drug and crime legislation and funded crime control efforts while reducing access to behavioral health treatment and recovery services. These policies created a vicious cycle that prohibits, worsens, and punishes individuals exhibiting criminal behaviors caused by their MISUD. This cycle perpetuates the conditions producing health disparities and inequities.

These policies aimed to end poverty, drug addiction, and violent crime by strengthening law enforcement (See Table 2.2). Since poverty, substance use disorder, and crime are intrinsically interconnected with social and health factors, crime control and prevention efforts have shape national, state, and local health care systems. Alarmingly, most of these policies are not informed or supported by scientific research. To illustrate, President Richard Nixon appointed the National Commission on Marihuana and Drug Abuse to evaluate the total impact of cannabis use. In 1972, the Commission found, "Marihuana's relative potential for harm to the vast majority of individual users and its actual impact on society does not justify a social policy designed to seek out and firmly punish those who use it." They strongly recommended the decriminalization of cannabis.[47]

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[46] Law Enforcement Assistance Act of 1965 -- Hearings Before a Subcommittee of the Senate Committee on the Judiciary, 89th Congress, 1st Session, 1965

[47] *Marihuana, A Signal of Misunderstanding: First Report of the National Commission on Marihuana and Drug Abuse.* Chapter 5: Marihuana and Social Policy. Washington, DC: National Commission on Marihuana and Drug Abuse, 1972. https://www.druglibrary.org/schaffer/library/studies/nc/ncrec1_6.htm

Table 2.2 *Major Crime Legislation in the United States*

Legislation Title	Enacted	Scope
Law Enforcement Assistance Act	1965	
Omnibus Crime Control and Safe Streets Act	1968	Law Enforcement Assistance Administration (LEAA) was created to direct federal funding in advancing state and local law enforcement. ($59.4 million in FY1969, $268 million in FY1970). LEAA distributed most of federal aid to state and local police.
Omnibus Crime Control and Safe Streets Act	1970	More federal aid was reauthorized to state and local law enforcement agencies ($3.55 billion from 1971 to 1973). New correctional grants required spending on law enforcement programs give a minimum of 20% to corrections. Federal aid coverage increased from 60% to 75% of program costs.
Comprehensive Drug Abuse Prevention and Control Act	1970	Federal drug laws and penalties for violations were revised. Federal support increased for drug abuse rehabilitation, treatment, and education as secondary prevention measures. "No-knock" search warrants were authorized.[48]
District of Columbia Court Reorganization and Criminal Procedure Act	1970	Controversial law enforcement measures (preventive detention before trial, "no-knock" search warrants) were authorized.[49]
Organized Crime Control Act	1970	Organized crime and standardized procedural rules for witnesses were combated.

[48] "Four Major Crime Bills Cleared 91st Congress." In CQ Almanac 1970, 26th ed., 05-125-05-126. Washington, DC: Congressional Quarterly, 1971. http://library.cqpress.com/cqalmanac/cqal70-1292693. No-knock search warrants permit law enforcement officers to enter and search without notice a place if there is probable cause to believe that the property sought—usually drugs or drug apparatus—would be destroyed or someone's life endangered if notice were given before entry

[49] "Four Major Crime Bills Cleared 91st Congress." In CQ Almanac 1970, 26th ed., 05-125-05-126. Washington, DC: Congressional Quarterly, 1971. http://library.cqpress.com/cqalmanac/cqal70-1292693.

Violent Crime Control and Law Enforcement Act	1994	Federal funding authorized to create 100,000 new state and local police officers, $9.7 billion for prisons, and $6.1 billion for prevention programs (from 1994-2000). The “three strikes” policy were enacted. COPs Program was created ($8.8 billion was authorized from 1995 to 2000). Additional grants programs (Byrne Grants, Crime Prevention Block Grants, Model Intensive Grants, Rural Law Enforcement) were created for local law enforcement crime control and prevention programs.

Nixon did not act on their recommendations. Instead, Nixon increased federal funds for drug-control agencies and proposed more severe, punitive policies to handle drug crimes.[50] Congress enacted mandatory prison sentences on drug-related criminal charges and restricted the discretion of criminal courts and judges.[51]

After Nixon resigned, many states decriminalized cannabis possession and expanded prevention and treatment service providers for cannabis use disorder. This brief period of decriminalization ended upon the arrival of the Reagan administration.[52] President Ronald Reagan rejuvenated the War on Drugs and reenacted the severe penalties from the Nixon era. The accumulation of local law enforcement expansion, stricter criminal policies, and federal mandatory sentencing requirements increased the arrest and incarceration rates for nonviolent drug-related crimes to unprecedented heights.[53]

The next two presidents continued the escalation of the War on Drugs. President George H. W. Bush increased the federal drug control budget from $5 billion in 1989 to over $12 billion in 1993. He wanted to end drug crime from a "strategy of punishment, deterrence and intolerance."[54] The Clinton administration adopted a similar strategy and created the Community-Oriented Policing Services (COPS) program in 1994. Congress authorized appropriations for $1.4 billion each year from 1995 to 1999 toward police recruitment initiatives

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[50] "Four Major Crime Bills Cleared 91st Congress." In CQ Almanac 1970, 26th ed., 05-125-05-126. Washington, DC: Congressional Quarterly, 1971. http://library.cqpress.com/cqalmanac/cqal70-1292693.
[51] "Four Major Crime Bills Cleared 91st Congress." In CQ Almanac 1970, 26th ed., 05-125-05-126. Washington, DC: Congressional Quarterly, 1971. http://library.cqpress.com/cqalmanac/cqal70-1292693.
[52] Clark, C. D., & Dufton, E. (2015). Peter Bourne's drug policy and the perils of a public health ethic, 1976-1978. American journal of public health, 105(2), 283–292. https://doi.org/10.2105/AJPH.2014.302233
[53] Rohrer, 2021; Saleh et al., 2018; Patch & Arrigo, 1999; Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, D. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services, 65*(4), 523-529. https://doi.org/10.1176/appi.ps.201300108
[54] Pembleton, Matthew R. *George H.W. Bush's biggest failure? The war on drugs.* 2018. Washington Post. https://www.washingtonpost.com/outlook/2018/12/06/george-hw-bushs-biggest-failure-war-drugs/

and state and local crime control and prevention programs.[55] These trends continued into the opening decades of the Twentieth century and, consequently, state and local governments nearly tripled their spending on local law enforcement from $44 billion in 1977 to $123 billion by 2019.[56]

After June 2020, federal and state governments enacted and funded law enforcement reform initiatives in response to global protests advocating to end police brutality, specifically brutality disproportionately targeting Black people in the United States.[57] In 2021, federal grant programs authorized funding toward state and local police reform for the first time. Reform initiatives included de-escalation training, mental health response, accreditation, and anti-bias and diversity training.[58] In this context, CIT programs offer the kind of alternatives to arrest that may help meet the new calls for decriminalization and law enforcement reform.

Filling the Mental Health Service Gap with Law Enforcement Response

The consequence of severe supply shortages in the mental health field drastically increased rates of homelessness, poverty, and crime-affiliated behavior among people with untreated, severe mental health and substance use issues. There were limited, if any, safety nets for untreated mental health needs. In other words, the lack of infrastructure for health and social services worsened mental health crises. Local law enforcement, which was increasingly well-funded by the federal and state governments, were the last ones available with the capacity to

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[55] U.S. Department of Justice. Violent Crime Control and Law Enforcement Act of 1994. Fact Sheet. https://www.ncjrs.gov/txtfiles/billfs.txt

[56] Airi, N., Dadayan, L., & Rueben, K. (2022). State and Local Finance Data: Exploring the Census of Governments [Source: US Census Bureau Annual Survey of State and Local Government Finances, 1977-2019]. Urban Institute. https://state-local-finance-data.taxpolicycenter.org.

[57] Cobbina-Dungy, Chaudhuri, S., LaCourse, A., & DeJong, C. (2022). "Defund the police:" Perceptions among protesters in the 2020 March on Washington. Criminology & Public Policy, 21(1), 147–174. https://doi.org/10.1111/1745-9133.12571

[58] CRS. Community Oriented Policing Services (COPS) Program. 5 February 2021. https://crsreports.congress.gov/product/pdf/IF/IF10922

respond to people who ended up on the street or those experiencing a mental health crisis. However, widespread stigma surrounding MISUD, traditional policing models, and the stress of policing meant that LEOs were more likely to arrest and physically confront individuals who exhibited signs of MISUD. The criminalization hypothesis and policing theories relating to perception and behavior around MISUD is discussed below.

Criminalization of Mental Illness (1970s to 1990s).

The deinstitutionalization of psychiatric hospitals and criminalization of stigmatized health issues tasked law enforcement with the responsibility of responding to individual health crises. People who needed mental health and rehabilitation services became more vulnerable in interactions with police, and LEOs were forced to handle situations involving individuals experiencing severe symptoms of mental illness and SUD. The insufficient number of outpatient treatment providers and reduced state hospitals lead to homelessness, lack of treatment, and increased arrest rates for minor, nonviolent crimes. Arrest rates increased due to stigma surrounding mental illness and SUD. They also increased because officers had no other option. Their jobs require them to keep order and enforce the law, and some symptoms and signs can be interpreted falsely as criminal or suspicious behavior without the proper mental health training.

The criminalization of mental illness refers to the criminal policies that unintentionally associate signs of mental illness and SUD as criminal or suspicious behavior. It comes from the negative stigma that associated mental illness with hostility, aggression, and violence. The funneling of people with mental illness into the criminal justice system is referred to as the "patient-to-prisoner" pipeline.[59]

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[59] Onah, M. E. (2018). The Patient-to-Prisoner Pipeline: The IMD Exclusion's Adverse Impact on Mass Incarceration in United States. American Journal of Law & Medicine, 44(1), 119–144. https://doi.org/10.1177/0098858818763818

The *criminalization hypothesis* proposes that police inappropriately and disproportionately use arrest to resolve encounters with people with MISUD; however, there is mixed research on whether it is supported. LEOs may unintentionally escalate encounters involving people with MISUD depending on officer-level awareness and perception of MISUD.[60] They use their discretion to determine when they connect an individual to mental health services or the criminal justice system, and each response will be contingent on the officers involved and situational context.[61] If an officer perceives behaviors caused by MISIUD as threatening, non-compliant, suspicious, or dangerous, the officer's perception changes the context of the situation and will increase the likelihood of using arrest or force.

Today, because in large part of deinstitutionalization, law enforcement are the de facto responders to mental health and substance use crises Historically, LEOs were limited to one primary type of response: arrest. Symptoms particularly associated with psychotic disorders were associated with suspicious and threating behaviors. The culmination of social stigma, criminalization of MSUD, defunding of social services, and health care inaccessibility gave legal, social, and political justification to arrest mentally ill individuals, especially those who do not have professional or family support. However, individuals with mental health histories commit fewer of the most violent offenses against law enforcement and police encounters with MISUD do not typically lead to significant injuries or fatalities among LEOs.[62]

Ghiasi N, Azhar Y, Singh J. (2021). Psychiatric Illness And Criminality. StatPearls. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537064/

[60] Engel & Silver, E. (2001). Policing Mentally Disordered Subjects: A reexamination of the criminalization hypothesis. *Criminology, 39*(2), 225–252. https://doi.org/10.1111/j.1745-9125.2001.tb00922.x

[61] Engel & Silver, 2001; Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). Police officers' attitudes toward and decisions about persons with mental illness. *Psychiatric Services, 55*(1), 49-53. https://doi.org/10.1176/appi.ps.55.1.49; Rohrer, 2021

[62] Watson, Corrigan, & Ottati, "Police Officers' attitudes toward and decisions about Persons with mental illness;" Agee, Zelle, H., Kelley, S., & Moore, S. J. (2019). Marshaling administrative data to study the prevalence of mental illness in assault on law enforcement cases. *Behavioral Sciences & the Law, 37*(6), 636–649.

LEOs routinely interact with individuals with mental health or substance use issues. When stigma and ignorance surrounding MISUD mix with frequent officer encounters, officers arrest individuals with MISUD at much higher rates than the general population. Individuals would be arrested and booked for misdemeanors such as suspicious person or activity, disorderly conduct, trespassing, jaywalking, and more. Untreated mental illness makes people more vulnerable to contact with law enforcement. Individuals with untreated mental illness are approximately sixteen times more likely to be killed in a police-involved shooting.[63]

Jails and prison historically did not offer rehabilitation and treatment services until most recent decades. In fact, studies have indicated that jails are more likely to be harmful to individuals with MISUD because of disruption in treatment continuity, exacerbation of their illness in a chaotic environment, isolation in solitary cells, and higher rates of assault.[64] Punitive responses to behaviors caused by MISUD typically worsens symptoms and facilitate a cruel cycle of crisis and carceral punishment.

Law Enforcement Response to MISUD According to Theories of Policing

Most law enforcement officers are not trained to identify the signs and symptoms of mental illness and substance use disorder. Their expertise of mental illness is limited to their first-hand interactions with people in crisis and minimal training in basic academy.[65] After formally incarcerated individuals were released into their communities without any support or

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https://doi.org/10.1002/bsl.2437; Kerr, A. N., Morabito, M., & Watson, A. C. (2010); Police Encounters, Mental Illness and Injury: An Exploratory Investigation. *Journal of police crisis negotiations, 10*, 116–132. https://doi.org/10.1080/15332581003757198

[63] Fuller et al., "Overlooked in the undercounted: the role of mental illness in fatal law enforcement encounters."

[64] Clark, 2004; Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric services, 58*(8), 1087–1094. https://doi.org/10.1176/ps.2007.58.8.1087; Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: the role of mental illness. *International journal of law and psychiatry, 31*(5), 385–393. https://doi.org/10.1016/j.ijlp.2008.08.005; Office of Research and Public Affairs, 2016.

