Street-Level Bureaucrats Defining, Responding to, and Negotiating Trouble:
CIT Officers’ and Mental Health Professionals’ Experiences in Defining and Responding to Crisis Situations with the Mentally Ill

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This thesis titled

Street-Level Bureaucrats Defining, Responding to, and Negotiating Trouble:
CIT Officers’ and Mental Health Professionals’ Experiences in Defining and Responding
to Crisis Situations with the Mentally Ill

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ABSTRACT

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CIT Officers’ and Mental Health Professionals’ Experiences in Defining and Responding
to Crisis Situations with the Mentally Ill (83pp.)

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Drawing on data collected through a qualitative approach, this study explores the
interactional processes involved in informing definitions of mental illness and mental
distress between CIT officers and mental health professionals. CIT officers build
empathy towards individuals in mental distress while mental health professionals assign
individual responsibility for criminal acts. Subsequently, particular responsive strategies
are imposed to mitigate the crisis. Lastly, attention is then turned to how these public
service professionals negotiate definitions of severity and mental illness in attempt to
impose a one-sided mitigating response to the crisis. Consistent with other previous
research surrounding public service professionals and social problems, this study reveals
the contextual, interactional and structural processes involved in how CIT officers and
mental health professionals define, respond to, and negotiate mental illness.

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Generally, it’s the mental health professionals that are saying we need to deescalate this situation but the person with the mental illness is not exempt from the consequences for their behavior. In fact it may be a good idea, necessary in fact, for them to have consequences for their behavior either through legal charges or, you know, having some interaction with law enforcement. The law enforcement agency in Canter County as well as at the VA don’t necessarily agree with that. A lot of times VA police will say, ‘Sorry Erin we don’t want to charge this person. The prosecutor’s office is just gonna throw it out anyway because they’re mentally ill.’ That makes no sense, I think it’s important for me to tell you that it’s counterintuitive.¹

CHAPTER 1: INTRODUCTION

One of the most troubling issues facing our society today is the increasing number of severely mentally ill in the community and the lack of mental health resources to adequately treat them. These individuals often come to the attention of law enforcement officers because they are arrested and enter the criminal justice system. Today, jails and prisons have become de facto psychiatric institutions which further complicate the problem of overpopulation in correctional institutions. In response to this social problem, local municipalities and jurisdictions across the country have begun implementing Crisis Intervention Training (CIT) programs for law enforcement officers. This training gives officers the rhetorical skills to non-physically deescalate crisis situations with the mentally ill and link them with appropriate mental health services (Compton et al. 2008). This partnership between the mental health and law enforcement systems is critical for diverting mentally ill offenders away from the criminal justice system and into community-based mental health treatment (Compton et al 2008).

¹ In person interview with Erin Kline, treatment supervisor, Canter County Veterans Affairs Medical Center.
Law enforcement officers and mental health professionals, who are characterized as ‘street-level bureaucrats,’ are the front line workers in service delivery and implementing policy responsive to their clients’ needs (Lipsky 1980). These street-level bureaucrats have significant discretionary authority and strive to respond to the crisis with a strategy that aligns with their commitment to their careers, public service and the status quo (Lipsky 1980). It is the official responsibility of these professionals to troubleshoot the situation and determine an appropriate response to mitigate the crisis while also preserving the safety of all parties involved (Vermette et al. 2005; Emerson and Messinger).

During crisis situations, CIT-trained officers often turn to the expertise of other street-level bureaucrats or trained mental health professionals to assist in assessing and determining an appropriate response to mitigate the crisis situation. However, CIT officers and mental health professionals often have competing definitions of what constitutes mental illness and mental distress. These discrepancies between public service professionals on what constitutes mental illness and mental distress have placed considerable strain on this unique and interdependent community partnership.

The research on CIT largely focuses on evaluative articles that examine the effectiveness of the CIT program at mitigating crisis situations with the mentally ill and linking them with mental health resources. In a similar vein, the existing studies on CIT largely focuses on crisis intervention programs that follow the ‘Memphis Model’ with its training of specialized officers in large, monolithic departments that serve urban communities (Deane, Steadman and Morrissey 1998; Steadman, Deane, Borum and

However, very little qualitative research exists on the social and structural processes involved in informing CIT officers’ and mental health professionals’ definitions of mental illness and how these definitions shape particular responsive strategies when involved in crisis situations with the mentally ill.

The analytic focus of this study is to explore the manner in which CIT officers and mental health professionals apply their knowledge in conceptualizing definitions of mental distress and how these definitions influence particular mitigating responses when involved in crisis situations with the mentally ill. As illustrated in Erin Kline’s vignette, mental health professionals and CIT officers often conflict with regard to definitions of acute mental illness and how the crisis should be approached and remedied. Drawing from Lipsky’s (1980) Street Level Bureaucracy and Emerson and Messinger’s (1977) Micropolitics of Trouble, I examine the processes of how these street-level bureaucrats come to define mental illness or “trouble” and how these definitions influence particular “remedies” and delivery of services during crisis situations with the mentally ill (122). Furthermore, I examine how definitions between public service professionals are negotiated and reconstituted in attempt to impose particular responsive strategies.
Mental health professionals operate in a frame of reference towards individuals in mental distress that is uniquely different from CIT officers. One of the key findings from my research was that CIT officers described mental illness as a biological condition which warrants a therapeutic approach. Comparatively, mental health professionals regard recalcitrant behaviors associated with some mental illnesses as criminal behavior and a punitive response may be necessary. This is especially interesting since historically officers have been perceived to be more punitive and mental health professionals to be more therapeutic when responding to crisis situations with the mentally ill. Furthermore, broader structural factors have considerable leverage in how the crisis is defined as well as the direction and nature of the mitigating response. This study seeks to examine how CIT officers and mental health professionals come to define mental illness and the variable factors that affect these definitions and responsive strategies.

This study reports on findings from a qualitative study conducted on three Midwest law enforcement organizations and two mental health treatment facilities. This study builds on the sociology of social problems, mental health and public administration literatures by exploring how professionals from the law enforcement and mental health system define, respond to, and negotiate situations related to persons with mental illness.

First, I review current relevant literature relating to the micropolitics of trouble and how it influences and delimits the discretionary authority of public service workers. Second, I will address the methodological design used for this study and explain how data was gathered and analyzed. Third, I will provide a background of CIT describing the origin and development of the program. I will then move on to present my empirical
findings on how mental health professionals and CIT officers define mental illness; how these definitions facilitate either therapeutic or punitive responses and how definitions are negotiated and reconstituted between intervening parties. I conclude that how mental distress is defined and responded to is contingent on professional beliefs and broader economic, political and organizational commitments.

**Public Service Professionals and Micropolitics**

There have been many studies on street-level bureaucrats that examine how these public service workers process client services, determine program eligibility and solve complex problems (Giallombardo 1966; Jacobs 1974; Horowitz 1995; Ayala 1996; Leo 2001; Marks 2003). The concept of micropolitics of trouble is useful in examining the processes involved in how human service workers construct and respond to definitions of trouble (Emerson and Messinger 1977; Spencer and Mckinney 1983). This perspective offers insight to how these human service workers interpret, define and respond to social problems. CIT officers and mental health professionals are known as ‘street-level bureaucrats’ who have a high degree of discretionary authority in implementing institutional policy in order to meet the immediate needs of their clients (Lipsky 1980). These professionals which include police officers, mental health professionals, social workers and teachers are responsible for the delivery of organizational services and must quickly adopt reactionary strategies in order to mitigate public concerns (Lipsky 1980). It is their job to construct and immediately apply general social problem policies to the complex and variable public circumstances of everyday life (Lipsky 1980; Holstein and Miller 1993). When troubles are conceptualized as social problems by these
professionals, rhetorical strategies and interactive power become imperative in the pursuit of their own organization’s economic, political and social interests (Spencer and Mckinney 1983). Similarly, definitions of trouble are shaped and responded to via interpretive and discursive processes and the availability of acceptable local resources (Holstein and Miller 1993).

The concept of trouble has two main referents when viewed from the micropolitics perspective. First, the concept of trouble has been used to refer to situations which are experienced by others as “irritating, unpleasant or unendurable” (Emerson and Messinger 1977: 121). Such troubles include mental illness, neighbor disputes and homelessness (Spencer and Mckinney 1997). Emerson and Messinger (1977) argue that the trouble and the response to mitigate the trouble are reflexively related. Second, trouble has also been used to refer to the divergence from public service professional’s preferences and the client’s expectations and behavior. Specifically, clients become defined as trouble as a result of discrepancies between their own definitions and the definitions of the professional (Emerson and Messinger 1977; Spencer and Mckinney 1997).

These street-level bureaucrats give citizens a direct experience with the government. However, these experiences are not customary and involve complex interactions between human service workers that inextricably affect the response or sanctions the citizen receives (Lipsky 1980). The experiences of the citizen and the services rendered by public service professionals are shaped by particular circumstances and other contextual factors. Workload and community pressures can also affect
discretionary authority of these professionals in unique ways which subsequently shapes procedures and responding strategies (Britnall 1981). In order to meet clients needs while also contending with substantial workloads and limited resources, street-level bureaucrats often must filter cases in order to identify the cases that are most severe or worthy of their professional attention and expertise (Britnall 1981). The pressure from large workloads provides an opportunity for public service professionals to be selective in the cases they treat while concurrently routinizing or stereotyping other cases deemed inferior to conserve organizational resources. This rationing of services and resources is also known as “creaming” where public service professional often choose or “skim off the top” cases that are more likely to succeed (Lipsky 1980:107). This correlates with Feeley’s (1975) study on criminal courts. He found that when lower-level court staff persons become encumbered with heavy caseloads, they adopt certain practices that allocate more attention to cases that are recognized as high importance while giving other cases only minimal professional over-site.