[65] Perez, Leifman, S., & Estrada, A. (2003). Reversing the Criminalization of Mental Illness. *Crime and Delinquency, 49*(1), 62–78. https://doi.org/10.1177/0011128702239236

services, many of them ended right back up in the hands of police. The lack of services and a criminal history trapped individuals in a cycle of incarceration and poverty. Over time, police and society associated MISUD with criminality and violence, which is then used to justify an arrest.

Stress and Aggression Among Police Officers

Theories of policing can add context on how the criminalization of mental illness occurred. Philip Matthew Stinson (2020) summarized several of the following theories and applied them to policing. Theories of stress and aggression among officers, their legal power and authority, and policing culture explain how greater levels of strain and stress make officers more sensitive to perceived threats and displays of aggression. The difference between officers and civilians is that officers are endowed with the legal authority and protection to use force and coercion. As a result, LEOs are more likely to perceive signs of MISUD as threatening, and traditional policing culture emphasizes control and compliance over de-escalation and public safety.

Police officers are more likely to see threats and respond to them more aggressively than others due to severe chronic exposure to stress, and these perceptions and responses become embedded in police subculture. Robert Agnew's general strain theory suggests that officers experience enormous amounts of actual and anticipated strain due to their profession's responsibilities.[66] Actual or anticipated strain leads to fear, anger, frustration, hopelessness, and other negative emotions, and negative emotions make it more difficult for individuals to effectively evaluate and de-escalate situations. Despite being negative, fear and anger are still excitatory emotions, and officers can legally use coercive force to exercise official duties and

[66] Stinson, P. M. S. (2020). *Criminology Explains Police Violence* (Oakland: University of California Press), 82-83

cope with strain. Strain theory addresses how strain has shaped aspects within police culture, factors that influence arrest, and the extent of law enforcement's power.

Similar to actual or anticipated strain, burnout predicts verbal and physical aggression among police. It is also associated with suicidal ideation and PTSD symptoms which are related to some of the other negative emotions described in Agnew's strain theory.[67] Burnout occurs when various individual, client, and organizational factors cause individuals (typically within helping professions) to feel chronically stressed, overworked, and helpless. Thomas Bernard's angry aggression theory explains that stress and strain predict aggression because individuals in a chronic state of psychological arousal are more likely to interpret events as threatening.[68] Within professions characterized by elevated levels of stress, such as policing, aggression becomes embedded in group values, norms, and worldviews.

In the broken window theory, James Wilson and George Kelling propose that deterrence strategies are effective crime prevention strategies, and aggressive order maintenance strategies targeting disorderly behaviors of individuals are less effective at reducing crime.[69] Regardless, Stinson succinctly summarizes that "police are legally justified in using the amount of force necessary to effectuate an arrest."[70] The differential association process developed by Edwin Sutherland argues that officers are more likely to attribute behaviors as violations of the law over behaviors that do not violate the law.[71]

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[67] Stinson, *Criminology Explains Police Violence*, 71-72
[68] Stinson, *Criminology Explains Police Violence*
[69] Stinson, *Criminology Explains Police Violence*, 41-42
[70] Stinson, *Criminology Explains Police Violence*, 14
[71] Ibid

What separates officers from everyone else is police are endowed with the legal authority to act and use coercive force and violence if they deem necessary.[72] To illustrate, order-maintenance policing gives LEOs the legal authority to operate under and enforce a moral mandate, and officers consider order-maintenance policing (maintaining order and peace) as a form of peacekeeping. [73]

Policing Culture Drives Officer Attitudes and Behaviors

Police subculture shapes everything a police officer does.[74] There is a well-documented informal social code within policing. "Police operate in a social environment whereby systemic secrecy allows a subculture to thrive based on unwritten norms."[75] David Klinger's negotiated order perspective says police behavior is derived from local workgroup norms within a police department.[76]

John Van Maanen details police socialization as a "distinct subculture governed by norms and values designed to manage the strain created by an outsider role in the community."[77] The most crucial phase of socialization into police subculture occurs after a recruit completes his or her police academy training and is assigned to shadow and work under the direct supervision and mentoring of a field training officer. The new LEO learns "how to survive on the job… how to walk, how to stand, and how to speak and how to think and what to say and see."[78] Furthermore,

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[72] Martin, J. T. (2020). Police Work versus Police Action: Justice, Discretion, and Arendt's Theory of Politics. Exertions. https://doi.org/10.21428/1d6be30e.fa89ed05
[73] Stinson, *Criminology Explains Police Violence*
[74] Stinson, *Criminology Explains Police Violence,* 3
[75] Stinson, *Criminology Explains Police Violence,* 75
[76] Ibid
[77] Stinson, *Criminology Explains Police Violence,* 75-77; Van Maanen, J. (1973). Observations of the Making of Policemen. *Human Organization, 32*(4), 407-418. https://www.jstor.org/stable/44127631
[78] Stinson, *Criminology Explains Police Violence,* 77

police commonly share certain personality and psychological characteristics due to the influence of targeted recruitment strategies, formal police academy training, and realities of police work.[79]

Thomas Bernard's angry aggression theory ties individual and cultural differences in aggression to arrest behavior. Chronic stress can predispose people to perceive events as threatening more often than others, and aggression can become embedded in group values, norms, and worldviews. Police officers, especially those without proper coping skills, tend to see more threats and respond to them more aggressively. In other words, they are predisposed to have more aggressive perceptions and responses, and these become embedded in police subculture.[80] As a result, the more a person is being difficult, talking back, or simply refusing to accept an officer's view of the situation, the more likely that person is going to be arrested because the officer perceives them as being disrespectful or non-compliant, which are both considered threats.[81]

Robert Agnew's general strain theory states that actual or anticipated strain causes negative emotions, such as fear or anger, and officers are engaging with people who may be resistant or hostile towards them. "Police officers tend to encounter people who are having a really bad day. And if it was not a bad day already, certainly the day just got worse when the police showed up."[82]

A key goal of CIT and similar programs is responds to these qualities of policing culture and behavior. CIT provides alternatives and can change violent police street justice tactics for innocent people without taking away police's power or legal authority. They achieve this by changing the law enforcement's perspective the people with whom they are interacting.

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[79] Ibid
[80] Stinson, *Criminology Explains Police Violence,* 69
[81] Stinson, *Criminology Explains Police Violence,* 78
[82] Stinson, *Criminology Explains Police Violence,* 69

Donald Black's behavior of law theory further argues that law is governmental social control and arrests result from citizens who mobilize criminal law against other citizens by calling the police.[83] He argues that arrests typically reflect the desire of the complainant. Officers exercise their discretion, so arrests, especially alleged misdemeanors, are made less often than the law allows. Arrest becomes significantly more likely if a) the incident involved serious felony crimes, b) there was a greater relational distance between complainant and suspect, or c) the suspect was being disrespectful of police.[84] For example, officers are more likely to arrest a suspect when the suspect and complainant are strangers.

Similarly, Hannah Arendt's theory of politics suggests that police discretion should be treated as a site in which the violence of state imperium is balanced against and integrated with the power of community as politics.[85] She explains that police follow an informal social code enforced by policing subculture that creates a norm of secrecy.[86] Policing culture is shaped by the demands and nature of formal police academy training and realities of police work. As a result, police share a common set of personality and psychological characteristics. Similarly, John Van Maanen explained process of socialization into police subculture changes an individual's "occupational worldview over a period of several years early in an officer's LE career." The most significant point occurs after a recruit completes his or her police academy training and starts working under the direct supervision and mentoring of a field training officer when the recruit learns about the cultural norms and unwritten rules of policing.[87] David

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[83] Black, D. (1972). The Boundaries of Legal Sociology. The Yale Law Journal, 81(6). http://dx.doi.org/10.2307/795221;
Black, D. (1971). The Social Organization of Arrest. Stanford Law Review, 23(6), 1087-1111. https://doi.org/10.2307/1227728
[84] Black, "The Social Organization of Arrest"
[85] Martin, "Police Work versus Police Action: Justice, Discretion, and Arendt's Theory of Politics"
[86] Stinson, *Criminology Explains Police Violence,* 75
[87] Stinson, *Criminology Explains Police Violence, 77*

Klinger's negotiated order perspective adds that the decentralized police force in the U.S. suggests that police behaviors and characteristics are also derived geographically and within each police department.[88]

Van Maanen also observed that order-maintenance policing is a policing approach characterized as community service, peacekeeping, and justice without due process and strongly associated with the "Ask-Tell-Make" framework, which emphasizes compliance, respect, and dominance. Due to the nature of the "Ask-Tell-Make" method, LEOs perceive difficult, disrespectful, or disobedient civilians as threatening and noncompliant, so they use arrest to control the situation.[89] Policing culture established the aforementioned approaches into an unwritten, unofficial moral mandate that operates through personal discretion and decision-making. Stinson goes as far to say that police subculture shapes officers every action.[90] Although not a solution, statewide participation in CIT programs should facilitate changes in policing subcultures as officers learn and execute alternative law enforcement approaches.

Transition to a Mental Health Crisis Response (1980s to Present)

The *21st Century Law Enforcement Report* recommended a new "smart" approach to policing in light of increased rates of arrest, incarceration, use of force, and police killings.[91] In particular, the report recommended the integration of CIT training into basic recruit officer training, so officers would be better equipped with non-violent, empathetic strategies while responding to individuals in crisis or experiencing mental health or substance use issues.[92]

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[88] Klinger, D. A. (1997) NEGOTIATING ORDER IN PATROL WORK: AN ECOLOGICAL THEORY OF POLICE RESPONSE TO DEVIANCE. *Criminology, 35*, 277-306. https://doi.org/10.1111/j.1745-9125.1997.tb00877.x; Stinson, *Criminology Explains Police Violence,* 75
[89] Stinson, *Criminology Explains Police Violence*, 78
[90] Stinson, *Criminology Explains Police Violence*, 3
[91] President's Task Force on 21st Century Policing. (2015). Final Report of the 21st Century Policing. Washington, DC: Office of Community Oriented Policing Services. https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf
[92] President's Task Force on 21st Century Policing, "Final Report of the 21st Century Policing," 56

Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit*, which specifically included CIT as an effective specialized response to mental health crisis aimed for diversion into mental health services and a best practice model for law enforcement.[93]

Interestingly, among all law enforcement agencies, Cobbina-Dungy and colleagues found that only 1 to 4% of police calls responded to mental health distress and were specifically categorized as a mental health call in 2022.[94] Despite mental health calls being a fragment of the types of calls LEOs respond to, LEOs typically spent one hour on average for each of these calls.[95] SAMHSA listed crisis response as "essential for public safety, suicide prevention," connecting people to the proper services, and reducing unnecessary arrests and emergency department psychiatric boarding. SAMHSA went to the extent of attributing "the criminalization of mental illness" and police encounters leaving "people with mental illness and officers dead" to the lack of specialized, police-based crisis response.[96]

Sequential Intercept Model

After decades of law enforcement interacting with people experiencing MISUD, the behavioral health and criminal justice systems are intertwined. The Sequential Intercept Model (SIM) clarifies the role CIT in the behavioral health and criminal justice systems by establishing six critical intervention points throughout stages of the criminal justice system (see Table 2.3).[97]

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[93] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[94] Cobbina-Dungy et al., "Defund the police: Perceptions among protesters in the 2020 March on Washington"

[95] Ibid

[96] SAMHSA, "National Guidelines for Behavioral Health Crisis Care"

[97] Comartin, Nelson, V., Smith, S., & Kubiak, S. (2021). The Criminal/Legal Experiences of Individuals with Mental Illness along the Sequential Intercept Model: An Eight-Site Study. *Criminal Justice and Behavior, 48*(1), 76–95. https://doi.org/10.1177/0093854820943917

Intercepts are opportunities to redirect individuals with MISUD from criminal punishment to mental health treatment.

Table 2.1 *Sequential Intercept Model Overview*

Intercept	Intervention Point	Examples
Intercept 0	Community based services	Religious service, community service board, harm reduction programs
Intercept 1	Law enforcement and emergency services	Crisis Intervention Teams, Marcus Alert System, Mobile Response Teams
Intercept 2	Initial detention and hearings	Drug Court, Mental Health Court
Intercept 3	Jails and courts	Drug court, jail recovery and mental health programs
Intercept 4	Reentry from jails and prisons	Re-entry assistance
Intercept 5	Community corrections	

As noted in Intercept 1, LEOs are "system gatekeepers" because their discretion significantly determines whether someone enters the mental health or criminal justice system.[98] Law enforcement agencies, mental health providers, and policymakers recognized the economic, social, and health costs of trying to fix the mental health crisis with punitive legal response. Officers also knew from personal interactions that traditional tactics were not working. However, the lack of standard data variables and procedures causes tracking law enforcement interactions and diversion outcomes to be difficult.[99] SAMHSA listed CIT under Intercept 1 saying,

> At Intercept 1, law enforcement and other emergency service providers respond to people with mental and substance use disorders who are in crisis in the community. In many jurisdictions, when a person in crisis exhibits illegal behavior, law enforcement officers have the discretion to place the person under arrest or to divert them to treatment or services. Effective diversion at Intercept 1 is supported by trainings, programming, and policies that integrate behavioral health care and law enforcement to enable and promote the diversion of people with mental illness away from arrest and a subsequent jail stay and into community-based services.[100]

The present research is examining how police choose to use to their discretion under the Intercept 1 model and why LEOs may be motivated to divert individuals from arrest. The results present in the interview data will suggest the extent to which CIT is successful in the field.