However, the way in which professionals respond and handle these troubles is contingent on the understandings of the perceived trouble. Emerson, Rochford and Shaw’s (1983) research on a psychiatric board examined the micropolitical processes of a psychiatric care facility and how understanding of troubles of the staff become critical determinants of resident responses and subsequently their fates. Through interactional processes, members of the staff identify and construct definitions of trouble. These definitions of trouble are tied to the residents’ institutional reputations among the staff which influence how the resident is responded to. In total, interactional processes
combined with residents’ definitions or reputations inform how they are responded to and treated by the staff.

Similarly, Van Mannen’s (1978) study examines police officers and the typifications they utilize to construct particular definitions of trouble. Van Maanen (1978) observed that officers’ definitions of offenders are largely shaped by past experiences as well as interactional processes. For instance, officers use their discretionary authority based on the behavior of the individual in question. If the individual is recalcitrant and perceived to be aware of his or her behaviors, the individual is defined as an “asshole” and culpable for their actions. In comparison, if the individual is recalcitrant but is perceived to be unaware of their actions or unable to conceive the consequences of their actions, they are viewed as a “soft-brained mental case” (Van Maanen 1978: 318).

Miller (1983) found similar interactional processes evident in her study of a work incentive program (WIN) which is intended to assist welfare recipients in finding jobs. However, clients who fail to cooperate with staff are mandated to attend a conciliation session where the definition of the perceived trouble is redefined and individual responsibility is taken into account. Likewise, Diamond (1983) found similar results when he examined a nursing home and how definitions of mentally impairment are constructed among nursing home staff. A large proportion of residents at this nursing home were defined as having senile dementia and were expected to be “trouble” by nursing home staff (Diamond 1983). In this sense, residents of the nursing home were not perceived as in trouble but as trouble. According to Emerson and Messinger (1977), an individual defined as troublesome or deviant should not be understood purely by their
character but who he or she is sided against. In this case, the reputations and definitions of the residents were reconstituted as troublemakers as a result of the staff being encouraged by superior authorities to side against them (Diamond 1983).

Definitions of mental illness are also likely to be negotiated among public workers in attempt to fulfill organizational goals. In Ferraro’s (1983) study of a battered women’s shelter, staff continually negotiated definitions of trouble which revolved around attempts to keep out non-battered clients and disruptive clients as a way to maintain order within the shelter. However, interpreting and defining trouble are not straightforward and are shaped by the ideological and interpersonal forces that functions between and within professionals (Emerson and Messinger 1977; Ferraro 1983; Spencer and Mckinney 1997). Diagnoses of the trouble, when first identified, are ambiguous and a more crystallized definition is developed through negotiations which reconstitute the trouble (Emerson and Messinger 1977; Ferraro 1983). For example, Emerson’s (1969) study showed how a juvenile-court staff strategically negotiate and construct definitions of troublesome adolescents in attempt to render incarceration as the only acceptable response. Similarly, Darrough (1990) showed how a probation officer used rhetorical strategies to persuade skeptical parents that placement in a juvenile institution was necessary and beneficial for the boy’s troublesome behavior.

The current study contributes to this body of literature by focusing on how social problems or “troubles” are defined, responded to, and negotiated between two different types of street-level bureaucrats that are involved in an important community partnership (Emerson and Messinger 1977; Lipsky 1980). I argue that professional beliefs and
experiences coupled with structural considerations influence how CIT officers and mental health professionals define, respond to, and negotiate mental distress. As Emerson and Messinger (1977) point out in their article, micropolitics of trouble, economic and other structural interests can have significant leverage in influencing how certain activities are defined and treated. In this study, I link micropolitics to broader structural forces or more specifically, macropolitics, and illustrate how these broader social forces can affect the discretion and decisions of these street level bureaucrats in unique and fundamental ways (Emerson and Messinger 1977). My data suggests that CIT officers’ and mental health professionals’ definitions of mental distress and how it is responded to is largely shaped by availability of acceptable community resources. Consequently, these public service professionals must often negotiate competing definitions of the trouble in an attempt to reconstitute the definition and impose a mitigating responsive strategy that correlates with their own professional beliefs and organizational interests.

**Setting and Methods**

To examine the perceptions of mental health professionals and CIT trained law enforcement officers, I recruited participants from a town located in the Midwest. To protect the confidentiality of respondents, pseudonyms were assigned to all people and places that were involved in the study. Mental health professionals and CIT-trained law enforcement officers were solicited from three small local agencies and a mental health hospital. All officers receive training on issues related to mental health prior to entering the field. In 2001, CIT was implemented across the city where officers were encouraged to apply for the training. In 2005, departments began implementing annual forty-hour
training blocks. In 2003, a total of seven law enforcement officers associated with these agencies were CIT-trained. In 2008, this number increased to a total of fifty-six officers (NAMI 2008).

The CIT program follows the Memphis CIT model but modifications have been made in order to fit the uniqueness of the community where agencies are small and must cover an extensive geographical area. Officers volunteer for the training; however, it is encouraged by their department that all officers eventually become CIT certified to ensure maximum coverage and availability (Ohio CIT Coordinators Committee 2004).

The premise of this study was guided by the following set of questions:

1. Do law enforcement officers and mental health professionals have different perceptions and how might these differences in perception shape CIT training and performance?

2. What factors are involved in the process for making decisions on whether a mentally ill individual is transported to a mental health facility or arrested and how might attitudes of CIT training shape these factors?

3. How does the knowledge gained from CIT training influence perceptions and how might these perceptions inform officers’ and mental health professional decisions when involved in crisis situations with the mentally ill?

Four weeks prior to beginning data collection, I sent recruitment letters to the chief of police of three local law enforcement agencies requesting interviews of CIT officers and mental health professionals. The recruitment letters described the nature of
the study and invited officers and mental health professionals to participate. The chief of police of each agency granted permission for CIT officers and mental health professionals to participate in the interview if they desired. Before the interview, CIT officers and mental health professionals were contacted via phone or e-mail requesting their participation in the study. Of the five CIT officers and four mental health professionals contacted, none refused participation. All officers and mental health professionals that were solicited agreed to participate in an interview while on duty and at their place of employment. Before each interview, the study was described and if the participant did not decline participation in the interview, informed consent procedures were initiated and the interview was conducted.

One component of the data collection was interviews among professionals. Nine conversational in-depth interviews were conducted among CIT trained officers and mental health professionals. Data were collected from five CIT trained officers and four mental health professionals associated with the CIT program in a rural community between August and November of 2010. Ages of the interviewees ranged from early thirties to mid-sixties. The interviews lasted approximately one hour each. The interview guide was loosely structured and consisted of three sections. Much of the interview guide was formulated and structured from participant responses.

The first section asked participants to describe their experiences with the training and how they became involved with CIT. The second section asked participants how they define mental illness and what factors are involved in referrals for treatment. The
third section asked each participant to describe their experiences with the mentally ill and what strategies and techniques they typically employ to de-escalate crisis situations.

A second component of data collection was the observation of CIT training. I observed the training over a three-day period in November, 2010, for approximately two hours each day. Extensive field notes were recorded and subsequently coded at the end of each session. Approximately thirty to forty officers and emergency response personnel from surrounding counties participated in the training. Training was presented by mental health clinicians from the community, representatives from the courts, police academy trainers, advocates and consumers. Archival data generated by the three local law enforcement agencies and training program were also collected. These include newsletters, feedback reports, training documents and any other public records related to the CIT program.

Data analysis of transcriptions and site documents was conducted during the fall of 2010. A journal was used to keep a chronological account of the research and analysis process. This journal contained strategies used in analyzing the data, newly-developed data codes and detailed records of the methods used in the research. After returning from interviews or fieldwork, recordings and notes were transcribed into computer files. During the transcription process, I recorded methodological notes on recurring themes and relationships. The materials were then coded to distinguish recurring themes, connections and different perceptions between CIT trained officers and mental health professionals. The materials were then combined to identify consistencies and inconsistencies across the collected data.
First, analysis of the data was done by open coding techniques which involves reading the transcribed data, line by line, to identify and segment the data into properties and concepts. The second part of analysis consisted of focused coding in which concepts were deleted, consolidated, and elaborated upon. In the third part of analysis, axial coding was conducted in which concepts were grouped into abstract themes.

Throughout the study I recorded reflective notes about what I was observing and learning from my data, otherwise known as memoing. The coding and memoing process occurred concurrently with the data analysis process. As more codes were being identified through the coding process, questions were the formulated to correspond more closely with the identified categories. The actual coding process was effectuated using a simple word processing program to preserve meaning and familiarity of the data.

**Overview of the Thesis**

In the following empirical chapters, I explore how CIT officers and mental health professionals define, respond to, and negotiate mental illness and mental distress. CIT officers’ and mental health professionals’ have competing definitions of mental illness and mental distress. These definitions come to be shaped and conceptualized by professional beliefs and community factors which subsequently influence the responsive mitigating strategies. Consequently, CIT officers and mental health professionals must negotiate competing definitions in attempt to impose a mitigating response that is aligned with their professional beliefs and organizational interests. The three forthcoming substantive chapters focus on the experiences of CIT-trained law enforcement officers and mental health professionals and how they define mentally ill persons in crisis and
how these perceptions influence strategies and mitigating responses. In chapter three, I examine how mental health professionals and CIT officers come to define mental illness and mental distress. In chapter four, I examine how definitions of mental illness and mental distress are shaped by structural factors and how these factors influence mitigating responsive strategies when involved in crisis situations with mentally ill. In chapter five, I examine how definitions of severity and mental illness are negotiated among professionals and other intervening parties in attempt to impose a one-sided mitigating response. In chapter six, I conclude the study by discussing scholarly implications and suggesting other possible avenues for future sociological research.
CHAPTER 2: BACKGROUND OF CIT

A major development in the treatment of the mentally ill occurred in the 1960’s as a consequence of the shift from institutionalized care to community-based care, which is commonly referred to as deinstitutionalization. The goal was to downsize mental health services and use the money saved from hospital closings to assist in the development of pharmaceutical options and outpatient community programs (Vickers 2000). Another central reason behind the downsizing of state mental hospitals was out of justifiable concern for the mentally ill many of who were mistreated and living miserable lives within these institutions. It was widely assumed that this shift towards community based-care would be more humane and would provide a more adequate quality of care for the mentally ill (Lamb et al. 2001).