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[98] Franz & Borum, 2010.
[99] Comartin, Nelson, V., Smith, S., & Kubiak, S. (2021). The Criminal/Legal Experiences of Individuals with Mental Illness along the Sequential Intercept Model: An Eight-Site Study. Criminal Justice and Behavior, 48(1), 76–95. https://doi.org/10.1177/0093854820943917
[100] Substance Abuse and Mental Health Services Administration. (2019). Data Collection Across the Sequential Intercept Model (SIM): Essential Measures (No. PEP19-SIM-DATA). Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-data.pdf

Law Enforcement Jail Diversion in Virginia

Several factors affect officer crisis response. State and local policy, mental illness awareness and training, collaboration or partnerships with behavioral health agencies, perceptions of people with MISUD, and resources (i.e., available sworn officers, budget, community behavioral health resources, alternative transportation) all influence LEO discretion. Stigma and the lack of mental health awareness may foster the perception of MISUD as criminal or threatening behavior, which will contribute to poor interactions. Then, civil commitment laws and decentralized, deficient behavioral health services may place more strain on law enforcement by increasing the number of mental health crises and limiting access, delivery, and quality of behavioral health services.

Virginia's behavioral health crisis laws tend to be enacted shortly after tragic events involving unmet behavioral health needs and law enforcement occur, which are detailed in the following sections. This may indicate that high profile events shortly increase public interest and legislator support for behavioral health initiatives.[101] The Virginia General Assembly typically expands law enforcement's discretion and tools and funding relevant initiatives to achieved changes in officer behaviors. State legislation is generally enacted after appalling circumstances involving the deaths of individuals with MISUD prompts public outcry and advocacy against local law enforcement, local jails, or state psychiatric facilities.

High Profile Events Relating to Mental Health and Criminal Justice Drive Policy Change

For the past fifty years, chronic underfunding of Virginia's behavioral health system has accumulated irreparable costs on system services, infrastructure, and the communities they serve.

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[101] Masters, Kate. (2022). As state mental hospitals struggle, lawmakers eye the agency overseeing them. Virginia Mercury. https://www.virginiamercury.com/2022/03/21/as-state-mental-hospitals-struggle-lawmakers-eye-the-agency-overseeing-them/

MISUDs, particularly at the crisis level, are characterized by psychological distress, dysfunction, or impairment in daily life activities. Gaps in prevention, assessment, diagnosis, treatment, and emergency services contributed to increasing levels of strain, deterioration, and inefficiency within health care and law enforcement. Historically, the state government has reduced budgeted expenditures in behavioral health care and crisis services.[102] Virginia's budget reflects the state's values.

In 2006, the Department of Criminal Justice Services (DCJS) of Virginia published a report on the issue of mentally ill citizens ending up in the criminal justice system rather than in health services.[103] They stated that community treatment services have not been meeting the needs of incarcerated individuals for over 30 years. People with mental illness who do not have proper insurance coverage end up in jails. They proposed to establish a group that would design a system to keep adults and juveniles with mental illness out of the criminal justice system and reduce the need for the criminal justice system to become involved providing mental health treatment. The prevention model would be a managed care model to keep non-violent mentally ill in the community without over-extending mental health and social welfare services. They also proposed developing jail and prison alternatives, such as community residential and day treatment facilities. For this model to succeed, communities must have sufficient and stable funding, so treatment services are available for reentry because treatment support and follow up were not readily available.

Judges may sentence people to jail to ensure they have some access to treatment; however, more time and resources could be focused on crime control if sick people were

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[102] Signer, M. E. (2014). Virginia's Mental Health System: How It has Evolved and What Remains to Be Improved. *The Virginia News Letter, 90*(3), 18; Masters, "State mental hospitals struggle"

[103] Virginia Department of Criminal Justice Services (DCJS). 2006 Blueprints for Change: Criminal Justice Policy Issues in Virginia – Mental Health Issues in Jails and Detention Centers. August 2006.

diverted. The field of law enforcement increased interest in and efforts to establish crisis intervention skills and programs to limit the potential for harm to himself and others, and that mental illness is distinctly differently from criminality.[104]

Virginia Tech Massacre of 2007

Government and public health officials took urgent action to repair state behavioral health services after the 2007 Virginia Tech shooting resulted in the deaths of 32 people.[105] After learning the shooter's history of severe, untreated mental illness, the following investigations revealed shocking deficits in mental health and crisis service access, capacity, quality, and delivery. It also raised public awareness about the skyrocketing rates of arrest and incarceration among people with mental illness.[106] Virginians recognized the profound costs of sparse mental health care: lives and liberty.

Virginia Mandates All Localities to Implement CIT

In response to the growing public outcry over Virginia's crisis services, the 2008 Virginia General Assembly (GA) began investing crisis services, case management, and outpatient services to urgently mitigate the effects of a collapsing behavioral health system. They developed a behavioral health crisis response and safety net using law enforcement.[107] In 2009, the GA added a new article on CIT programs to the Code of Virginia (Title 9.1, Article 13, Sections 9.1-187 through 9.1-190). The act amended basic training and recertification requirements for law enforcement employment to include crisis intervention training. The act also permitted use of federal and state funds to develop and establish CIT programs.

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[104] Virginia Department of Criminal Justice Services (DCJS). 2006 Blueprints for Change: Criminal Justice Policy Issues in Virginia – Mental Health Issues in Jails and Detention Centers. August 2006. p. 4
[105] Masters, "state mental hospitals struggle"
[106] Signer, "Virginia's Mental Health System"
[107] Signer, "Virginia's Mental Health System"

Every locality was mandated to establish or join a CIT program.[108] This act expanded response options by authorizing officers "to release person with mental illness, substance abuse problems, or both, whom they encounter in crisis situations from their custody when the crisis intervention team has determined the person is sufficiently stable and to refer him for emergency treatment services."[109] CIT Assessment reports were submitted to the Joint Commission on Health Care in 2009, 2010, and 2011.[110] In addition to the original goals of the Memphis CIT program model, the Code of Virginia lists other subordinate goals for CIT programs (see Table 2.4). [111] In 2012, the GA expanded the crisis care continuum by funding assessment "drop off" centers.

[108] Va. Code Ann. § 9.1-188 (2009)
[109] Va. Code Ann. § 9.1-189 (2009)
[110] Va. Code Ann. § 9.1-190 (2009)
[111] Va. Code Ann. § 9.1-187 (2009)

Table 2.2 *Code of Virginia § 9.1-187-190*

1. Providing immediate response by specially trained law-enforcement officers
2. Reducing the amount of time officers spend out of service awaiting assessment and disposition
3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations
4. Reducing the likelihood of physical confrontation
5. Decreasing arrests and use of force
6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care
7. Providing support and assistance for mental health treatment professionals
8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment
9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility
10. Public recognition and appreciation for the mental health needs of a community
11. Decreasing injuries to law-enforcement officers during crisis events
12. Reducing inappropriate arrests of individuals with mental illness in crisis situations
13. Decreasing the need for mental health treatment in jail.

In addition to the Virginia Tech Massacre, several other major events involving the deaths of mentally ill citizens became the catalyst for criminal justice reform in policing and jails regarding people with mental illness and substance use disorder.

Death of Jamychael Mitchell at the Hampton Roads Regional Jail

Jamychael Mitchell was diagnosed as intellectually disabled and with bipolar disorder as schizophrenia before he was 15 years old. Due to the severity of his mental illnesses, he was hospitalized several times. On April 22, 2015, Mitchell was arrested and detained for shoplifting $5 worth of snacks from a 7-Eleven. 101 days later, he was found dead at the Hampton Roads Regional Jail from starvation and wasting syndrome while waiting more than two months for a bed at Eastern State Hospital.[112] This incident caused public outrage against Mitchell's living conditions in jail and negligent treatment, and it reformed local criminal and crisis procedures regarding forensic psychiatric beds to prevent future deaths.

Death of Senator Creigh Deeds' Son

In November 2013, the son of Virginia State Senator Creigh Deeds (D-Bath) was placed into custody for involuntary civil commitment (i.e., under an emergency custody order) for a mental health emergency and was released when no beds opened before the time limit, which was four hours at the time. After he was released from officer custody and returned home, he stabbed his father thirteen times and died by suicide shortly after.[113]

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[112] Adams v. NaphCare, Case 2:16-cv-00229-RBS-LRL (2016). UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA: Norfolk Division. https://i2.cdn.turner.com/cnn/2016/images/05/17/57326569ee0ac.pdf; Scott Daugherty. (2019). $3 million settlement reached in death of Jamycheal Mitchell at Hampton Roads Regional Jail. The Virginian-Pilot. https://www.pilotonline.com/news/crime/article_a22a2f58-1bff-11e9-8abd-6ff64450e893.html

[113] O'Dell, Larry. (2016). Senator sues state, mental health officials over son's death. AP News. https://apnews.com/article/43578c04c8934841a5327b035d6110ac

After the incident, Senator Deeds took major legislative action to change the involuntary civil commitment laws in Virginia. Sen. Deeds sponsored the "bed of last resort" law. The enacted bill established an acute psychiatric bed registry, extending the holding time for civil commitment to eight hours, and made it illegal for state facilities to refuse someone who is deemed eligible for a temporary detention order admission. [114] New civil commitment requirements has significantly affected law enforcement officers because only LEOs have been authorized to place individuals into custody, transport them to a mental health or crisis facilities, and supervise them while waiting for a mental health evaluation. Waiting times and transportation increased significantly after these policies were enacted.

Death of Marcus David Peters

In 2018, Richmond Police Officer Michael Nyantakyi killed Marcus-David Peters, an unarmed 24-year-old Black biology teacher experiencing a mental health crisis.[115] In response to community protests over his death calling for crisis response reform,[116] the Virginia General Assembly enacted the Marcus-David Peters Act to develop and maintain the Marcus Alert System, a regional call system that would dispatch teams of police and mental health providers in crisis situations.[117]

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[114] SB 260, 2014 Virginia General Assembly. 2014 Reg. Sess. (Vir. 2014). https://lis.virginia.gov/cgi-bin/legp604.exe?141+sum+SB260

[115] Lavoie, D. (2020). Virginia prosecutor finds 2018 police shooting justified. Associated Press News. https://apnews.com/article/biology-shootings-police-mental-health-health-fa032844ac462e651627caf37c44be17

[116] Associated Press. (2018). Protesters march in response to police shooting of naked man. Associated Press News. https://apnews.com/article/e4959fe608994132b1d4e9877b5d8dca

[117] Lavoie, D. (2020). Sister of man killed by police blasts 'ineffective' law. Associated Press News. https://apnews.com/article/ralph-northam-biology-shootings-police-mental-health-e3a9254c89faca999c31d7579425a145

Additionally, government and health officials launched a plan in 2018 to redesign and enhance the behavioral health system called "Behavioral Health Redesign."[118] Their goal was to develop the nation's leading behavioral health system model and solve the State Hospital Census Crisis. The State Hospital Census Crisis described the simultaneous staffing shortages and bed overutilization among state psychiatric facilities.[119]

The psychiatric bed crisis worsened civil commitment waiting times for LEOs and the people in need of crisis services. Additionally, negative perception of law enforcement pushed by news media and government officials caused statewide shortages in sworn LEOs. Since LEOs were required to transport and supervise the person, law enforcement's diminished staffing capacity became overextend.

COVID-19 Pandemic

COVID-19 exacerbated the prevalence and severity of psychological distress and substance use worldwide.[120] As pandemic-related stressors multiplied the need for behavioral health services, Virginia's health care systems were overwhelmed and collapsing due to high demand, and without enough capacity, the number of people with unmet behavioral health needs in the state increased. Virginia's state psychiatric facilities were overcrowded and operating

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[118] Virginia Association of Community-Based Providers. (n.d.). Project Bravo. https://www.vacbp.org/behavioral-health-redesign.html

[119] Land, A. (2021, July 15). Update on State Hospital Bed Census and DBHDS Initiatives [PowerPoint]. Joint Subcommittee to Study Mental Health Services in the 21st Century. https://studiesvirginiageneralassembly.s3.amazonaws.com/meeting_docs/documents/000/001/048/original/Presentation._DBHDS_7.15.21.pdf?1626296968

[120] McGinty, E. E., Presskreischer, R., Han, H., & Barry, C. L. (2020). Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020. *JAMA, 324*(1), 93–94. https://doi.org/10.1001/jama.2020.9740; Bounoua, N., & Sadeh, N. (2021). A longitudinal investigation of the impact of emotional reactivity and COVID-19 stress exposure on substance use during the pandemic. *Journal of affective disorders reports, 6*, 100284. https://doi.org/10.1016/j.jadr.2021.100284; Roberts, A., Rogers, J., Mason, R., Siriwardena, A. N., Hogue, T., Whitley, G. A., & Law, G. R. (2021). Alcohol and other substance use during the COVID-19 pandemic: A systematic review. *Drug and alcohol dependence, 229*(A), 109150. https://doi.org/10.1016/j.drugalcdep.2021.109150

beyond full bed capacity while experiencing unprecedented levels of staffing shortages. In consequence, risk of injury to patients and workers drastically increased and five out eight Virginia's state hospitals closed to new admissions in 2021.[121] When behavioral health services disappear, the problems associated with MISUDs transfer from the mental healthcare system to local law enforcement and emergency departments, which do not provide MISUD treatment and support services.