The resources that were collected and conserved from the downsizing of state institutions were not disseminated back into the community as planned. States had reallocated their savings and many individuals suffering from mental illness were without adequate social support systems. As a result, many individuals with severe mental illness could not be properly monitored, stopped taking their medications, and were placed within the care of their own families who were unable to sufficiently care for their mental conditions (Vickers 2000).

Consequently, this shift towards toward insufficient-community based treatments often meant that the police were first ones to respond to crisis situations with mentally ill persons. Before the CIT program, if an officer responded to an individual in crisis who was disturbing the peace, the common outcome would be to take them to jail, commonly
referred to as “cuff em and stuff em.” Data from mental health consumers and family members suggest that most people with severe mental illness will be arrested more than once in their lifetime (McFarland et al. 1989). In a study examining arrest rates among the mentally ill, twenty percent out of a sample of 331 people with severe mental illness reported being arrested (most commonly for crimes of public disorder) approximately four months before being admitted to a hospital for treatment (Borum et al. 1997).

Prisons have become the new mental hospitals today where at least 250,000 individuals with mental illness are inmates (Vickers 2000). In the past, jail was typically considered to be the most common outcome for individuals suffering from severe mental distress.

Before the CIT program was implemented, officers felt inadequately prepared to manage these situations with the most appropriate response and outcome being punitive rather than therapeutic (Borum et al. 1998).

However, within the past fifteen years the dominant paradigm in American policing has shifted from a traditional to a community-policing model (Borum et al. 1998). CIT directly fits with other changes and transitions in police work by providing an innovative, community-oriented approach for responding to psychiatric emergencies enhancing relationships and connections with the mental health system. Today, officers commonly take on the role of ‘gatekeeper’ in deciding whether an individual with a mental illness enters the mental health system or criminal justice system (Lamb et al. 2002). The partnership between mental health and law enforcement systems has facilitated specialized training for officers that exclusively focuses on how to manage crisis situations with individuals in severe mental distress. The primary goals of the crisis
intervention training program is for law enforcement officers is to: 1) provide officers with the tools they need to successfully deescalate a crisis situation; 2) prevent and reduce injury to all parties involved and 3) find appropriate care for the consumer and establish a treatment program that will reduce recidivism (Vickers 2000; Reuland 2004).

Research to date suggests that 400 CIT programs are currently in operation in the United States (Watson et al. 2008). Police in all states have the authority to transport and link those they suspect with severe mental illness to appropriate mental health services (Lamb et al. 2002). Numerous crisis response models have emerged in recent years with the main intention of neutralizing crisis situations with the mentally ill and providing a mental health response. Jurisdictions and municipalities across the country typically conform to one of these three models to respond to crisis situations with the mentally ill (Dupont 2000; Vondran et al. 2006).

A more traditional model, the mental health based specialized mental health response is where cooperative agreements are developed and implemented between law enforcement and mobile mental health crisis teams. These mobile mental health crisis teams exist apart of the local community and are independent of law enforcement agencies. The Knoxville Police Department in Tennessee is an example of this type of model. The Knoxville mobile crisis unit serves a five county area and responds to crisis situations in the community and the city jail (Steadman et al. 2000).

The police-based specialized mental health response is where mental health professionals are employed by police departments to provide on-site and telephone assistance to officers when involved in crisis situations in the field. The community
service officer program in Birmingham, Alabama, is indicative of this model. Incidents with mentally ill persons are handled exclusively by mental health professionals employed by the Birmingham Police Department. These mental health professionals or Community Service Officers (CSOs) assist police officers during times of mental health emergencies. CSOs are civilian police employees that have professional training in social work or other related areas. Newly hired CSOs participate in an intensive six week training regimen of classroom and field related instruction (Steadman et al. 1996; Vondran et al. 2006).

The *police-based specialized police response* is where sworn officers have specialized mental health training are the first responders to crisis with the mentally ill within the community. This model is popularly known as the Crisis Intervention Team (CIT) or “Memphis Model” which, as the name suggests, was developed in Memphis, Tennessee in 1988 (Vickers 2000). The CIT training program was started after a fatal shooting involving an African American male who was mentally ill. In September, 1987, Memphis police officers responded to a nine-one-one call involving a young African American man with a history of mental illness. When officers arrived at the scene, the young many had many self-inflicted wounds. As officers were trained to do before the implementation CIT, they confronted the man and demanded that he drop the weapon. The man became increasingly agitated at the officers’ orders and decidedly ran at them while wielding the knife. Out of fear for their own safety, the officers responded by shooting and killing the man.
The public outcry from the young man’s death galvanized action from the mayor of Memphis. The mayor sought the input and expertise of psychologists, representatives from NAMI, mental health professionals and local citizens with the intention of creating a task force with its central purpose of finding ways to prevent similar tragedies in the future. A year after the establishment of this task force, the CIT training program was created and implemented (Vickers 2000).

The Memphis Model, and its training of specialized officers, is the most widely implemented model across the country which his primary reason why most research on CIT has focused on this model (Compton et al. 2008). The CIT model is specifically designed to enhance officers’ interactions with mentally ill persons while improving the safety of all parties involved (Compton et al. 2008). When a CIT officer arrives at the scene of a mental health crisis, the officer will attempt to compassionately engage the individual to deescalate and avoid physical aggressive action. After the individual is stabilized, the officer will then determine what type of immediate assistance he or she requires (Vondran et al. 2006).

CIT Officers typically undergo 40-hour training regimen which is composed of core modules. The training focused on understanding the accessibility of the mental health system, general overview of different mental illnesses, family and consumer perspectives on mental illness, the understanding of different stakeholder roles, de-escalation procedures, the referral process for treatment and role play scenarios. A significant portion of the training is devoted to listening to family and consumer perspectives where officers take part in asking questions and telling stories about their
experiences with the mentally ill. On the last day of the five-day, forty-hour training regimen, personnel who participated in the training were mandated to utilize their de-escalations skills and participate in a role play exercise which is evaluated and critiqued by mental health clinicians. Following the role plays, officers and other personnel are honored with a graduation ceremony and awarded “CIT-Certified” pins.

CIT curriculum is developed around four fundamental goals that include: 1) enhancing the feeling of safety in the community; 2) increasing the safety of all parties involved in a crisis situation; 3) enhancing officer competence when engaging a person with mental illness in crisis, and 4) making mental health resources more accessible to law enforcement officers (Ohio CIT Coordinators Committee 2004).

Hybrid programs have also been developed which combine one or more of the three primary intervention models. For example, law enforcement agencies within Montgomery Country, Maryland combine the ‘Memphis model’ with the mental-health based specialized mental health response (Rodney et al. 2004; Vondran et al. 2006). Officers act as first responders to crisis situations involving the mentally ill and when necessary, officers are assisted by mobile mental health crisis units. Similarly, the Los Angeles Police Department in California employs full-time mental health professionals who are paired with specially trained CIT officers (Vondran et al. 2006). Modifications have also been made to programs to fit the immediate needs and resources of the community. Rural communities are especially challenged in implementing a successful and effective CIT program. Rural law enforcement agencies are often small, lack manpower and cover extensive geographical regions. Contrary to the credo of the
Memphis model on only training select officers, smaller, rural, agencies typically aim to train every officer due to limited manpower and coverage.

The CIT program is being aggressively implemented across the United States. Today, law enforcement officers are ultimately the gatekeepers of both the criminal justice system and mental health system (Watson et al. 2009). Hence, this specialized training in interacting with persons suffering with severe mental illness is integral. The central aim of CIT training is to divert individuals with mental illness away from the criminal justice system and link them with the appropriate mental health services (Watson et al. 2009). This collaboration between the law enforcement and mental health systems is critical to the decriminalization of persons with mental illness and for improving the safety of all parties involved in crisis situations with the mentally ill. However, CIT is more than just a partnership between the mental health system and law enforcement. It is a unique partnership between numerous community stakeholders which include law enforcement officials, mental health professionals, mental health advocacy groups as well as consumers and their families (Ohio CIT Coordinators Committee 2004).
CHAPTER 3: DEFINING TROUBLE

CIT officers and mental health professionals come to define mental illness or trouble differently (Emerson and Messinger 1977). The concept of trouble has been used to refer to a “state of affairs experienced as difficult, unpleasant, irritating, or unendurable” which requires the delivery of public services from public officials (Emerson and Messinger 1977: 121). These street-level bureaucrats’ definitions of trouble are largely shaped by expertise, context and other situational factors. Drawing from Emerson and Messinger’s (1977) work on the micropolitics of trouble in which they examine the processes by which troubles come to be defined, responded to, and sometimes transformed into deviance by intervening parties, I examine the definitions of mental illness between CIT officers and mental health professionals and the social processes involved in how they come to define mental illness and mental distress.