Overview of Virginia CIT Programs

Law enforcement and mental health providers in Memphis established the Memphis CIT model in 1988. The "Memphis Model" created a specialized, selective team of officers designated to respond to calls involving mental illness, substance use, or both. Officers completed a 40-hour week-long training on psychiatric issues, crisis intervention, de-escalation, and relevant community services to become CIT certified.[122] The goal of CIT has been to improve public safety and wellness by using law enforcement as an interception point to identify individuals who need services and connect them to community stabilization and treatment services. It achieves this by altering officer-interactions with people displaying signs of MISUDs. CIT strengthens officers' confidence, motivation, and ability to respond more appropriately to people in crisis.[123]

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[121] Land, 2021

[122] de Tribolet-Hardy et al., 2014; Kerr et al., 2010

[123] Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, D. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Effects on Officers' Knowledge, Attitudes, and Skills. *Psychiatric Services, 65*(4), 517-522. https://doi.org/10.1176/appi.ps.201300107; Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, D. M., Oliva, J. R., Thompson, N. J., & Watson, A. C. (2014). The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services, 65*(4), 523-529. https://doi.org/10.1176/appi.ps.201300108

Today, there are over 3,000 CIT programs in the United States, and the CIT model is internationally recognized for improving law enforcement's mental health response and successfully diverting individuals with mental illness and substance use disorder from arrest.[124] CIT programs traditionally operate under a voluntary basis, and usually, less than a quarter of the police force are CIT officers. The small number of CIT officers means that they can only respond to a fraction of mental health calls, so untrained LEOs are still more likely to handle calls involving MISUD.[125] One meta-analysis found insufficient evidence for the effect of CIT officer injury and no overall effect of CIT on arrest or use-of-force outcomes. The study also found that CIT-trained officers were more likely to transport people with MISUD to mental health services than non-CIT-trained LEOs.[126]

Local LEAs in Virginia became interested in CIT shortly after the Memphis Police Department implemented the first CIT program in 1988. Agencies could not develop their own until they had more community services and partnerships. One police department completed the CIT Training with Memphis CIT program and developed their own operational program in 2004.[127] By 2006, Virginian officials recognized local law enforcement's interest and implementation of crisis intervention programs and strategies.[128] Virginia was the first state to

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[124] University of Memphis CIT Center, 2019; Franz & Borum, 2010; Wood et al., 2017; Teller, J. L. S., Munetz, M. R., Gil, K. M., Ritter, C. (2006). Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls. *Psychiatric Services, 57*(2), 232-237. https://doi.org/10.1176/appi.ps.57.2.232

[125] Helfgott, J. B., Hickman, M. J., & Labossiere, A. P. (2016). A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program. International journal of law and psychiatry, 44, 109–122. https://doi.org/10.1016/j.ijlp.2015.08.038

[126] Taheri, S. A. (2016). Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis. Criminal Justice Policy Review, 27(1), 76-96. https://doi.org/10.1177%2F0887403414556289

[127] Martin, D. R. (2020). Evaluation of the Impact of Virginia's Senate Bill 1294 on Crisis Intervention Team Cooperation. [dissertation]. Walden University. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=10020&context=dissertations

[128] Virginia DCJS. 2006 Blueprints for Change: Criminal Justice Policy Issues in Virginia – Mental Health Issues in Jails and Detention Centers. August 2006.

require the development and establishment of CIT programs for all localities by state law.[129] As of June 2021, 16 states referenced CIT and/or Law Enforcement Assisted Diversion (LEAD) programs in their state laws. Among those states, only three states successfully passed state laws requiring the establishment of CIT programs:[130]

- Virginia (2009)[131]
- Illinois (2016)[132]
- New York (2021)[133]

Annual reports published by the DBHDS provides a basic overview of Virginia's CIT programs and assessment sites; however, information on Virginia's CIT programs is only collected and reported at the state-level. Thus, information by locality, program, or agency are not available. For CIT programs specifically, the Office of Forensic Services published annual reports on Virginia's CIT programs from 2012 to 2015.[134] The 2015 CIT Inventory Survey report indicated the following:

- 33 fully active CIT programs (37 CIT Programs in total)
- 32 CIT assessment sites (operated by 28 CIT programs)

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[129] Legislative Analysis and Public Policy Association (LAPPA). (2021). Deflection Programs: Summary of State Laws. LAPPA. http://legislativeanalysis.org/wp-content/uploads/2021/07/Deflection-Programs-Summary-of-State-Laws.pdf

[130] Maine was excluded because their CIT program did not involve law enforcement. Maine's community-based crisis intervention team program was mandated before the Memphis CIT model, so their teams comprised only of mental health professionals primarily in the emergency room setting. They currently do not have a state-mandated law enforcement diversion program; Me. Rev. Stat. Ann. Tit. 34, § 3621-22 (1987)

[131] Va. Code Ann. § 9.1-187-§ 9.1-190 (2009); LAPPA, 2021

[132] Ill. Comp. Stat. Ann. 705/10.17 (2016); LAPPA, 2021

[133] New York law only required the establishment of a CIT program in cities with more than one million residents (LAPPA, 2021)

[134] Office of Forensic Services. (2016). Virginia's Crisis Intervention Team Programs: 2015 CIT Inventory Survey. Virginia Department of Behavioral Health and Development Services. https://dbhds.virginia.gov/library/forensics/ofo%20-%20cit%20inventory%202015%20final%20report.pdf

- Active CIT programs in 117 of 133 localities (95% of Virginia's total population live in area covered by a CIT initiative)
- 141 police departments and 111 sheriff's offices participated in CIT programs
- 6,877 LEOs completed a 40-hour CIT training
- 3,850 individuals were assessed at CIT Assessment Sites with 2,313 resulting in TDOs

After 2015, the state only collects and publishes data on Virginia's CIT assessment sites. Virginia's CIT Assessment Sites annual report for 2020 provides a limited but more up to date overview of CIT in Virginia:[135]

- 38 CIT programs
- 40 CIT assessment sites
- 14,670 total assessments at Virginia's CIT assessment sites
- 8,636 temporary detention orders issued (59% of total assessments)
- 9,500 discretionary law enforcement hand offs to CIT assessment sites (2019)

More detailed statistics on CIT programs, data collection and analysis of program characteristics and outcomes varies by agency and program. In November 2021, the CIT Assessment Site Program Coordinator at the DBHDS emailed that "each locality is responsible for keeping the data on their training" and other program measures and CIT programs are locally created and administered. Definitions and variables for program evaluation may differ between agencies and programs, and statewide reports do not capture details of officer and program outcomes.[136]

CIT programs rely on interagency partnerships between LEAs and CSBs, and CSBs Since each CIT program is developed by the local CSBs, LEAs, and other stakeholders, each

[135] Schein et al., "Virginia's CIT Assessment Sites: FY2020 Annual Report"
[136] Schein et al., "Virginia's CIT Assessment Sites: FY2020 Annual Report"

program differs for each jurisdiction. CIT programs are encouraged by the state government and Virginia CIT Coalition to integrate a list of essential core elements into their programs. The core elements include community partnerships between law enforcement and mental health providers, an official CIT Coordinator position for each program, basic CIT training for LEOs, Train-the-Trainer classes to train new CIT instructors, crisis assessment sites and procedures, and data collection to measure progress. [137]

Programs can cover one to more than seven localities depending on the population density of the programs' jurisdictions.[138] For example, a highly populated area, such as Fairfax City or Virginia Beach City, runs a local CIT program through the CSB and LEAs within the jurisdiction of their city. More populated areas tend to have large police departments and sheriff's offices too. In rural areas, a CIT program is a regional collaboration between police departments, sheriff's officers, local and regional jails, community services, and sometimes churches among multiple counties and independent cities. It is important to note that law enforcement agencies only affiliate with one CIT program according to conversations with CIT officers and coordinators in Virginia.

Although the state mandated CIT programs for each locality, CITs are completely decentralized. The CIT programs formed the Virginia CIT Coalition to better coordinate partnerships and communication between jurisdictions. The only official position in the state government who coordinates programs is the Statewide CIT Site Assessment Coordinator.

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[137] Virginia Department of Criminal Justice Services and Department of Behavioral Health and Developmental Services. (2014). Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs (CIT). Accessed from https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/dcjs/essential-elements-commonwealth-virginias-crisis-intervention-team-programs-cit.pdf

[138] Schein et al., "Virginia's CIT Assessment Sites: FY2020 Annual Report"

While the goal of jail diversion stays consistent, the characteristics of CIT trainings differ by program. Approximately 70 percent of the training module is standardized by state legislation, and individual programs can determine the remaining time on the agenda.[139] All trainings involve site visits to mental health facilities within their community, intensive role plays, and educational presentations on crisis intervention skills. They also learn how to identify and respond to several types of mental illness.

Since the Virginia General Assembly mandated CIT programs in 2009, it has remained one of the few states to do so. Other states have enacted funding towards CIT programs to expand and support program development; however, very few states mandate the creation and participation of programs.

Virginia's CIT Programs May Reflect Widespread Changes in Law Enforcement

The literature review summarized theories that may explain how CIT is transforming law enforcement across the state of Virginia. Based on previous studies, this study expects that police discretion drives the improvement of safety and diversion outcomes. CIT targets police discretion by training individual LEOs in progressive law enforcement approaches rather than the traditional models that historically criminalize and punish MISUD. CIT trainings aim to influence individual officers' perceptions, actions, and values relating to mental health crises. Since Virginia systemically established CIT programs across the state, CIT may be evolving the entire field of local law enforcement in Virginia. Theories of policing and SIM explain how targeting individual and organizational factors, such as awareness and perception of mental health, communication skills, compassion, values, and goals, drive broader, meaningful changes in law enforcement.

[139] CIT Instructors at the Rockbridge Area CSB shared the training model during a CIT class in November 2021.

Chapter 3: Method

Research Design

This study assesses the influence of CIT on policing behaviors and attitudes through semi-structured phone interviews (N = 27) with local sworn officers and CIT Coordinators actively employed by local police departments and sheriff's offices in Virginia. Major findings are extracted from the interview notes by evaluating and comparing reoccurring themes and phrases across participants by hand.

Individual interviews develop a comprehensive understanding of policing behaviors and attitudes by asking open-ended questions. Participants talk in-depth about police-specific factors, outcomes, and effects of CIT programs that survey questionnaires are prone to exclude or overlook. Additionally, participation was predicted to be more effective if officers were asked to complete a short, unrecorded phone call instead of a time-consuming, arduous questionnaire. Interviews emerged as the most appropriate method of data collection considering the process of recruitment, data collection, and interview analysis given the allotted time period to conduct this study.

Initially, this research aimed to explore CIT programs through a mixed methods design that evaluated the changes in arrest and diversion outcomes after the Commonwealth compelled all jurisdictions to join or form a CIT program in 2010.[140] There are numerous important and outstanding problems related to collecting sufficient and accurate data which preclude such an approach. For instance, statewide arrest and diversion data was not identified or collected. For arrest rates, they were found to be an unreliable indicator of jail diversion for mental health consumers since individuals may be arrested for a wide range of charges, which may include

[140] Va. Code Ann. § 9.1-187-§ 9.1-190 (2009)

suspicious activity, trespassing, soliciting, drug-related charges, or theft. This outcome variable only corresponds to one response option an officer may choose from. LEOs may also resolve the call on-site, offer a voluntary transport, or conduct an involuntary transport.

In addition, the decentralized nature of local LEAs indicates that the arrest and diversion processes are not standardized. Consequently, arrest rates are an unreliable and invalid measure of jail diversion to compare across localities. Nonetheless, more than one CIT Coordinator claimed that CIT programs reduced the number of arrests, officers injured, and citizens injured.[141]

Importantly, program-level data should continue to be considered unreliable and invalid measures because definitions of jail diversion, arrest, and mental health issues are not standardized across agencies and programs. Furthermore, performance metrics used to evaluate success are also unregulated. Outcome variables may include resolved mental health calls, number of transports (voluntary or involuntary), ECOs, TDOs, and percentage of CIT-trained LEOs.

Databases describing CIT programs' law enforcement and medical partnerships, jurisdiction(s), and community resources were not available in the public domain. To obtain program-level raw data, the CIT Coordinators were individually contacted by email with a request for data on their CIT programs. The approach obtained important and useful information for the present study, but also revealed that a much more extensive and separate data standardization and gathering effort is essential for rigorous quantitative analysis of CIT programs. The emails of CIT Coordinators were collected from the Virginia CIT Coalition website. Since the DBHDS collects data from CIT programs for the annual CIT Site Assessment

[141] Phone calls with CIT Coordinators during November 2021.

report, the CIT Assessment Site Program Coordinator at the DBHDS was also contacted by email and phone call with a request for statewide data and the following questions:

- How many law enforcement agencies collaborate with your CIT program?
- How many officers in the participating agencies are trained in CIT?
- How many individuals have participated (i.e., diverted from arrest) from this program? Is there any data on the number of those who have participated in CIT programs by locality or CSB?

This preliminary stage of quantitative data collection illustrated the vast organizational differences between programs. On one end, a well-developed program in an urban setting provided exact numbers of CIT-trained officers in each LEA that included the number of mental health calls-for-service, number of transports (i.e., voluntary/involuntary transport, Emergency Custody Order, Temporary Detention Order), and number of people diverted from potential arrest. On the other end, several CIT Coordinators did not have any official data to share. Most CIT Coordinators were able to supply the names of their law enforcement partners.

The decentralized nature of CSBs, LEAs, and CIT programs brings about inconsistent data variables that cannot be statistically compared across programs. The State CIT Assessment Site Coordinator responded, "diverted arrest numbers are a moving target that local police departments collect inconsistently," and this data is "local-level information and each local program is responsible for collecting and maintaining this, if they choose to."[142] While the raw dataset were not available, the Coordinator delivered what he did have, which were the annual CIT reports. The lack of existing data reveals more than a methodological limitation in this

[142] Gathered from an email response from the DBHDS CIT Assessment Site Program Coordinator on Monday, December, 27, 2021

study. The state currently does not standardize or collect measurable outcomes that are necessary to evaluate the progress of police-based jail diversion programs over time.

The next alternative was to collect data from the agency- or program-level; however, differences in definitions and data collection methods would produce major constraints for data analysis. A survey may collect diversion rates for each CIT program, but the survey must require specific definitions and parameters. Designing, recruiting, and conducting a survey of this magnitude was not realistic considering the time and resource constraints of this project.

Insufficient statistics on CIT programs revealed that this project would be unable to evaluate the impact of state policy on diversion outcomes. Thus, qualitative measures, such as semi-structured interviews, came to be the leading, most achievable modality of data collection. The discovery of such data limitations is on its own an important finding of the present research and indicates the need for a more systematic state-wide effort to collect data that allows for rigorous evaluation of CIT programs.

Participant Selection

Virginia maintains a criminal justice directory page that provides contact information (contact name, address, email, phone number, website) for all LEAs in the state. The directory was filtered by agency type to police departments and city and country sheriff's offices. Only county or independent city LEAs listed in the "Crime in Virginia 2020 Report" were contacted. This report listed each agency's number of full-time law enforcement officers (sworn), the 2020 population estimate of their jurisdiction, and total breakdown of reported offenses and arrests.[143] They also classified agency by type (county/town, city, other, college & university, and state

[143] Crime in Virginia. 2020. Data Analysis & Reporting Team (DART). Department of State Police.

police). Only contacting agencies within this report meant agencies could be more reliably compared by their agency type, size, population density, and crime rates.

Approximately 160 contacts (typically the police chief or sheriff) representing city or county police departments and sheriff's offices were emailed. Emails requested to chat with law enforcement officers about CIT programs for an undergraduate honors thesis. In total, interviews with experienced CIT instructors, CIT Coordinators, police chiefs, or sheriffs were scheduled with about a quarter of agencies contacted. In the end, 25 LEOs and 3 CIT Coordinators were interviewed. Interviews were conducted at the end of December 2021 and during January 2022.

Almost all of the participants were training instructors, program coordinators, or in senior law enforcement leadership positions. In other words, participants were likely to possess a specialized set of knowledge and skills that strongly aligned with the CIT programs in their agency and across the state. The resulting sample shows that agencies were more likely to choose to participate if their CIT programs were supported and well represented. The goal of this project was to measure the individual attitudes and behaviors by hearing from everyday CIT-trained and traditionally trained officers.

Most law enforcement participants were police chiefs, sheriffs, and CIT instructors. In general, police chiefs and sheriffs did not complete the 40-hour CIT training, but they were familiar with the training from attending portions. All participants were employed by agencies with fully operational CIT programs, and each program and agency had unique sets of characteristics and resources (See Table 3.1). Most participants were male with at least 10 to 30 years of experience in law enforcement. Race, gender, and other sociodemographic variables were not formally collected during the interviews.

Table 3.1 *Demographic Characteristics of Study Interviews with Law Enforcement Officers*

	N = 24
Total number of participants	%
Agency Type	
Police Department	70.8
Sheriff's Office	29.2
DBHDS Region	
1	20.8
2	29.7
3	25.0
4	12.5
5	12.5
Rank segment	
Line level	20.8
Midlevel management	25.0
Command level	54.2
Experience (years)	
< 9	4.17
10-19	20.8
20-29	45.8
30+	20.8
Unknown	8.34
CIT Training (40-hour week-long training)	
Not completed	20.8
Completed	70.8
Instructor	29.2
Unknown	20.8
Size of Employed Agency	
Small (1-99)	33.3
Medium (100-249)	33.3

Large (250-999)	29.7
Unknown	4.17

Note. The U.S. Department of Justice there is not a universal standard for the structure, size, or governance of police departments in the United States.[144] The agency size divisions were determined modeled after agency size breakdown.[145] Rank segment was divided by line level (officer, detective, corporal), midlevel management (sergeant, lieutenant, captain, major, colonel), and command level (commander, deputy chief, assistant chief, chief of police). The Completed CIT variable includes CIT instructors.

[144] Community Relations Service. (n.d.). *Community Relations Services Toolkit for Policing: Policing 101*. U.S. Department of Justice. p.1. https://www.justice.gov/file/1376626/download

[145] Hofer, M.S., Savell, S.M. (2021). "There Was No Plan in Place to Get Us Help": Strategies for Improving Mental Health Service Utilization Among Law Enforcement. J Police Crim Psych 36, 543–557. https://doi.org/10.1007/s11896-021-09451-0

Three CIT Coordinators were interviewed and asked about their experiences with CIT and how it has influenced law enforcement behaviors and attitudes. CIT Coordinators reported a strong background involving law enforcement. Some used to be officers, dispatch workers, or mental health partners. Since they continue to frequently collaborate and work alongside LEOs through CIT, their interviews were included in the final analysis. They could offer adjacent perspectives and experiences that address how CIT has influenced law enforcement.

Data Collection

Thirty-minute semi-structured telephone interviews were conducted in late December 2021 and January 2022. Interviews were not recorded as an added measure to protect confidentiality and reduce the level of risk to respondents, or the agencies or individuals mentioned in the interview. The level of occupational risk in discussing sensitive subjects, such as policing mental health, was conditional on protecting confidentiality. While confidentiality can never be guaranteed, original audio files and transcriptions require more deliberation and expertise to properly secure than interview notes. Audio or transcription data were not collected to reduce potential for researcher error and the level of risk for participants if a breach in confidentiality happened to occur. Additionally, the risk that comes with recording sensitive subject matters might discourage LEOs from participating or openly expressing their perspectives. In sum, not recording interviews increased confidentiality and facilitated a safe, open environment to freely share experiences and opinions. This study design was reviewed and approved by the Institutional Review Board (IRB) from the researchers' institution.

Then, an interview protocol was developed and used as a template for notes in each interview. The opening introduced the project and provided information regarding informed consent. Upon agreeing to the informed consent, five questions with optional probes were listed.

The first two questions prompted the conversation to begin with their professional background and CIT experience. The last three questions were listed in order of importance in case time ran short. They addressed the impact of CIT on policing behaviors and public safety. For the closing, participants were asked if there were any last thoughts they wanted to share about CIT programs. The researcher's contact information was provided in case the participant had any future questions or concerns.

The questions asked about the effect of CIT programs on law enforcement behaviors and attitudes when mental health and substance use issues were involved. Questions were reworded when interviewing CIT Coordinators, so they could share their experiences and perspectives that illustrated how CIT has affected policing. All participants were asked about the advantages and disadvantages of CIT programs and how much CIT has improved public safety and health.

Since interviews were not recorded, interview notes were written down by the researcher during interviews with detailed notes added from memory immediately following each interview. By conducting interviews over the phone, participants' responses were transcribed live as accurately as possible.

Data Analysis

Interview notes were recorded in a prepared interview protocol template under the appropriate questions for each participant. After the final interview, the protocols were printed. All responses were analyzed using the same method. First, interview data was first condensed using values coding and identifying text related to the research question. Emphasized or repeated phrases and words were noted. This data was condensed into an analytic memo that summarized relevant experiences, narratives, themes, and attitudes. This condensed data into more manageable units for analysis. An analytical memo for each interview was written (typically

1,000 to 1,300 words). Each memo compared the participants' attitudes, beliefs, language, and narratives.

After nine interview memos were written, a meta-memo synthesized findings from the nine analytic memos. Findings consisted of emerging themes, theoretical constructs, narratives, and comparisons across interviews. The distilled information within the memos enhanced the capacity to identify and compare 27 similar artifacts.

Each memo included comparisons to other participants' answers or experiences. Quotes of interest were included for consideration in the analytical memo and results section.

The lack of audio-based transcriptions was a limitation of the study. To ensure complete transcription, abbreviations were employed to describe commonly used words to describe people in crisis. For example, PWMI ("person with mental illness) replaced mentally ill person, mental health consumer, suspect, person with mental health issues, and person in crisis. CIT may have affected which labels officers used or if labels differed by agency culture. Post-transcription would have guaranteed word-level accuracy for these descriptors.

Chapter 4: Results

This study aims to investigate the impact of CIT programs on local law enforcement attitudes and behaviors in Virginia, which mandated statewide participation in CIT programs in 2009. Interviews with LEOs and CIT Coordinators taking part in local and regional CIT programs provided firsthand descriptions of program experiences, structures, norms, advantages, disadvantages, officer attitudes, and diversion outcomes relating to CIT programs. Findings indicate how Virginia's statewide implementation of CIT programs for officers, agencies, and systems, including how behavioral health and legislative structures interact with and affect law enforcement operations.

Various theories of policing and SIM support the assumptions that police discretion drives the improvement of safety and diversion outcomes, and CIT has transformed policing by reshaping LEOs disposition and discretion in situations involving MISUD. As a result, CIT advances public safety and diversion outcomes by transforming policing at the individual and organizational levels.

In general, CIT is a welcomed, necessary force of transformation within law enforcement with little disadvantages. LEOs have been the primary first responders for mental health crises, and CIT lets LEOs get people the help they need. However, CIT incorporates LEOs as a core component within Virginia's dysfunctional crisis services, and the shortage of services and providers places substantial amounts of strain on law enforcement.

Major Findings

Participants from all over the state indicated CIT trains officers on a specific set of skills and knowledge to enhance their ability to respond more appropriately during mental health crises. CIT achieves this by giving officers more tools and methods to choose from to improve public safety and connect people to crisis services. CIT minimizes the need for physical confrontation while emphasizing de-escalation and effective communication. CIT enhances crisis response by expanding officer discretion by adding response options (e.g., transport to services or a referral) and enhancing their ability to make informed, appropriate decisions.

The severe deficit in mental health services turned a health care issue into law enforcement's issue, and law enforcement inadvertently became the primary responders for mental health crises. The issue was that officers were not historically trained to recognize signs of mental illness or respond appropriately calls involving people with mental illness. Instead, officers learned through trial-and-error that traditional policing practices did not solve the

problems at hand. They would be called back a couple of days later after a person was released and in another mental health crises. Additionally, these calls were more likely to escalate because people with MISUD or in crisis were less willing to obey an officer's orders (i.e., the "tell" step of the "Ask-Tell-Make" approach). LEOs were trained and expected to handle the situation quickly, even if that meant going hands on to force obedience or compliance.

Arresting people for minor crimes was not effective, and the number of mental health calls was steadily increasing. Since traditional law enforcement training did not properly prepare officers to respond to cases involving mental health issues, physical confrontations, injuries, use of force, and arrest were more likely to occur. Furthermore, someone who was just arrested would be in crisis again right after being released. LEOs in Virginia began adapting the CIT model for their agencies after 2000 when they had more community partnerships, support, and resources. Officers and CIT Coordinators spread the program to other agencies by training other agencies' officers and helping those agencies develop their own CIT programs. Interview data indicates that agencies implement CIT differently. Some agencies appear to have a distinguished team of CIT Officers, who responds to specifically to mental health calls and recognized by a CIT patch on their uniforms, while others aim for all their officers to be CIT-trained. These agencies may or may not distinguish their CIT-trained officers from untrained officers.

Role Plays and Site Visits Most Valuable Parts of CIT Training

Officers described their agencies' CIT programs with a focus on training. They repeatedly named role plays and site visits as the most beneficial or memorable aspects of the training. They also emphasized that CIT centers compassion and relationship-building to successfully maintain safety and connect people to the proper resources. CIT achieve this by deemphasizing dominance, control, and compliance, which are emphasized by traditional

policing practices. Officers can choose to implement CIT skills to minimize the need for physical confrontation and maximizing safety. CIT integrates the following five competencies into the strategies, principles, and structure of law enforcement:

1. De-escalation
2. Communication
3. Compassion
4. Collaboration
5. Education on mental illness

All these competencies shape the skills, preferences, perceptions, goals, and values, and they are taught and carried out on the individual level. CIT officers become familiar with their community's mental health services and resources.

They also visit peers in recovery from mental health and substance use issues, and they exchange their stories and perspectives surrounding officer-civilian interactions. Chief Adam[146] [Chief of medium-sized police department with more than 30 years of policing experience] said, "the most helpful part of CIT is listening to the consumers firsthand at site visits. The most helpful part of hearing the consumers' perspectives. They're just trying to be functioning members of society." He is not a CIT officer himself because their agency is prioritizing patrol officers first, but more than 90% of their officers are CIT trained.

CIT training strengthens de-escalation and communication skills through daily role plays and increasing the difficultly of the situation over the course of the week. Participants remarked the site visits of health facilities and role plays were the most consequential components of the training.

[146] All names were changed using a random name generator to protect the identity of participants.

CIT Slows Officers Down on Calls

In addition to strengthening individual skills and knowledge, CIT normalizes the use of arrest alternatives, which regularly require more time, relationship-building, and communication to accomplish. Sheriff Alan, a CIT-trained sheriff of a small agency with 25-30 years of experience (LEO23), observed the shift within law enforcement:

> [CIT] changes the mindset of the officer. Before, if you don't know any different, you don't have the knowledge to help. […] [Nearly 30] years ago,[147] I would approach someone differently now than at the beginning if given the exact same scenario.

Officer James [CIT patrol officer at a large police department, LEO17], explained that the traditional mentalities were "ask them, make them" and "catch the bad guys." Officer James observed, "those mentalities have dwindled. [Officers] try to look for the root cause now." Looking for the root cause means LEOs need to de-escalate and communicate with the person in crisis to determine the problem they are struggling with. In the past, officers normally put the person into custody if they are being disorderly or non-compliant without investigating potential problems driving their behaviors.

Similarly, Chief Ryan [Chief of Police at a large agency with more than 30 years of experience, LEO14] shared how the lack of awareness lead to officers mistakenly treating people with MISUD as criminals. Chief Ryan explained, "Traditionally trained or untrained officers might go into a situation that they may interpret as violent and take the person into custody unnecessarily. […] A lot of charges can be brought based off strange behaviors." His claims were reflected in other LEOs responses, particularly among senior leadership.

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[147] The participant listed an exact number that may have been identifying. The reported number was rounded to reduce identifiability.