Encounters between police and persons with mental illness are more frequent today than ever before. When an officer arrives on scene, he or she is responsible for providing an appropriate response in order to neutralize the situation. Often times, when officers are involved in crisis situations with the mentally ill they request mental health professionals to determine the appropriate response. Through the course of my research, it was recognized that CIT-trained officers and mental health professionals have differing understandings of what constitutes mental illness. I observed that CIT officers develop empathetic understanding of mental illness through listening to the personal accounts and stories of those afflicted by mental illness. It is through his empathetic understanding of mental illness that assists in recognizing it as a multifaceted disease where affronting
behavior of someone in mental distress is symptomatic of their illness and necessitates a therapeutic response. In comparison, mental health professionals do not always inextricably associate mental illness with criminal behavior. Mental health professionals argued that personal responsibility and accountability for criminal actions should always be considered when determining the nature and direction of the response. They contend that criminal behavior, in some cases, is willful and intentional and should not be exclusively tied to the person’s mental illness.

**Building Empathy**

Mental illness in American Anglo law is often conceptualized to include any psychological impairment that is internal, stable and involuntary and independent of any situational or contextual factors (Livesley 2001). The CIT officers that participated in the study commonly attributed mental illness from biological aberrations. CIT officers frequently stated in interviews and during their 40-hour training that mental illness was a disease or a disorder which manifested due to a chemical imbalance in the brain. During pre-service training or the training they undergo before they enter the field, officers learn basic mental illnesses and mental health issues. CIT officers most likely perceive and recognize mental illness as a biological condition from pre-service training. Prior to entering the field, officers participate in basic training where they must learn mental health issues and the different psychological disorders they may encounter. Upon graduation, officers have the choice to volunteer for CIT training where they learn the fundamentals of de-escalation and how to appropriately link individuals in mental distress with mental health resources. Lieutenant John Ashby, a CIT certified, twenty
year veteran for Wilson University Police Department described how he conceptualizes mental illness. He said:

It can range from a chemical imbalance in the brain to a personality disorder and genetics plays a part in that too.

Zach Reiner, a twenty-seven year veteran and CIT certified Lieutenant for Canter County Sheriff’s Office, made a similar response explaining how mental illness is a hereditary, biological aberration induced by an imbalance of chemicals in the brain. He stated:

There’s some type of chemical imbalance that’s occurring in the body and the brain that’s just obviously not natural and it affected them for a specific reason. It is hereditary? I’m sure that there are some things that they have passed down from mother to father or whatever the case may be.

It is during this training that officers reported developing an empathetic understanding of mental illness and its symptoms. It is through hearing the stories of mental health consumers and their families that assists in building empathy and gaining an understanding of mental illness. Specifically, it is the personalized accounts of consumers and their family members that shape officer definitions and visceral understandings of mental illness.

**Hearing Stories**

One of the ways that law enforcement officers build empathy is by hearing stories. While officers are cognizant of the different definitions of mental illness, officers reported that it was through listening to the stories and interacting with individuals who suffer from acute mental illness and their families that helped them gain an understanding of mental illness.

During the training, consumers and family members of mental health services talk about their experiences with their mental condition and their personal accounts with
police involvement. All of the officers interviewed reported that this module was the most important element of the training regimen. Officers claimed that it was only through this empathetic understanding that allowed them to acquire an actual sense of what it is like to have a mental illness and what the individual in mental distress experiences in crisis. _Empathy_ or the ability to share feelings of the person in crisis is vitally important in understanding the cognition of someone that is mentally ill or emotionally disturbed.

Officers compared listening to the stories and experiences of consumers to being maced or tased during pre-service training. Officers argued that they were able to “walk in their shoes” and get a chance see life through their eyes. Lieutenant Zach Reiner of the Canter County Sheriff’s Office explained how listening to the experiences of consumers was comparable to being tased by a “stun gun.”

Well I walk in his shoes, I know what they’re doing. And like I said, that’s the whole premise of being shot with a taser or being sprayed with mace, so you know what you’re doing, is doing to that person. That’s the concept behind those. It’s kind of the same thing except you can’t inject me with schizophrenia for a few minutes but I can still walk in his shoes for a few minutes-sit beside him and hear what he has to say and how it affects him and how schizophrenia – what they’re thinking, the stuff they hear. That was the most important part for me.

Twenty year veteran, Deputy Ryan Pepper for Canter County Sheriff’s Office, described his experience during the training when he and other trainees took a field trip to a local support group for individuals suffering from acute mental illness. He explained how interacting with individuals who suffer from mental illness assisted in gaining an empathetic understanding of their condition.

We went to the gathering place and walked around the facility and talked to the people that were living there and sat down and had a conversation with them and
had lunch with them and sort of try to get a better understanding of where they’re coming from, mentally, what they’re thinking about.

Sergeant Tom Johnson, CIT certified, fifteen year veteran for the Wilson University Police Department, explained his perspective on the consumer panel and its importance in understanding mental illness.

They have a consumer panel where they actually have people with a mental illness come in and talk about, basically their situation, their life story about how mental illness affects them, how they live with it every day. And that’s just why, to find out what that person’s going through is really a big eye-opener and I mean really just learned a lot from that.

Officers also reported that listening to the family and consumer panels galvanized individual action in aspiring to help individuals that suffer from acute mental illness.

Thirty-two year old officer Paul Riley of the Canter County Police Department explained how listening to the experiences of the consumers and family panels emotionally touched him and motivated him to adopt a therapeutic frame of reference when involved in crisis situations with the mentally ill.

It’s one of those things and seeing from their eyes and from the eyes of parents um that have had to deal with those that have lost a child that hat dies because of a mental illness. It’s one of those things, it’s heartbreaking but it’s one of those things that’s like, ‘damn, I can let this happen, I need to do everything I can to try to help keep that from happening.’

Through listening to the experiences of those with acute mental illness, CIT officers can live vicariously through them. Understanding the perceptions of the acutely mentally distressed persons assists officers in building empathy towards the mentally ill as well as perceiving mental illness as a multifaceted disease which warrants treatment much like any other injury or disease.
Seeing Mental illness as a Multifaceted Disease

A second way that law enforcement officers build empathy is by seeing mental illness as a multifaceted disease. Officers reported that mental illnesses such as bipolar disorder, schizophrenia, personality disorders, and depression are not conditions that can be easily “shrugged off.” Much like a broken leg or any other palpable injury, officers perceive mental illness as an “injury” that must be treated like any other debilitating physical condition. Similar to how a broken leg is subject to gangrene and possible death if left untreated, officers also perceive mental illness as life-threatening if not adequately treated and managed.

Lieutenant John Ashby who serves Wilson University argued how mental illness is comparable to any other life-threatening injury that must be treated or face the risk of death. He said:

I think mental illness is a physiological thing. I don’t know if there’s a lot of, I mean there might be a lot of uninformed. I think physiologically, chemicals in the brain - it’s something that can be treated and there can be improvements in someone’s life but untreated, I think it’s just a cruel illness. Like not treating a bone through the leg would eventually be gangrene, infection and death. I think mental illness untreated has the same potential. I just think that it’s something that needs diagnosed and proper treatment given or it’s just a painful, spiral down.

Most officers reported responding to calls where mentally-impaired individuals were off their medication. These individuals usually use drugs or alcohol in attempt to self-medicate and manage the symptoms of their mental condition. Officers in all three agencies reputed that the majority of the calls they respond to involve individuals that have depression and other disease-related problems or what Lieutenant Reiner refers to as “having a bad day.” He continued:
The majority of those in this county that I have dealt with that have mental health issues, they’re not violent. They’re having a bad day and they’re medication isn’t right or they haven’t filled their medications, intoxicated, under the influence of drugs, something of that nature. But other than that, they’re pretty much - talk to them, get them to go along with the program, get them to understand what’s going on.

Individuals with mental illness that are acknowledged by officers as “having a bad day” are usually off their medication and/or under the influence of drugs or alcohol.

Throughout my research, it was observed that officers demonstrated a sensitized perception of mental illness and were sensitive to the fact that many of the individuals with mental illness they frequently encountered had substance abuse problems. Officers reported that one of the primary reasons individuals with severe mental illness have concurrent substance abuse problems is due to medication not being consumed properly or not at all. They perceived substance abuse as a means to ameliorate and manage symptoms associated with their illness rather than using for recreational purposes.

Lieutenant Ashby explained his position on why individuals in mental distress are more inclined to abuse drugs and alcohol.

We understand a form of substance abuse and mental illness. A lot of times folks are self medicating, they’re or they’re trying to find, they don’t think their medicine is exactly what they need so they’re interjecting things trying to find this good balance.

Similarly, Sergeant Johnson explained a situation with a student who was clinically depressed and addicted to pain-killers.

He was in a car wreck broke an arm and a leg and ended up getting pretty severely depressed and getting hooked on the pain medications. And another issue there, the father was initially, ‘that worthless piece of crap and he needs to suck it up, he needs to toughen up.’ And it’s like, this is an illness, it’s extremely tough, it’s going to be extremely tough for him. And I ended up talking to the father for probably about, probably on a couple of occasions, one time it was about 45 minutes or so, went through some of the stages, some of the things he was going
to have to go through and some of the troubles he was having, and the father finally said, ‘well, I just didn’t think about it that way.’

Sergeant Johnson statement suggests that substance abuse is an effect of acute mental illness. Substance abuse was seen not as a crime, but as a means to manage their mental health condition. If it is observed that an individual with acute mental illness has consumed drugs or alcohol, it is perceived as situation that necessitates clinical treatment and not punishment. Furthermore, CIT officers are also reluctant to assign culpability to recalcitrant individuals perceived to be in mental distress and disturbing the peace. This perception of mental illness suggests that officers are less likely to have negative views and more likely to have positive and therapeutic reactions to persons with acute mental illness (Watson et al 2009).