CIT-trained officers slow down during calls and aim for de-escalation. Slowing down allows officers to recognize which actions each situation call for. More than five participants specifically used the phrase "slows down" to describe how CIT has changed policing. As indicated by James, Alan, and Ryan, officers were traditionally trained to get situations under control as quickly as possible, as communicated in the "ask them, make them" description of traditional policing mentalities. The "ask them, make them" mentality refers to the "ask, tell, make" model for taking control of a situation and ensuring compliance. This method has been widely accepted and taught in policing academies and has since been associated with dominance, aggression, escalation, and conflict.[148]

CIT aims to increase safety by using cooperation and problem-solving to minimize resistance. The "ask, tell, make" model aims for compliance and control. The CIT model aims for cooperation and safety. Officer Walter [LEO27, CIT Officer employed at a small police department with 10-20 years in law enforcement] explained how slowing down relies on communication and de-escalation skills instead of physical force and said:

> It is easier to spend time talking to someone to get them to do what you want to do versus physically making them do what you want them to do. Talking can take about an hour to get them to voluntarily go. Even if you have to take them into custody, talking to them for an hour can make things smoother and quicker.

In comparison, several officers estimated that it takes less than 30 minutes complete an arrest. Although arrest is much faster, it is not the best solution in the long run. Captain Kelly [LEO4, a police captain at a large police department with over 20 years of experience in law enforcement] clarified how slowing officers down is better for people in crisis:

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[148] Stoughton, S. W. (2016). Principled policing: warrior cops and guardian officers. *Wake Forest Law Review, 51*(3), 611-676. https://heinonline.org/HOL/P?h=hein.journals/wflr51&i=637

> [CIT] slows them down and gets them to what the problem is rather than just putting on a Band-Aid […] Jail is the worse place for people with mental illness to be. Locking someone up is the easiest but not always the best answer.

In further detail, Major Jackson [a CIT-trained major at a midsized sheriff's office, LEO7] gave details on why arrest is not always the best answer:

> Before, [officers] would just take the drunk person to jail, and they would have to come back for the same person on another call. The right type of treatment can turn someone's life around. […] Another benefit is that it reduces the call volume because the people who need help won't need to call back over and over again. CIT trainings allow people to treat the source of the issue.

These examples support the finding that CIT has progressed law enforcement toward more effective, humane, community-oriented practices and principles, and that law enforcement experience more advantages by using less tactical approaches. It also supports how targeting the individual level and expanding discretion are fundamental to CIT's success. Every situation has its unique context, and every officer has their own set of competencies. CIT helps each officer do their job better, which is why most CIT-trained officers volunteered to complete the training.

CIT Enhances Crisis Response by Providing More Tools, Humanizing Law Enforcement, and Facilitating Community Collaboration

Participants overwhelmingly report favorable attitudes toward the CIT model because CIT integrates more compassionate, humane approaches into law enforcement's training and crisis response infrastructure. LEOs assert that CIT rehumanizes the profession of law enforcement and allows them to engage in more effective communication and collaboration. These findings indicate that traditional law enforcement models dehumanize both officers and

people in crisis, and CIT transforms policing by offering tools that humanizes both groups. CIT assumes that LEOs want to help people to the best of their ability, and CIT illustrates how much more effective de-escalation, connection, and communication are during calls compared to more tactical approaches.

According to participants, CIT equips LEOs with more "tools," and then, officers use these tools to effectively help cases involving people with MISUD. Jennifer (CIT Coordinator, 10+ years, CIT13) took her first CIT training course with LEOs more than 10 years ago. She realized that LEOs "want to keep people safe and help people" just like the people on her side of the mental health crisis. Now, as a veteran CIT instructor, she asserted, "law enforcement takes their job very seriously, and they're awesome students because they want to learn new things that they can actually use." With the number of mental health calls rising, CIT training also acts to confirm and expand upon strategies that officers traditionally learned through years of trial-and-error. Then, officers prevent wasting time and taking unnecessary risks or making easily avoidable mistakes. It is a reasonable method of improving officer and civilian safety and making a meaningful difference within one's community.

Several officers emphasized that CIT promotes the humanity of LEOs and people with MISUD. Captain Kelly (LEO4) acknowledged, "You forget that everyone is human… […] It makes people remember why they got in the job. It humanizes the job of law enforcement again." It indicated that officers feel detached from the communities they serve. Most officers entered law enforcement because they wanted to help people feel safe. Traditional approaches that emphasize compliance and control do not necessarily help people or make them feel safe; it stimulates resistance, hostility, and resentment from both parties. CIT gives officers unwritten

permission to take more time to help solve people's problems in a meaningful, collaborative way.

On humanizing mental illness, Captain Carl [Commander in a midsize police department for over 10 years, LEO2] said, "[CIT] humanizes mental illness, more so than any other training up to that point. […] [Officers] are more equipped to ask better questions" and respond more appropriately. For example, CIT officers may ask someone if they take medication and if so, have they been taking it as prescribed. They may also ask if they are seeing any mental health clinicians and use basic active listening techniques to learn more. Since CIT officers work closely with mental health professionals in their community, they often know who to contact or where to take the person in crisis in their community.

CIT bridges the mental health and law enforcement professionals by creating and maintaining community partnerships. Sheriff Daniel explained, "We work very closely with mental health. […] We are very connected with community, mental health professionals, substance use providers and courts. There are a lot of options. It's not jail or no jail [anymore]."

Officer William (CIT Officer and Instructor at midsize police department with over 10 years of experience, LEO18), said, "Marcus Alert requires what CIT is already doing, which is promoting collaboration between mental health agencies and law enforcement." Collaborations between behavioral health providers and law enforcement are essential to the success of CIT and similar programs, such as Marcus Alert.

These results indicate that traditional law enforcement models dehumanize people with MISUD and officers. Programs like CIT and Marcus Alert transform law enforcement response by cultivating connection and compassionate in officer-civilian interactions.

Most Favorable Outcomes Were Voluntary Transports and On-Site Resolutions

CIT authorizes law enforcement crisis response to include voluntary transport, involuntary transport (i.e., Emergency Custody Order), and on-site resolution as alternatives to arrest. Officers overwhelmingly agree that the ideal outcomes for mental health calls were either voluntary transport or on-site resolution. This finding demonstrates that officers' valued safety and respect more than compliance or control, and CIT-trained officers choose the less restrictive options to the best of their ability. Typically, CIT-trained officers de-escalate a situation, communicate to find the root problem, and negotiate the pathway to evaluation, if warranted. Sergeant Janet [police sergeant employed by a midsized agency with about 20 years of experience, LEO9] explained:

> CIT and de-escalation training helps them minimize the amount of time [spent] on calls-for-services, especially if they can generate voluntary compliance. There is a lot of paperwork involved when making arrests or using force. It trains them to take an extra moment, listen, work together, and build rapport. When someone is in crisis, it's likely that the officer will see them again, so this builds the trust between the [person in crisis] and officers.

However, officers are generally required by law to place a person in custody during voluntary and involuntary transportations. A couple of participants expressed that putting an individual in custody still felt like they were treating people with MISUD as criminals, but they had no choice because of protocol. Additionally, LEOs must wait until mental health providers determine whether a person needs intensive inpatient care. If a psychiatric bed is needed, officers transport them to the next open psychiatric bed in the state.

For on-site resolution, a mental health call is resolved at the site of the call-for-service. Officers do not have to place a person in custody or transport them for immediate evaluation. This is more typical if the person has less severe or non-life-threatening symptoms. One officer expressed that as the most ideal outcome because officer transportation and institutionalization tend to be counterproductive. Calls are resolved at the officer's discretion; however, officers cannot legally conduct mental health evaluations.

Resolving mental health calls becomes more effective when mental health providers can provide their skills and services on-site. According to Captain Kelly (LEO4), "the person is assessed in their house rather than a facility or jail." His agency had an operational Mobile Co-Responder Team, which LEOs and mental health providers partner together to respond to mental health and follow up calls. The mobile team has been so successful that his agency's goals "changed from jail diversion to civil commitment diversion." The only people with MISUD that go to jail are those who have committed a violent felony, and with improved access to mental health services in jails, those people can still get more help than they have in the past.

These findings indicate that CIT may give LEOs competencies that enhance their abilities to help people; however, the extent of their choices and abilities may be determined by their community's resources.

CIT Promotes Public Safety

First and foremost, CIT was designed by and for LEOs. LEOs supported and promoted the benefits of CIT skills and strategies, and they helped neighboring agencies develop their own programs. CIT skills, such as de-escalation, improved officer safety and reduced the number of officer injuries and use of force incidents. LEAs were promoting the framework to other agencies and state lawmakers. In 2009, the Virginia General Assembly enacted legislation

requiring every jurisdiction to join or develop their own CIT programs. Sheriff Daniel [sheriff of large agency with 10-20 years in law enforcement, LEO24] started his agency's CIT program, and there was way less resistance than he expected. He explained, "the overwhelming majority of officers see the benefits. [It is a] well received program."

A major benefit of CIT was the widespread use of de-escalation and communication skills promotes safety for officers and civilians. De-escalation drastically improves safety by reducing the physical officer-civilian interactions. Officer George (LEO1) observed that CIT skills "benefit officers in any situation that needs de-escalation or involves crisis." When officers avoid the use of physical coercion, the person in crisis is less likely to put up a fight or struggle. In other words, de-escalation reduces the risk of a physical altercation and injuries during officer-civilian interactions.

The majority of participants said CIT improved public safety by minimizing physical confrontation. Replacing force with communication and empathy meant more people received the help they need. Officer Walter (LEO27) found that connecting people to treatment "generally reduces the crimes associated with mental health or substance use issues."

In contrast, Captain Mark is a CIT-trained commander at a small-sized sheriff's office with over 20 years of law enforcement experience (LEO22), and he disagrees:

> It may help individuals but not overall public safety. They need to push a lot of funding. Smaller agencies need help with recruiting and retention. They can barely handle the caseload as it is. Now, they focus so much resources on mental health calls. They don't have the resources, budget, or manpower.

Mark motioned to the practical limitations of CIT caused by the growing volume of mental health calls and unprecedented deficits in crisis evaluation and treatment services. Although CIT

may improve public safety, some agencies simply do not have the time or capacity for de-escalation. This indicates that CIT operates under the assumption or is only realistically operational when a minimal threshold of available crisis services. More information on these limitations is listed below under additional findings.

Debate Over Making CIT Training Mandatory for Every LEO

Officers and CIT Coordinators brought up the debate around mandatory CIT training in Virginia. On one hand, the DBHDS recommends each agency should train 25% of their police force. Voluntary participation in CIT training is viewed as a core component of the CIT model, and the goal of CIT is to create a specialized response team. On the other hand, some officers, especially those in senior leadership positions, believe every officer benefits from participating in CIT training. They want to make (or have already made) the 40-hour training mandatory for the entire agency.

The two sides disagreed upon the application of CIT skills. Both agreed that crisis response is contingent on officer-level characteristics; however, one side argues all officers are not meant to be CIT officers. Effective CIT officers need empathy, excellent communication and people skills, and effective personal coping strategies. Not every officer possesses or can learn those qualities. Officer Michael (CIT-trained Resource Officer in midsized agency, 20-30 years in law enforcement, LEO25) observed, “Not every officer needs to be a CIT Officer. […] To be a good CIT officer, you have to have empathy. LEOs are human, and not all humans don’t have empathy. We all have our own specialties.” His perspective indicates that officers possess various levels of compassion, and each officer has their own specialties. At least two other participants identified a difference between CIT and SWAT officers as an example for this

argument. They claimed that CIT and SWAT officers operate in roles that play to their distinct strengths and personality characteristics.

The other side argues that learning about signs of MISUD, communication, and de-escalation benefits all officers, and all officers should complete the basic CIT training. Although the state does not mandate every officer to be CIT-trained, some agencies require all sworn officers to complete the training. Typically, mandatory CIT training is an unofficial policy, and officers are "voluntold" to participate. At least five distinct agencies in this study reported that 100% of their officers completed the basic CIT training. Chief Steve (Chief of Police for small department, over 30 years in law enforcement, LEO8) said:

> …Mandatory CIT required by the state is the right move for law enforcement…many agencies did not mandate the training. Mandating the training is going to help the profession of law enforcement a great deal by giving officers the resources and skills to handle mental health calls.

Several officers made a comparison between CIT and negotiation units. They compared de-escalation and communication skills with negotiation skills. CIT officers need to be good communicators.

Law Enforcement Want Out of Mental Health Crisis Response

Surprisingly, LEOs argued that they should not be involved in mental health crisis response. Sheriff Alan (LEO23) explained, "[LEOs] are not mental health experts, even after CIT training. CIT is not a magic wand. It's not a quick fix." It was surprising to find that many participants described the situation akin to being trapped or unwillingly tied to the responsibility of crisis response. Deputy Police Chief Keith (LEO10) depicted the disadvantages of relying on police for mental health crisis response:

> Without the clinician, the person has to be put into handcuffs and transported for the screening. It brings stigma and embarrassment, and shame. Then, it becomes adversarial from the point on. With the clinician, it can avoid looking like one is being arrested, so they can get farther and do much better. […] [I want] to dis-involve the police in mental health matters, so community teams are involved rather than police."

Currently, Virginia policy authorizes "only the police [to] take someone to an involuntary committal for an ECO or TDO." These examples show that those with the authorization and training to evaluation and treat mental illness are prohibited from responding and transporting people with MISUD. State policy has locked law enforcement as primary crises responders. Chief Jimmy [Chief of Police of small department, more than 30 years of experience, LEO8] vented:

> There has been a lot of talk but little action or money towards making that change. Police are still the primary responders to mental health. Until the state gives them the funds or resources for specially trained first responders, it will continue to be insufficient.