The issues of mental illness often intersect with important questions about individual responsibility and accountability of actions. However, CIT officers recognized that they need to be sensitive to any rampant or erratic behavior that an individual with acute mental illness may be exhibiting. CIT officers were quite reluctant to attribute the affronting and aggressive behavior of someone who is mentally ill to their character rather than their state of mind. This is a prime example of Van Maanen’s (1978) “theory of assholes” in which he argues that officers are generally resistant and hard-pressed to arrest individual’s suffering from mental illness that are exhibiting affronting behaviors.

For example, Lieutenant Ashby explained his situation with a mentally impaired individual who was agitated and observed to be disturbing the peace.

I think he was angry that somebody didn’t let him just do what he wanted. ‘I don’t care if I’m getting on a wrong bus.’ So he displayed in the road out here, in the parking lot not in the road, but then he’d just say, ‘must get on the bus, must get
on the bus.’ finally, I called transportation services and said, ‘hey can you bring a bus up here?’ And the guy was up here in short order and we rode around. The next day, he was going up to get pink slipped.

Lieutenant Ashby’s account suggests that CIT officers often recognize an individual who is suffering from some type of mental or emotional condition and remain reluctant to deem a person culpable for their actions. Instead of attempting to deescalate the situation authoritatively, Lieutenant Ashby engaged the situation therapeutically by recognizing mental illness as a condition that creates a distorted sense of reality. It is through this empathetic understanding that the individual in mental distress is perceived by the officer as a victim where their behavior is a consequence of a distorted psyche.

Instead of individualizing behavior and ascribing fault to the person in crisis, police are likely to institutionalize the responsibility in which the person is perceived as “clearly a nut” (Van Maanen 1978: 318). Officers do not assign blame or fault to the individual in mental distress. When officers arrive on scene, and it is recognized that an individual is under mental distress, the trouble is recognized as a condition where the individual is unaware of their own actions and behaviors. CIT officers conceptualize this trouble as conflict derived from a physiological imbalance rather than intentional or deliberate recalcitrance. Mental illnesses are largely considered to be mitigating factors by officers. An individual who suffers from any mental condition, regardless of severity, is undeserving of punishment and in need of clinical support. Officers’ assessments of substance abuse, being off medication, signs or symptoms of mental distress and violence to self or others are factors that have influence in the officer decision to transport the individual suffering from mental distress to clinical services. However, mental health
professionals contend that mental illness should not always be a mitigating factor with recalcitrant behaviors and responsibility for these behaviors should be deftly defined.

**Defining Responsibility**

Contrary to officers’ perceptions of mental illness, mental health professionals defined mental illness as being more nuanced and complex – not exclusively originating from biological determinants. Mental health professionals are less likely than CIT officers to attribute the erratic or aggressive behavior of someone in mental distress to their illness. Specifically, mental health professionals perceive a degree of moral responsibility and accountability with individuals in mental distress.

While a CIT officer may perceive individuals exhibiting affronting behaviors as symptomatic of their mental illness and in need of treatment, a mental health professional may conceptualize this same behavior as willful manipulation and not symptomatic of their mental illness. Mental health professionals reported that mental illness is one “big gray area” and how you define it depends on the context and many times it is a condition that cannot be quickly recognized and diagnosed.

Patrick Miller, a mid-forties mental health social worker and director of the community crisis center explained the complexity and nuances of diagnosing mental illness.

People have extreme difficulties just functioning day-to-day because of illness or some type of a brain disease. So it’s hard- looking in the DSM, they have tobacco-nicotine dependence is in the DSM, which I don’t typically kind of consider that a mental illness but technically you can use that as a diagnosis. I kind of, I look at a lot of these issues as rather as gray rather than black and white, whether than mentally ill or the mentally well. Everybody has some difficulties and it’s just kind of a level of difficulties that you have that determine whether or not you get a diagnosis or you end up being admitted to a hospital.
John Fritzer, a mental health clinician who has been practicing for thirty-five years in the community mental health hospital explained his position on mental illness.²

It depends on what your trying to do again, there’s all kinds of statistical ways of looking at it, there’s all kinds of- take the DSM, were now on four, and five is gonna come out shortly, and look at symptom patterns and so if the person meets those criteria and all those sorts of things.

Diagnosis of particular mental illnesses depends on meeting certain criteria.

Contrary to officer perceptions, mental health professionals stated that some mental illnesses are behavioral in nature, while others, the more debilitating illnesses and disorders, are biological. Mental health professionals observe particular behaviors and actions of someone in mental distress and utilize diverse classification schemas to define and categorize the mental condition.

When asked how she would define mental illness, Dr. Cathy Mayes, A fifty-seven year old mental health clinician and chief psychologist of Canter County Behavioral Hospital explained.

I think of it in two ways. There are the major mental illnesses that are clearly biologically based illnesses that when something changes in the body, causes a change in perception and the limbic system. That causes the person to either experience incredible distress that doesn’t need to be there or to alter the way they interact with the world in a way that’s not going to allow them to achieve what they really want. But even, there’s also though the behavioral side that people learn to solve problems in ways that they were taught and those ways don’t always work and if they persist in trying to solve problems in a way that just makes things worse - things get worse and worse and worse and worse and they develop more maladaptive behaviors.

Mental health professionals perceive mental illness one of two ways – biological or behavioral. The severe, more debilitating illnesses, which are commonly associated

² John Fritzer also volunteers his time to the Canter Police Department as a Reserve Commander.
with psychosis or mania, are considered to be the result of genetic endowments. In comparison, the behaviorally-based illnesses are considered to be a result of socialization where affronting behavior should not be treated as a mitigating condition. When assessing an individual perceived to be in mental distress, mental health professionals consider responsibility of actions and determine if there should be a distinction between mental illness and any associated criminal behavior.

Making Criminal Distinction

One way that mental health professionals define mental illness is by assessing behavior and making criminal distinction. Mental health professionals reported that they do not expeditiously link criminal behavior to chemical deficits. Certain psychiatric illness or diseases are manifested behaviorally from abnormalities of thought or feeling and not solely from a chemical imbalance in the brain. A distorted perception of reality is a result of irregular thought processes stemming from early socialization.

Mental health professionals differed from officer’s definitions of mental illness with regard to personality disorders not significantly affecting an individual’s psyche and rational thought processes. They perceive an individual who is suffering from a personality disorder and engages in criminal behavior as rational and should not be exempt from receiving punitive consequences. Mental health professionals regarded individuals who have personality disorders as understanding of their behaviors and actions. Consequently, they should be culpable for recalcitrance or criminal behaviors and receive a punitive response. John Fritzer explained his position on mental illness and criminal behavior, “Sometimes you find, ok this person’s mentally ill but there also a bad
person, we still want them to go through the criminal justice system.” John’s statement suggests that some persons with acute mental illness can understand their own affronting behavior or flagrant disregard for authority. Criminal behavior and moral comprehension of someone perceived to be mentally ill should be considered when deciding the direction of the mitigating response.

Similarly, mental health professional, Patrick Miller, explained that a punitive response may be necessary for mentally-impaired individuals who have engaged in criminal behavior or have caused harm to others.

There’s that disagreement, sometimes we think someone needs to go to jail. The cops say, ‘no, he needs to go to the hospital, he’s saying he’s gonna kill himself.’ Well just because he’s saying he’s going to kill himself doesn’t mean he’s mentally ill, meaning he needs to be in the psych hospital. He just punched his girlfriend in the face, he needs to go to jail.

Patrick’s account suggests that there is a discernable distinction between mental illness and criminal behavior. Where an officer may regard someone as mentally disturbed and in need of psychiatric services, a mental health professional may perceive this behavior as intentional criminal behavior and not mental illness. The mental health professional indentifies and evaluates the behavior of the mental as rational and perceives the individual not as a victim but a troublemaker who has “injured, harmed or wronged” wherein a punitive response becomes a necessary course of action (Emerson and Messinger 1977: 127).

Mental health professionals rarely considered recalcitrant individuals with emotional disorders devoid of rational thought. Consequently, if a crime is committed,
mental illness should not be a mitigating condition for punitive consequences and individual in question should be held accountable for their actions.

Erin Kline, a supervisory mental health professional at the Veterans Hospital in Winchester County explained how she believes punitive consequences for some individuals with mental illness are a necessary recourse.

Generally, it’s the mental health professionals that are saying we need to deescalate this situation but the person with the mental illness is not exempt from the consequences for their behavior. In fact, it may be a good idea, necessary in fact, for them to have consequences for their behavior either through legal charges or having some interaction with law enforcement.

The statement suggests that mentally-impaired individuals who engage in criminal behavior should receive a punitive response for violating established rules and regulations. Even though mental illness may affect a person’s rational thought processes, it is usually not considered severe enough by mental health professionals to be absolving of punitive consequences.

Erin goes on to elaborate on a situation with a female veteran who failed to comply with mental health treatment mandates.

Frankly, she needed to be charged not because she was mentally ill but because she was cheeking medication. She was refusing to engage in treatment. There has to be consequences for behavior. And she was-she pretty much knew what she was doing was wrong. You don’t get a get-out-of-jail-free-card just because you’re mentally ill. The police refused to charge her. They said because she was mentally ill it will never get to the court. I think that that is irresponsible and frankly, it sends a real dangerous message to our veterans.

Erin’s statement suggests that there is a distinction between mental illness and individual responsibility. She argues that the individual understood her actions in refusing to comply with treatment mandates. The allocation of blame is placed on her and not her mental illness which decidedly warrants a punitive response. In this case, the
individual was perceived as willful and rational by the mental health professional but perceived to be mentally ill by the officers and undeserving of punishment. Erin conceptualized the trouble as a result of individual agency where her mental illness did not exclusively influence her actions. Similarly, John Fritzer, explained his position on mental illness and individual accountability. He said:

Sometimes people with personality disorders are manipulative and they need consequences for their behavior. It doesn’t mean that we don’t offer them help and we talk about that a lot too. But if they’re doing something illegal and you’ve attempted to work with them but they don’t want your assistance, then what other choice do ya got?

John’s statement suggests that individuals exhibiting behaviors symptomatic of personality or emotional disorders that are recalcitrant, a punitive interventional strategy becomes a necessary option. Similar to Erin’s statement, John also acknowledges that some individuals in mental distress, specifically those with personality disorders, must be held accountable for their actions. If an individual continues to refuse treatment and not comply with therapy mandates, it is perceived as intentional by the mental health professional. Specifically, if the intention is clear the individual must be taught the error of their ways through punitive actions.

These empirical examples demonstrate how mental illness is defined and how these definitions are shaped. CIT officers learn mental illness through empathy or listening to the experiences of those suffering from acute mental distress. By listening to these stories, officers develop an empathetic understanding of mental illness and come to see it as a multifaceted disease where affronting and criminal behavior is a result of their illness and not their moral character. Contrary to officer perceptions, mental health
professionals suggest that mental illness is more nuanced and complex, where criminal behavior does not always manifest from an individual’s mental condition. A criminal distinction needs to be determined where mental illness should not always be treated as a mitigating condition for absolving punitive consequences. However, extrinsic factors can have considerable weight in informing definitions of mental illness in how it is recognized and resolved. The following chapter explores how CIT officers and mental health professionals orchestrate responses that are shaped from their definitions of mental illness as well as the consideration of other extrinsic variables.
CHAPTER 4: RESPONDING TO TROUBLE

CIT officers’ and mental health professionals’ role as street-level bureaucrats allow them to make ad-hoc decisions as a result of their high-degree of discretion. This high-degree of discretion allows these professionals authority to make judgments and quickly execute decisions in the face of extreme workloads and dynamic working environments (Lipsky 1980). These street-level bureaucrats are ultimately viewed upon as official “troubleshooters” whose job it is to identify, isolate, and respond to an extrinsic public trouble (Emerson and Messinger 1977: 126). When troubles are no longer personal but become relational the assistance of officers and mental health professionals to “remedy” the trouble are needed (Emerson and Messinger 1977: 123). Furthermore, particular responses necessitate a human or discretionary element which requires sensitive observation and flexibility with all decisions. However, the nature of these occupations and economic pressures can constrain the discretionary authority and prevent the utilization of a strategy that is congruent among all intervening parties.

The strategy or remedy used to mitigate the crisis is strongly influenced by the analyses of the mental condition as well as the consideration of other extrinsic variables by each official intervening party (Emerson and Messinger 1977). Specifically, the availability of mental health services may have significant influence in the options that CIT officers and mental health professionals have when involved in crisis situations with the mentally ill. The decisions of these street-level bureaucrats not only influence particular definitions but also how the trouble is mitigated and the institutional network it enters (Emerson and Messinger 1977; Lipsky 1980).
Contingent on how the trouble is defined, CIT officers and mental health professionals employ a repertoire of strategies used to facilitate outcomes. However, the strategies that are utilized are influenced by the particular understanding of troubles dynamics, availability of mental health services and broader economic interests. The most recurring strategies that were employed for responding to crisis situations with the mentally ill were *Mercy Bookings, Contracting, Diverting Frequent Flyers and Pink Slipping*.

**Mercy Bookings**

As explained in chapter three, CIT-trained officers operate with a conditioned ideology of mental illness as a biological disorder which requires a therapeutic institutionalized response (Emerson and Messinger 1977, Van Maanen 1978). Officers are more inclined to adopt a therapeutic position that is committed to remedying the crisis through treatment and care. The decision to arrest individuals who were mentally distressed was often met with extreme reticence by officers. However, when an individual is in severe mental distress and a mental health professional is unavailable or denies the request evaluate the individual because of drug or alcohol consumption, a “mercy booking” or arresting the individual for protective custody becomes the most viable option (Lamb et al. 2002: 1277).

This suggests that characteristics of the community, such as the unavailability of mental health services, can significantly constrain the officer’s discretionary authority and influence the decision to arrest the individual in mental distress. If mental health resources are perceived as unavailable or ineffective, officers may become disillusioned
and feel the need to mercy book the individual for safety (Lamb et al. 2002; Bureau of Justice Assistance 2006; Wells and Schafer 2006).

Booking the individual in mental distress becomes a therapeutic strategy meant to protect and monitor the individual and not meant to castigate the person. The individual does not incur a label of deviant but victim where jail becomes a necessary remedy in order to isolate, protect and prevent them from harming themselves or others.

Lieutenant Reiner shared his experience with individuals in mental distress and how sometimes jail becomes the only available option.

Now, they’re acting like this [violent and threatening] and now we’ve got to get them in a situation where they can get some meds or and unfortunately sometimes the only recourse is to take them to jail and like I said and that’s really not what they need. They don’t need to go to jail.

Sergeant Johnson remarked how jail is used as a means by to regulate and monitor the safety of the individual in mental distress.

A few other folks in the homeless population who also have illnesses we had one guy who ended up—they wouldn’t deal with him anymore, at the one location so he ended up going to jail for the night. At least we can take care of him for that night, we were trying to calm him down, trying to calm him down and he just couldn’t. And sometimes that’s the situation we’re kinda dealt with. You use everything that you had and it just doesn’t work.

Officer Riley explained why individuals who observed to be severely mentally impaired are sometimes arrested and taken to jail.

Depending on what kind of crisis they’re in, what type of threats and things like that for themselves, we can arrest them, take them in, in what’s called protective custody especially if they’re a threat to themselves or anyone else and take and have them evaluated then committed.

Mercy bookings are perceived by officers as an effective way of protecting mentally ill persons from further harm and danger. When no other option is available,
mercy bookings are employed to ensure that the individual in distress will be adequately monitored and provided for. The above accounts illustrate how policing strategies are sometimes influenced by broader economic interests and, in turn, how these interests shape definitions and responses to the mental health crisis (Emerson and Messinger 1977). Similarly, a therapeutic strategy often utilized exclusively by mental health professionals is contracting the mentally ill person for safety.

**Contracting**

If an individual is observed to be suicidal by officers but upon evaluation by the mental health professional, does not meet the imminent risk criteria for hospital admission, the mental health professional will often “contract” the individual for safety. Contracts, also known as, “no suicide contracts” in their simplest form are agreements in which persons with mental illness promise not to hurt or kill themselves. Contracts commonly include an explicit statement that the individual will not harm or kill themselves as well as contingency plans if the contract conditions cannot be kept (e.g contacting 911 if contemplating serious thoughts of suicide).

Contracts are often used when officers respond to crisis situations with individuals who are suicidal and evaluation from a mental health professional is requested. After CIT officers successfully deescalate the situation, and the individual is observed not to have consumed alcohol or self-harming substances, officers will transport the person to a secure environment where a mental health professional will evaluate them. If a mental health professional feels that that an individual who is under mental distress (i.e. suicidal) but does not meet the criteria for immediate clinical admission, the
mental health professional will request that the individual sign a “no suicide contract” promising that they will not harm or kill themselves. The mental health professional assesses the severity of the crisis and decides that admission into the community mental health hospital is unwarranted.

Contracts are used as mechanism for hospitalization control which is meant to divert individuals away from the hospital and towards out-patient community mental health services. Upon signing of the contract, the individual is released and provided with a follow-up date with a mental health clinician for treatment. Mental health professionals reported that they are encouraged not to hospitalize from the community mental health board unless it is determined by them to be a genuinely severe case. Mental health professionals explained that there is a fiscal motivation not to hospitalize because of limited resources and lack of bed space in the community mental health hospital. Instead of committing someone, mental health professionals will often “contract” the individual for safety. Patrick Miller explained the rationale behind contracting mentally ill persons for safety.

Most people that we see we let go. We contract them for safety, they’ve got a supportive family, they want to go home, they don’t meet the criteria. People threaten to sue us. We have a very good track record I must say. It’s happened where we let people go and they killed themselves, um, not often. But you can’t read people’s minds and you can’t predict the future and that’s what I kinda tell people when I first sit down with them. It costs our board and our agency five hundred dollars a day for someone to be in the psych hospital. So there’s a huge motivation not to hospitalize some people in the state hospital - huge financial motivation not to do that.

Patrick’s statement suggests that suicidal threats become “stereotyped” and contracting becomes “routinized” in order to ration mental health resources and meet the
needs of only the most worthy or most severely distressed clients (Lipsky 1980).

Specifically, economic interests of the community mental health system influence the perspective of the mental health professional and the subsequent strategy for remedying the crisis (Emerson and Messinger 1977). The responsive decision to contract derives from the supply and demand of resources where suicidal individuals are likely to be stereotyped by mental health professionals as a reaction to the unstoppable stream of demand for their services (Lipsky 1980). This suggests that the availability of community resources have significant influence in the way mental health professionals organize their interpretations and attach meaning to different symptoms and behaviors (Holstein and Miller 1993). Once an individual is contracted for safety they are required to follow-up with a mental health clinician at a later date for further evaluation and treatment. Contracts are perceived as a therapeutic device by mental health professionals for linking individuals with out-patient mental health resources as well as a device for curtailing hospital admission rates.