Officers recognize they do not have the proper mental health training. It is a behavioral health issue; it is not a law enforcement issue. However, the statewide mental health crisis worsens when lawmakers diminish funding into mental health services despite staffing shortages and escalating mental health crises. Chief Wayne (Chief of Police at small department with 20 years of experience in law enforcement, LEO26) said: "If law enforcement could get out of the process with mental health crisis, they would get out of it tomorrow. They are the only people tasked with responding."

Recognizing Limitations of the CIT Model

Officers feel like CIT costs more time, staff, and resources to implement, which results in practical limitations. Substantial limitations that hinder the diversion process can build up frustration and resentment among LEOs and CIT Coordinators who want and know how to help people with MISUD. Without a threshold of beds, most cases cannot get help and end up waiting for days for one bed to open. While CIT is significantly changing policing, it has also pushed LEOs to advocate for the complete disinvolvement of police in mental health response. LEOs in Virginia perceive signs of MISUD as being sick or in crisis, and it is inappropriate and ineffective for LEOs to be involved in behavioral health issues. Transportation and waiting days for assessment becomes counterproductive.

The most effective CIT program has access to the proper number of mental health resources, so LEOs do not have to waste time waiting for beds to open. CIT programs may continue to promote safer strategies and skillsets among officers; however, insufficient crisis services defeat the purpose of CIT: prearrest jail diversion and connecting people to the proper resources.

Officers and CIT Coordinators blame policymakers for the current crisis. Lawmakers' chronic underfunding in behavioral health services has resulted in severe service and staffing shortages. Furthermore, participants acknowledge that LEOs are not trained to evaluate or treat mental illness, and they want mental health professionals to respond to crises and mental health calls. While officers appreciate CIT training, they are wasting time when they have to wait for days for each behavioral health crisis. There are simply not enough mental health workers or crisis centers to evaluate and treat people with mental health needs. For one agency, the strain of mental health calls has reduced their capacity to enforce traffic law violations and minor theft.

Deputy Chief Keith [Deputy Chief of Police at large department with more than 15 years of law enforcement, LEO10) similarly said, “it takes 30 minutes to arrest someone for a minor crime […] for a civil commitment, it takes hours to days.” Staffing and bed shortages have caused significant strain and limitation on LEAs and officers. The following paragraphs summarize the most urgent limitations reported by participants.

Shortage of Health Crisis Services Hinders Law Enforcement Crisis Response

Psychiatric bed shortages, insufficient mental health workforce staffing, and poor access to crisis assessment centers make jail diversion options more time and resource intensive. Officer William (LEO18) explained that “state hospitals aren’t even at full capacity, but they can’t take more patients because they don’t have anyone to work because no one wants to do it for low pay. […] getting attacked is a part of the job.”

Nearly all participants mentioned mental health service shortages. The shortage of psychiatric beds was typically referred to being a “crisis” or a “broken” mental health system. The greatest evidence to support this claim are the long waiting and transportation times to connect people to proper available resources. Most participants complained about the excessive time spent waiting for open psychiatric beds up, and it is common to wait up to three days (See Table 4.1). Long waiting times meant officers were off the street to the detriment of the officers and the people they are supposed to be helping.

Table 4.1 *The Severity of Psychiatric Bed Shortage: Quotes from LEOs*

Participant	Agency Size	Example Quote
Lieutenant (LEO6)	Large PD	Mental health services are "almost not an option... You can't help people without beds"
Major (LEO7)	Midsize SO	"The cost of no beds is losing response coverage to the public. Instead of responding to calls, LEOs are spending their entire shifts waiting at the hospital for a bed with the person in crisis"
Police Chief (LEO8)	Midsize PD	"An officer has to stay with the person waiting for the evaluation. Sometimes up to 48 hours. If the person needs to be transported, the [officers] transport them to the only bed empty in the state […] One officer can spend their entire shift waiting at the hospital." His department only has 6 to 10 officers working during a shift, and they have 1 to 4 mental health calls a day.
Sergeant (LEO9)	Large PD	"The issue is staffing and the amount of time required for mental providers to obtain beds. People with ECOs and TDOs are waiting for beds much longer than 12 hours in state hospitals or private institutions, so the issue lies with the mental health process […] officers are sitting their entire 12-hour shift at the hospital waiting for beds."

Deputy Police Chief (LEO10)	Large PD	"It used to take 3-5 hours, but now, with COVID, it takes days to get clearance […] the police get caught up in this medical clearance game. The person who is waiting is now agitated and has to wait up to two days while sitting in the ER, eating lunch out of a box, off their medication, experiencing their mental health symptoms… these nightmare cases are a ticking time bomb before they try to walk out and have to be restrained."
Police Chief (LEO11)	Midsize PD	"They receive thousands of calls per month, and they don't have the time or staff for community policing. The wait times for ECOs and TDOs are crippling because officers can be waiting for 2 to 4 days for an available bed. They can spend multiple shifts (2 days) at a hospital, waiting for a bed to open. The number of beds has decreased. The whole ECO/TDO process is time consuming. This negatively affects the consumer, especially those in crisis."
Captain (LEO15)	Midsize PD	"Bedspace greatly decreased after closing the state hospitals. A person will stay with an officer for 3 days instead of getting treatment"
Sheriff (LEO23)	Small SO	"They spend hours and days guarding TDOs and ECOs. It's not the best for the individual"
Investigator (LEO27)	Small PD	"The disadvantage is time. Departments are stretched thin on personnel. When [an officer] spends an hour talking to someone,

calls are backing up. Thankfully for us, we aren't as busy as bigger cities, so it doesn't back up too bad."

To clarify, LEOs did not name CIT programs as the issue. Many participants said there was no disadvantages of CIT. Instead, participants attributed these major practical limitations and costs to ineffectual policy choices which is linked to the severe deficit of mental health crisis services and providers. Currently, officers are required by law to supply transportation to facilities and monitor the individuals who are likely experiencing psychological distress or dysfunction. One mental health call may last up to six consecutive 12-hour shifts if beds in the state are at full capacity. Across participants, LEOs emphasized how calls last up to three days simply on waiting for an open bed. The State Hospital Census tells us that bed utilization rates are over 100%.[149] Chief Ryan (LEO14) oversees a large police department and mentioned the need for crisis centers more than five separate times. By setting up more crisis receiving centers, CIT officers can perform a warm hand-off to trained mental health professionals.

While participants reported that CIT does not have any major disadvantages, CIT cannot be fully implemented due to bed shortages and underfunding of mental health services. To the dismay of LEOs, mental health workers, and people with MISUD everywhere, this indicates that CIT operates under the false assumption that an adequate amount of mental health services are available. Several participants repeated that the number of mental health crises, ECOs, and TDOs dramatically increased after the COVID-19 pandemic. Ultimately, LEOs cannot connect people to mental health services if there are not enough services to connect them to. The benefit of CIT under these conditions is that CIT strives to minimize any harm experienced by officers and civilians in crisis.

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[149] Land, A. (15 July 2021). *Update on State Hospital Bed Census and DBHDS Initiatives* [PDF slides]. Joint Subcommittee to Study Mental Health Services in the 21st Century, DBHDS. https://studiesvirginiageneralassembly.s3.amazonaws.com/meeting_docs/documents/000/001/048/original/Presentation._DBHDS_7.15.21.pdf?1626296968

"Band Aids on a Gaping Wound" – Perspectives from a CIT Coordinator

LE did not ask for this. It happened because of the deinstitutionalization of mental health facilities. When people didn't have services, they ended up on the streets and it become a criminal law issue rather than a health one. They have lost over 200 mental health beds in the last 15-20 years. Lack of equity. […]

Cases among kids are exploding and are basically being incarcerated at the hospital. There are more mental health crises among kids. The percentage of calls and ECOs for juveniles is growing rapidly. From social isolation to disconnect from schools to anxiety, the lack of mental health support, services, and training in schools is horrific. […] [Marcus Alert] has to be properly developed and funded in the proper way. Right now, there is such a loss of staffing in all fields from law enforcement to nurses to counselors to social workers to first responders.... It needs to be implemented and funded correctly. Right now, they are only **putting band aids on a gaping wound**. […]

The way the system works means law enforcement respond to mental health, which is *crushing* them. They may have to hold an individual for days because there are no mental health hospitals. Law enforcement is being completely burned by ECOs because human beings are being held for a medical issue. […]

CIT needs to develop a better crisis response system. Instead of calling 911, we call 988. If 911, it can be transferred to a mental health line, and most can be handled over the phone, or they can be referred to services. If there needs to be a response, there can be a mental health crisis response team. Instead of jail or hospital, they can go to a crisis center that can't refuse them. […]

Marcus Alert wants [police] not to respond, but Marcus Alert doesn't change incidents that can't be de-escalated. The state would need to double the current mental health budget to meet the same equity of amount of money they are making at the gross national level. Legislators don't want to raise taxes. This is a public health and medical issue. As serious as cancer. As serious as COVID and opioid crisis. - **Chris the CIT Coordinator (CIT12)**

CIT is More Expensive and Less Efficient for Small, Rural LEAs

Related to the practical limitations of CIT, the time and financial costs of sending officers to the basic training and conducting transportations often overwhelm smaller or more rural agencies. In consequence, smaller agencies have experienced less change and are more likely to follow traditional policing models. As Officer Williams puts it, "those little agencies don't have the financial capability to send an officer to a 40-hour course."

Chief Randy [CIT-trained Chief of Police at midsize agency with 20 years in law enforcement, LEO20] and Chief Ryan (LEO14) share that they must pay their officers overtime while they are attending the CIT training, which is a significant financial cost. In fact, the financial costs of sending officers to training were one of the only negative aspects that Chiefs Randy and Ryan mentioned.

Officer William (LEO18) shared that his agency also offers salary increases for if officers "attend a certain amount of training and years of experience." Agencies need resources to train people. Smaller agencies may only have up to a few sworn officers during a shift, so they do not have the time and money to send an officer to a 40-hour, weeklong training. As a result, the financial and time costs of CIT training places smaller agencies at a greater disadvantage if they are not well funded. Chief Ryan said, "Smaller agencies don't have the ability to train their officers."

Impact of Bed Shortage on Law Enforcement

[Officers] are not clinicians or providers by any means […] When you take someone into custody for their mental health evaluation, if they need further care, officers are stuck waiting with someone for days. It's not the best person someone needs when they are in crisis or for officers. […] When it comes to mental health in Virginia, it's a **band aid on a wound**. To stop the crisis, we need a much bigger band aid. We need less wait time for evaluations, more clinicians, more bed space. If you were to experience a mental health crisis and taken into custody, you may have to wait for 24-48 hours with an armed officer in a packed emergency room. More often, people are worse than when they come in. By code, after bed availability is checked, the default is the state hospital. Now, the state hospitals are not taking them. They are doing two spot ECOs. If you don't have a place to put someone, they are TDO'ed without a destination, and [officers] have to babysit them. […] It's a much bigger issue at the state level with mental health. I don't even know what a price tag would be to fix this issue." Said the **Police Chief of a small department (15-20 years of policing experience)**

CIT Does Not Always Work

The interviews revealed that safety is the number one priority and fundamentally determines how officers respond. LEOs cannot use CIT skills in every situation, particularly in situations that cannot be de-escalated or situations involving weapons or violent felonies. Officer Michael (LEO25) has been involved with CIT for over 15 years and repeatedly emphasized officer safety specifically as a basic component of the CIT training. Major Jackson (LEO7) explained, "If someone is combative, a danger, or has weapons, you are more likely to take them into custody because they pose a threat." However, Major Jackson also repeated that the top priority of CIT is to help a person, and CIT helps reframe potential threats as opportunities to identify the source of the problem. Although CIT is widely applicable, it is not universal. Captain Kelly (LEO4) said, "Sometimes, you have to take someone to jail. That's just what it is."

Another limitation is that the policies does not work for chronic returners or people who lack long-term recovery services, housing, or familial support. Officers discovered that there is also a cycle between mental health crises and inpatient psychiatric hospital for some folks. Individuals who LEOs often interact with are called returning callers or chronic returners. They prevent these individuals from ending up in a correctional facility, and they end up building rapport with reoccurring callers. Major Jackson (LEO7) articulated, "the goal is to stabilize, but after 3 or 4 times of stabilization, we need to reevaluate a person's treatment." To the frustration of LEOs and providers, there is not much more they can do to help chronic returners due to policy and resource limitations. CIT at least helps with building rapport, so these calls go more smoothly.

Chapter 5: Discussion

Implications

This study investigated CIT's impact on LEOs on the individual, agency, and state levels, particularly in relation to aggression, strain, legal power and authority, and policing culture. These mechanisms explain how greater levels of anticipated and actual strain and stress make officers more sensitive to perceived threats and displays of aggression. The results of this study provide support and add context to the previous findings on CIT programs, which tend to focus on CIT's effects on officer-level outcomes (e.g., individual perception, decision-making, attitude, and crisis response outcomes). Participants support that CIT improves officers' knowledge and attitudes about MISUD, and CIT trains officers utilize on-site resolutions, referrals, and transports to mental health services in alternative to arrest.[150] This indicates that CIT reduces aggression and strain while expanding legal power and authority beyond the traditional scope of law enforcement. Findings also indicate that CIT training changes the law enforcement subculture within individual agencies and their larger network by adjusting the unwritten rules of policing response.

Virginia requires local law enforcement in the state to implement CIT. Officers endorse the CIT model improves safety and diversion outcomes by enhancing police discretion. CIT equips individual LEOs with competencies and skills around individuals with MISUD and crisis response, and police are authorized and encouraged to their discretion to divert people from the criminal justice system and connect them to the proper resources. CIT could be said to improve

[150] Watson, Corrigan, & Ottati, "Police Officers' attitudes toward and decisions about Persons with mental illness;" Compton et al., "The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Officers' Knowledge, Attitudes, and Skills;" Compton et al., "The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest;" Teller et al., "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls"

mental health jail diversion outcomes by expanding the parameters defining effective, appropriate law enforcement. CIT empowers officers to enforce the law in ways other than arrest and physical coercion. Since CIT is implemented on the state level, CIT should adjust more than individual officers and agencies. Virginia's CIT programs should have substantial effects on formal law enforcement policies and more importantly, the unwritten rules of policing across the state of Virginia.