Contracts have often been the impetus for tension and disagreement between systems. CIT Officers have reported that when a mental health professional is requested for the evaluation of the mentally distressed individual, they are typically released which is counter to the desired outcome of the officer. While officers may perceive contracts as ineffective and irresponsible, mental health professionals perceive contracts as a therapeutic device meant to link a mentally distressed individuals, who are not considered to be high-risk, with mental health resources. However, when CIT officers respond to situations where an individual has consumed a controlled substance or committed a minor
criminal offense, officers typically use the services at the local crisis center and do a pre-booking diversion as a way to link the individual with mental health services, a strategy to which I now turn.

**Diverting Frequent Flyers**

Unlike contracts, which are an exclusive mental health option, “diverting frequent flyers” or pre-booking diversion takes into account any observed criminal behavior of the individual in mental distress. The local crisis stabilization center, known as HELPD, is often used by officers as a therapeutic remedy for individuals known as “frequent flyers.” According to officers, frequent flyers or individuals in the community with a history of mental illness, drug abuse and frequent encounters with the police are usually placed in the pre-booking diversion program. The pre-booking diversion program is considered an interstice between criminal justice and mental health systems. Officers often use HELPD when they encounter someone who is mentally distressed, under the influence of a controlled substance or have engaged in a non-violent criminal act (e.g. disorderly conduct or public intoxication). Instead of arresting and transporting the individual to jail, officers use HELPD as a jail diversion in which the person is summoned to court and mandated to undergo mental health treatment. The program offers eligible offenders a treatment option that is judicially monitored. It is designed to divert mentally impaired individuals away from the criminal justice system and into community-based mental health treatment.

CIT Officers and mental health professionals perceive the criminal charges as a therapeutic harness where the individual can be monitored and treated. CIT officers
identify the trouble as a mental conflict and attempt to remedy this trouble through therapeutic means. The trouble is then treated as a “case” where a distinctive history of the individual is collected and subsequently enters a system of institutional referrals (Emerson and Messinger 1977: 128). Officers are fairly reluctant to charge and mentally-impaired in the diversion program. This suggests that CIT officers view the charges as a leverage or “carrot and stick” where the individual can be adequately monitored and receive treatment. Both CIT officers and mental health professionals reported having favorable opinions of the pre-booking diversion program.

Lieutenant Ashby explained how pending charges are meant to be a therapeutic rather than punitive strategy.

It’s one of them things where you don’t really want to charge them or you just don’t want to add to their problems. It may have not been that big of a deal so we can just take them there, to the crisis center and let them stay there. Get themselves stable and treated.

Deputy Pepper explained how the diversion program is used as an access to treatment and not meant to be punitive.

We don’t have to charge them but if there’s, you know, even if there’s a stretch of criminal charges that would be relevant to what brought us in contact with the person and they obviously are in some level of crisis so we can say, ‘how about’ this, you know, in lieu of going to jail, you go to HELPD, and there are people out there, that can help you.

The pre-booking diversion program is a mental health treatment compliance mechanism used by officers for individuals who have a history of mental illness in the community and frequent encounters with the police. Mental health professionals also acknowledge the benefits of the pre-booking diversion program. It is perceived as an integrated approach between the criminal justice and mental health system which reduces
unnecessary incarcerations and directs mentally ill offenders towards community treatment. Erin Kline explained her position on the jail diversion program.

It gives the legal system an opportunity to hold that person in kind of a cocoon – ‘we’re gonna watch you, but you have the opportunity and the obligation to engage in treatment in such a way that your life improves because if your life improves, we don’t have to see you. And if your life improves that makes us happy and that makes you happy too.’

Cathy Mayes made a similar response and explains how the diversion program is utilized as a therapeutic strategy meant to facilitate treatment.

And that’s the sort of thinking, it’s like you’re bringing them to the crisis center or to the emergency room maybe an entree’ into getting them into to treatment.

Instead of charging the individual for the crime they committed, a pre-booking diversion is used if they comply with program mandates. Mental health professionals and CIT officers contend that if history of the mentally-impaired individual is known and is observed to be nonviolent, HELPD is the most likely option. However, in order to be eligible for the diversion program, the individual must be temperate enough to willfully enter the facility and comply with the mandates of the program. Eligibility for the program is informed by the criminal justice system and defendants who opt for the pre-booking diversion program are not coerced by officers or mental health professionals to participate.

Patrick Miller explained how diversion is used for participating individuals with known mental conditions that authorities frequently encounter.

Now, if someone, we’ll tell people, if someone is just making a scene. You know, sometimes these are frequent flyers - they’ve been drinking. We’ll take them on a jail diversion at the crisis center if they can walk in faithfully under their own power.
Sergeant Johnson explained the usual outcome for frequent flyers or mentally distressed individuals who have frequent encounters with law enforcement.

I know that was one of the things they had spoken about trying to get him into the crisis center-because they remembered who he was and they kinda hand them to similar folks because of who they are, they are frequent customers- they’re frequent flyers - folks that we know about and try to work with them.

Pre-booking jail diversion is utilized as a therapeutic means and enhances the quality of life for those with serious mental illness. The pre-booking diversion program is used as a strategy which allows individuals in mental distress to avoid further penalties and involvement in the criminal justice system. The criminal justice and mental health systems work together to marshal existing resources and reduce the number of persons with acute mental illness in the criminal justice system. However, when a mental health crisis is defined as “severe” by a mental health professional, admission into the mental health hospital will be the most likely intervening response.

**Pink Slipping**

Pink slips are used as a therapeutic remedy for immediate hospitalization when responding to individuals perceived to be in severe mental distress by mental health professionals. In the community, officers explained that they have the authority to pink slip according to the Ohio Revised Code (ORC). Officers argued that despite having the authority of the ORC, they still do not have the authority pink slip an individual they perceive to be severely mentally ill. A trained mental health professional only has the authority to admit someone into the hospital for treatment. In a sense, mental health professionals, not officers, are the ultimate gatekeepers to the mental health system today. However, during the course of my research, it was observed that there was confusion
among officers about why they lack the power to pink slip someone they regard to be in severe mental distress.

Deputy Pepper explained why CIT-trained officers lack the authority to pink-slip and must request the evaluation of a mental health professional to hospitalize.

Well in this county, we don’t pink slip. Deputies don’t pink slip. We got to justify somebody’s job. We got to justify Canter County Mental Health’s job. That and the ORC is under our jurisdiction and we should be allowed if we’re properly trained, CIT trained, to be able to recognize the symptoms and pink slip when necessary – that’s in the ORC. But here, we have to justify county mental health. So we have to bring somebody here and call Canter County Mental Health and they evaluate them. But I don’t think deputies should have the authority to just pink slip like the olden days. They should have to go through CIT training and that should be part of there – I shouldn’t have to justify Canter County Mental Health and their grants and their numbers and their bull crap. As a deputy, if I can recognize the symptoms and the signs of what’s going on, then I should be able to pink slip - no, I justify Canter County Mental Health.

The officer argued that the primary reasons CIT-officers lack the authority to pink slip is a result of economic incentive for the local mental health system. Economic considerations and the availability of mental health resources shape how the crisis is defined as well as the appropriate institutional response (Emerson and Messinger 1977).

Deputy Pepper went on to further explain his position on why only mental health professionals only have the authority to pink slip and not specialized CIT officers.

Because we have county mental health, we have to justify them and it’s all about dollar. ‘Oh Canter County Mental Health so we can put on this grant we were called seven thousand times last year, we need that money. We need those grants because we were called out seven thousand times.’ They are justifying their job, justifying their existence.

However, mental health professionals explained that in the past, officers did have the authority to pink slip. At one time, officers did have the authority to freely transport and admit someone they perceived as severely mentally ill into the community mental
health hospital for treatment. However, there was controversy over if the persons’
officers were admitting into the hospital actually were mentally-impaired and if the
symptoms associated with mental illness were being correctly identified.

John Fritzer argued that officers were not accurately recognizing behaviors
commonly symptomatic of acute mental illness. Upon inspection of the admission data,
it was discovered they were admitting individuals who did not meet the high-risk criteria
for immediate psychiatric admission.

Let’s look at the data about the admissions that police officers bring to the
hospital. Is there a problem? Are they bringing people who don’t belong? And
somebody went, hm, interesting question, so we started looking through the
research, looking through what was coming through and everybody went, ‘yeah,
tyhey have a very high hit rate, it’s well into the 90 plus percent, mid nineties,
upper nineties,’ these guys – again – may have no clue what they got…

Patrick Miller made a similar response on why officers not longer have the
authority to pink slip.

I think it’s a money issue, it just got to be too huge-too many people, where the
cops could just bring anyone there. So they had these gatekeepers in place, in
large part because of the money, because it cost - we contract for so many bed
days a year, we’re not supposed to go over that. We do, we did last year - we went
way over.

The accounts suggest that officers were admitting individuals into the psychiatric
hospital at an alarming rate. His account suggests that officers were peremptorily
medicalizing the problem and removing the allocation of blame from the individual in
crisis. Officers were adopting an asymmetrical or one-sided stance of alignment where
signs of distress were automatically attributed to their mental illness (Emerson and
Messinger 1977). However, after examining records relating to officer admission rates,
their authority to pink-slip was revoked leaving only a licensed public medical officer the
authority to admit. Mental health professionals argued that hospitalization is only an acceptable option under the most severe cases. Erin Kline elaborated on mental health severity and when it is appropriate to pink slip.

They way that our legal system is set up is we don’t hospitalize people unless it’s under really extreme circumstances. It takes a lot to get pink-slipped.

Similarly, Patrick Miller spoke of his experiences with severe mental crisis and suicide attempts at the local jail.