CIT programs are unique in Virginia because every locality participates in CIT. This provides an opportunity to observe the complex, dynamic interactions between law enforcement, behavioral health systems, state and local governments, and other institutions. An essential component of CIT are formal partnerships with behavioral health providers and community organizations, so implementing CIT at the state level also establishes statewide infrastructure for collaboration and coordination between the law enforcement and behavioral health systems.

First, law enforcement embraces CIT because CIT skills and strategies enhance officer and civilian safety, connect people to the proper medical resources, and reduce the amount of returning callers. CIT programs also increase levels of community trust and rapport with local police departments and sheriff's offices. Another advantage is that CIT skills and strategies are applicable in any situation that requires de-escalation; it works beyond behavioral health crises. One officer said he used CIT skills at home to de-escalate family arguments. This indicates that CIT has a widespread impact on policing approaches, and officers want to become CIT-trained to learn how to de-escalate all situations.

Second, CIT assumes that most officers strive to uphold safety and serve people who need help, so it expands officers' skills and knowledge to handle crises more effectively. This indicates that police discretion affects public safety and diversion outcomes. It appears that CIT

is successful because it reduces ignorance and stigma surrounding MISUD by equipping and empowering LEOs with the proper skills, knowledge, and strategies. Participants add that CIT improves safety in present and future situates because CIT skills aim to minimize the risk or need of physical confrontation and build rapport. CIT emphasizes safety, connection, and compassion and deemphasizes compliance and dominance. As a result, officers are less likely to perceive people with MISUD as threatening or suspicious and act less aggressively towards them. This means that LEOs are less likely to arrest them or use force.

Additionally, the importance of police diversion in the CIT model indicates the value of programs targeting Intercept 1 in SIM. While Intercept 1 traditionally applies to just the criminal justice system, some participants revealed that their agency's goal was to divert individuals from any institutional facilities, which included state psychiatric hospitals. LEOs also possessed the ability to refer civilians immediately to local resources, which increases access to services.

Third, personal safety is one of the strongest factors influencing officer discretion. Since CIT targets police discretion to promote diversion, CIT trainings emphasized the importance of officer safety. Contrary to traditional policing models, senior officers discovered that CIT drastically reduced the risk of officer injury and use of force incidents. A more personal, compassionate, communicative, and problem-solving approach promoted compliance from civilians more effectively than physical coercion. By minimizing physical confrontations, officers made situations safer for everyone involved and simultaneously, the rates of arrest, use of force, and officer injuries declined. However, several participants argued that CIT skills should not be taught to officers without at least one year of experience because it risks their safety. They would not know when CIT should not be used. Every case is different, but one established rule is to not use CIT in cases involving weapons or violent felonies.

Fourth, CIT rehumanizes the profession of law enforcement by emphasizing de-escalation, cooperation, and safety. CIT reinforces the principle that every call and situation is different, so every response needs to be tailored to the situation using communication. It normalized spending more time to de-escalate and find the source of the problem. CIT also authorized and standardized the use of arrest alternatives and strategies for situations involving mental health issues. Traditional policing approaches tended to escalate situations involving mental health or substance use issues into conflict. Offices realized now that jail is typically the worst place and the "Ask-Tell-Make" approach is a counterproductive, escalated approach in situations involving crises and mental health issues. In contrast, CIT calls for more cooperative, mutual power dynamics where officers see and talk to the people with MISUD on a personal level.

Perhaps paradoxically, the success of CIT depends on the availability of behavioral health services, and there is a severe deficit of services. The increasing shortage of behavioral health services and growing number of mental health calls overstrain law enforcement's times and resources. This indicates that CIT operates under the assumption that adequate crisis services are available. The most successful CIT programs seemed to have access to crisis response centers or CIT assessment sites where officers could hand off consumers to the mental health providers. Many participants mentioned their agency was trying to establish crisis centers in their area to reduce waiting and transportation time.

The issue law enforcement faces today is that officers cannot connect people to services if there are not enough services or providers to connect them to, and the actual crisis in CIT is the lack of access to mental health services. CIT may have emerged as a crisis management model to mitigate the impact of the deteriorating behavioral health system on law enforcement safety and

resources. This approach hopes to reduce the total number of mental health crisis calls, number of returning callers, and correctional costs in the long-term. However, most localities in Virginia are mental health provider shortage areas, a problem compounded when COVID-19 overwhelmed state hospitals. Behavioral health facilities and LEAs experienced unprecedented levels of staffing vacancies. As the extent and effects of staffing shortages worsen, officers cannot effectively divert individuals

Although LEOs explicitly attribute CIT for improving safety and diversion outcomes, CIT programs are a band-aid for a broken mental health system. Law enforcement officers and CIT Coordinators overwhelming agreed that law enforcement should not be responding to mental health crises. They are not trained, nor did they sign up to be mental health providers. Even now, active sworn officers in full uniform are not the best people to be waiting with people in a mental health crisis for up to three days.

Overall, these findings support that the CIT model positively impacts more than individuals with untreated MISUD or experiencing a crisis. CIT has evolved the culture and structure of law enforcement by integrating more collaborative and humanitarian values, strategies, and skills. As crisis services change over the next few years in Virginia, CIT may expand to include civil commitment (institutional) diversion as the state invests more in community-based behavioral health facilities.

Limitations

The study is limited by data collection and analysis. There are no standard definitions or measures of CIT programs or jail diversion throughout the Commonwealth. CIT Coordinators and officers claimed the CIT reduced the number of officer and civilian injuries, use of force

incidents, and number of arrests among people with mental health issues. Then, they would clarify that was just their experience, but they did not have any numbers.

Another limitation is the effect of bias on the results due to self-selection bias in sample recruitment and participation. It is likely that officers and CIT Coordinators who were willing to be interviewed possessed specialized CIT program experience or held primarily positive perspectives of the CIT model. Self-selection bias reduces reliability of the results.

Nonverbal data was not collected due to the phone call method of interviewing. Although this restricted nonverbal data collection, it prevented the effects of stereotyping between the interviewer and participants. Gender and race are particularly salient identities in law enforcement due to it being a profession dominated by white men. Blind phone calls reduced the effects of social identities, and conversations and connections were easy to maintain.

Another limitation is the effect of social desirability bias, which is when a respondent responds in a way to appear socially acceptable to the interviewer. For example, many participants used the phrases “CIT slows officers down” or go “hands on” to describe LEO crisis responses. The meaning and details of these phrases were unclear until one participant explicitly described that CIT encouraged officers to introduce themselves by name, take the time to listen to the person in crisis, and not use physical force to make them comply.

Finally, data collection and analysis may be limited by the interviewer’s early learning effects with a sample of this size and with law enforcement officers. However, as the findings we can draw from this study indicate – whatever their qualifications and limitations – this subject demands better systemic efforts to systematically collect data at the program and state levels, so that future research can more thoroughly explore the key questions raised.

Future Research

Qualitative data will continue to be crucial for understanding contextual evidence and the influence of CIT on various ecological levels of law enforcement. Jail diversion outcomes and officer attitudes may be affected by their agency's culture, norms, partnerships, and resources. Their individual attitudes and behaviors may also be influenced by their personality characteristics, years of experience, and coping or self-soothing skills. Personality characteristics could be collected using scientifically validated and reliable personality surveys, such as the Big Five Personality Test.

Future studies could also investigate language among officers when describing calls involving mental health issues. Throughout the interviews, most officers used passive voice to describe calls. It would be interesting to investigate officers' sense of responsibility and ownership in how physical force and violence are used during calls. Vague language and coded narratives may mitigate feelings of guilt or accountability that officers would normally feel.

More interviews should be conducted and analyzed with law enforcement officers from wide range of positions and CIT experience. Furthermore, CIT operations and its effects may be affected by or interact with mobile co-response teams and the Marcus Alert System.

There is a need for quantitative research to assess the effects and outcomes of CIT programs on arrest, safety, and health outcomes. Standard measures of jail diversion are needed to conduct reliable, valid data analysis. Future studies may be implemented by developing a standard survey and requesting data directly from agencies. Optimally, these performance metrics would be clearly defined and collected by the state, and the data would be open to the public. Jail diversion outcomes may differ between agencies depending on agency size, access to resources, staffing capacity, and cultural norms or expectations. Currently, the Virginia

Department of Justice collects arrest data, so future research could measure the effect of the statewide mandate of CIT on arrest rates by comparing arrest rates before and after 2009.

Several CIT-trained officers, including those in senior command positions, shared they were only able to offer "anecdotal" evidence on the impact of CIT. The lack of data collection indicates insufficient monitoring and measurement of CIT programs across the state. Data collection was stated as an essential element for CIT programs in Virginia by DBHDS, Department of Criminal Justice Services, and Virginia CIT Coalition. Significant quantitative data limitations indicate an urgent need to establish systematic, state-driven data collection practices that allows for rigorous evaluation of CIT programs and their success.

Chapter 6: Conclusion

Federal and state governments nearly eliminated all state psychiatric hospitals. For decades, they neglected to properly replace these mental health services or establish a new safety net. Decades of serious deficiencies in behavioral health services and neglected mental health needs accumulated into a national public health crisis. Without mental health providers available for mental health crisis response, LEOs then became obligated to serve as the first responders for mental health crisis. Before CIT, LEOs in Virginia received no formalized de-escalation training or how to recognize signs of MISUD. Without these skills, LEOs commonly perceived these signs as dangerous or exhibiting criminal behavior. For this reason, they treated people exhibiting signs of MISUD as criminals, and traditional policing approaches to mental health crises became increasingly ineffective.

When the Memphis CIT model emerged in 1988. this new law enforcement framework was designed to anticipate and mitigate the short-term and long-term effects of the behavioral health crisis on law enforcement. CIT fundamentally modified law enforcement practices by

integrating more appropriate, collaborative, and informed policing practices that simultaneously enhanced efficiency and public safety. Officers learned that the traditional tactical approach was both harmful and ineffective for promoting public safety in situations involving MISUD. CIT-trained LEOs to properly recognize and respond in these situations and added basic mental health education, de-escalation, and transportation for mental health evaluation and treatment to law enforcement's responsibilities and training.

The success of CIT and law enforcement-led advocacy efforts led to the statewide mandate requiring all LEAs and CSBs to participate in CIT in 2009. As of 2022, LEOs and CIT Coordinators report that LEOs widely support CIT, and CIT has significantly enhanced officer and civilian safety and the standards of policing. However, the absence of standard data collection protocols on CIT outcomes across the state inhibits any attempt to reliably measure CIT's success and find evidence to support participants' claims.

Although CIT is typically referred to as a crisis intervention model for individual-level situations involving behavioral health crises, interview data suggests that the CIT model is more similar to a crisis management framework to mitigate the impact of a systems-level behavioral health crisis on law enforcement. The behavioral health system crisis adversely affected traditional policing practices and people with substantial unmet behavioral health needs, which impacted crime rates, public safety, and access to proper health care. As mental health services in Virginia continue to be severely underfunded, and shortages of crisis assessment services and psychiatric beds is overextending law enforcement's limited resources and staff. While there have been added benefits of these skills, law enforcement agencies do not have the staff and resources to sustain behavioral health crisis response in the long term.

The recommendations below offer strategies for the Virginia General Assembly and LEAs to enhance support for police-based mental health crisis response:

1. Continue promoting and normalizing CIT skills and strategies as a new standard in law enforcement practices.
2. Assist small and rural agencies in training at least 20% in basic CIT.
3. Increase the availability of psychiatric beds to alleviate the growing practical strain on law enforcement's staff, time, and resources.
4. Strengthen workforce development for mental health services by expanding recruitment and retention initiatives, such as offering pay, benefits, and total loan forgiveness programs that are competitive with private providers.
5. Standardize data collection and evaluation procedures regarding CIT program outcomes at the local and state levels, so behavioral health and law enforcement initiatives can be appropriately evaluated and adjusted for success.
6. Allocate considerable amounts of federal and state funding towards authorizing and preparing mental health providers to be the primary responders for mental health crises, so officers only may be involved when necessary for maintaining the safety of the situation.

These recommendations were necessary before the COVID-19 pandemic. After 2020, pandemic-related stress and isolation exacerbated mental health issues and substance use worldwide, worsening the crisis within Virginia's behavioral health system. The system's collapse revealed the CIT model is not designed to be a long-term, ample solution to the behavioral health system crisis. Instead, CIT only offers temporary, superficial relief to law enforcement without addressing the true source of the problem: insufficient resources. Fundamentally, this study

exposes that CIT operates under the assumption there are sufficient resources available for LEOs to successfully connect people to. Without adequate services available, CIT becomes futile and costly. LEOs across Virginia expressed that the state's underinvestment in services impacts more than the individuals who need evaluation and treatment. They argued that the communities they serve pay a substantial cost because LEAs' and local emergency departments' capacities shrink as the behavioral health crisis grows more dire. LEOs are forced to devote less time and effort to responding to other calls-for-service and crime response.

From the perspective of LEOs, CIT has drastically improved public safety and the profession of law enforcement overall; however, CIT-trained LEOs and CIT Coordinators strongly assert that LEOs should not serve as first responders for behavioral health crises. While most participants found no disadvantages in the CIT approach, they also indicated that officers are not trained, nor did they sign up to be mental health providers. CIT programs operate as a band aid for a collapsing mental health system. As long as the federal and state government avoids investing in meaningful systemic transformation, LEOs, people with MISUD, and their communities will all continue to incur the escalating costs and burdens caused by decades of poorly resourced mental health services.

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