If someone is psychotic and not treated, not on meds, we usually hospitalize them out of the jail. So we get a fair amount of jail holds over there too, people that come from the jail either because they did a serious suicide attempt, like wrap something around their necks - serious cutting. We do see people cut and leave them there but if they do a serious cut, we’ll hospitalize them or psychosis mania, we’ll hospitalize people for. The hospital will treat them - it doesn’t count against their jail days and bounce them back to the jail once they’re well.

John Fritzer explained the difficulty in admitting and why only the most severe cases warrant hospitalization.

It’s so hard to get in there. From our catchman area, typically any one day, we probably have fifteen people in there and they have eighty beds and it’s not that unusual for them to be full over the past two-three years. Especially, since Cambridge closed. There are eighty beds over there! And it’s close to full! And people are getting help, despite people thinking that no one gets in there or no one gets any help. We admit people all the time!

John’s statement suggests that the extreme limitation of resources in the hospital prevents many CIT officers from admitting individuals they perceive in severe mental distress. The availability of beds and economic concerns determines who is admitted into the facility. Similarly, it is only through the definition of mental health crisis of the mental health professional that grants urgency and admittance into the community mental health hospital.
Both mental health professionals and CIT officers are both acknowledged as official troubleshooters responsible for employing strategies that facilitate institutional outcomes. Mercy Bookings and Diverting Frequent Flyers are used as therapeutic strategies to monitor and enhance the quality of life for the severely mentally ill.

Contracting is used as a mechanism for controlling hospital admission rates and linking individuals with out-patient community resources instead of in-patient hospital services. Lastly, Pink Slipping is a strategy employed by mental health professionals only when the individual in distress meets the high-risk criteria defined by the mental health professional. We need to consider how both systems define mental illness and how these definitions influence the direction and type of intervention used to respond to the crisis. I conclude that the direction and type of strategies that are employed are contingent upon how the crisis is recognized by official intervening parties as well as the consideration of structural interests. However, intervening parties are likely to negotiate their own definitions with other parties conflicting definitions in an attempt to reconstitute the trouble and impose a response more aligned with their own professional beliefs and organizational desires.
Goffman (1961) defined the shift of a trouble from one agent to another as the “circuit of agents” where the problem moves upward towards greater troubleshooter specialization. During crisis situations with the mentally ill, officers are perceived to be the “generalists” who identify an ambiguous or complicated trouble and pass on the trouble to “specialists” or mental health professionals who crystallize the trouble (Emerson and Messinger 1977: 127). Specifically, officers are often the first to arrive at the scene of crisis situations where they must quickly identify the source of the crisis. After the crisis is successfully deescalated by the officer, the assistance of a mental health professional is requested to reevaluate and/or reconstitute the definition of the trouble.

CIT officers and mental health professionals often encounter situations where their professional definitions of mental illness come under scrutiny and are purposely redefined by other intervening parties. Definitions of mental distress between officers, mental health professionals, and other parties are largely constructed by their own expertise. Consequently, definitions of mental health crisis are likely to lead to conflict between parties in defining and responding to the individual in crisis. A direct complaint made to the other is likely to change the dynamics of the perceived trouble where it becomes reconstituted and reinterpreted (Emerson and Messinger 1977). Official intervening parties must often confront and must negotiate mental health severity and definitions of mental illness with other intervening parties in an attempt to impose particular one-sided responsive strategies.
Negotiating Severity

CIT officers reported being in situations where their definitions of mental illness severity were challenged and often looked at with incredulity by mental health professionals. Conflict results when an officer’s request for immediate evaluation and treatment is dismissed by mental health professionals. CIT officers at times have to negotiate definitions of mental illness and risk with other official troubleshooters in order to procure acceptable mental health services for individuals they regard to be in a state of severe mental distress.

Officer Paul Riley remarked how in the past he has put authoritative pressure on mental health professionals in order to get compliance and get someone perceived to be severely mentally distressed admitted into the mental health hospital.

‘I’m telling you right now, if you don’t put this person in the hospital, you’re accepting full responsibility for whatever this person may do. They go, ‘what do ya mean?’ ‘I’m telling ya, this person’s gonna hurt somebody and if you don’t do something with them, I’m washing my hands and you’re gonna take full responsibility because I’ve done everything I can to put this person in the hospital and I’m gonna document it as such.’ More times than not when you put that kind of pressure on em, ‘no we’ll try and do something.’ Sometimes it comes down to that, I mean the best advocate for those with mental health you would think would be someone in the mental health community.

Officer Riley’s account suggests that his complaint assisted in reconceptualizing the trouble and securing mental health services for the individual in mental distress. The jurisdiction of the officer and fear of liability had considerable leverage in the mental health professional reconstituting the trouble and directing a response that was favorable for the responding officer.
Deputy Pepper explained a similar experience in attempting to get hospital admission for someone perceived to be severely mentally distressed.

The mental health professional could be sitting in that room talking to them but when it’s all said and done, Canter County mental health is going to make the decision. I’ve talked to people many times and said, ‘hey, this person’s having a lot of issues, they’re seeing people, they’re saying they wanna harm themselves or others and they end up not going to the hospital.

Similarly, Lieutenant Reiner expressed his frustrations with mental health professionals’ definitions of mental health crisis.

This person needs help, they’re pretty disturbed, and they end up not going to the hospital. And you go man, what’s it-what’s it take? And they go, we only have one bed and it’s the weekend and if I put this person in there, the potential for this to happen.

Lieutenant Reiner’s statement illustrates how availability of resources shapes the definition of severity and the subsequent response. Many times officers reported becoming disillusioned because of failed attempts with negotiating with mental health professionals. Lieutenant Ashby recalls prior experiences with the mental health system where individuals in severe mental distress were not being adequately being treated to the purview of the responding officers.

Yes, we’ve disagreed there are several people we thought, not necessarily need to be locked up but need to go somewhere to be observed for a few days to make sure so they didn’t kill themselves.

Officer Riley talked about his frustrations in negotiating acute mental distress with mental health professionals.

We’ve had people in there that had guns and threatened to kill themselves. ‘Well, I’m gonna kill my frickin self.’ It’s not like we heard it from a cousin or heard it from somebody else we heard it from there mouth. They come here, talk to em for a half hour and come out, ‘well they’re gonna go home now, yeah they’re not gonna kill themselves, they promised they wouldn’t.’ I’m not jokin buddy, I’m serious!
Officer Riley then elaborated on the adverse outcomes of some of the individuals who were perceived to be in a state of severe mental distress by officers, but were only evaluated and released shortly after by a mental health professional.

Yeah guys got a gun, threatening to kill himself and we get there and he’s like ‘I’m gonna kill myself.’ We talk him out of it and get him to come in here and talk to somebody, hey buddy did you threaten to kill yourself, ‘yeah I’m feeling really low, I wanna kill myself.’ Okay, want to come in and talk to somebody from county mental health?” ‘Sure lets go.’ They go in that little room there so they can have their private conversation. Thirty minutes later they come out. ‘Well, they’re gonna go home and they promised me they wouldn’t kill themselves.’ It can be like a Friday, ‘well they’re gonna follow up on Monday at county mental health.’ Well, they’re not the ones who are gonna go out - they should be the ones who come out and help us clean up, carry the dead body out and not clean the scene up but they should see the brains splattered all over the wall and hair stuck in the ceiling.

The above statements suggest that CIT officers become disillusioned due to the numerous failed attempts to obtain treatment for someone in severe mental distress. CIT officers observe the behavior of the individual in distress to be axiomatic which engenders a mental health response. However, mental health professionals redefine the officer’s perceived trouble by their own expertise and from the consideration of economic and organizational interests to determine that hospitalization is not an acceptable response.

Similarly, CIT officers have expressed frustrations with being unable to get an evaluation from a mental health professional if the individual has consumed alcohol or a controlled substance. Both mental health professionals and CIT officers explained to me that if an individual had consumed any amount of alcohol or drugs, evaluation from a mental health professional is not an option. Mental health professionals typically refuse to evaluate a person under these conditions. This denial only further adds to officer
dissatisfaction and frustration with the community mental health system. If a mental health professional denies assistance because the mental has consumed drugs or alcohol, mitigating responding strategies for the officer become even more restricted.

The mentally distressed individual must first be medically cleared by a physician before a mental health professional will consider evaluation. CIT officers contend that if an individual has consumed alcohol but observed not to be inebriated, a mental health professional should still be able to evaluate the individual in mental distress. CIT officers argue that is through their perpetual interaction with individuals in the field, they can determine if a person is intoxicated and impaired.

Deputy Pepper explained his position regarding alcohol consumption of someone perceived to be mentally-impaired.

You need to take them to the hospital and have and have em checked out. They’re not intoxicated! If they’re threatening to kill themselves and they’ve had one drink, they’re still fine. If they’re falling down drunk – that’s another thing. There are times where I’d say, that person shouldn’t be driving a car. Okay, there ya go. If I think they’re steady enough, voice patterns are fine and everything else to drive a vehicle - absolutely you should talk to them - use officer discretion. And then they wanna question our ability to tell if somebody is drunk, for crying out loud. Have they been drinkin? Well, they said they had one sip of wine but they’re okay.

Even though the officer identifies that individual as having consumed alcohol, the problem is attributed to the individual’s mental illness where a label of victim, not criminal, is incurred (Emerson and Messinger 1977). It is through interacting with the individual in mental distress that the officer interprets the trouble and directs the conflict towards the appropriate and most acceptable services. However, despite being perceived
as sober and competent by the officer, a mental health professional will still deny the request for clinical evaluation.

Patrick Miller explained his position on why evaluation for clinical admission is not an option if someone who is regarded to be severely mentally distressed has consumed alcohol.

We were hearing the guy had drank a fifth of booze. We don’t go see drunk people. We can’t counsel them, we can’t hospitalize them. So that kind of thing comes up a lot. The police - the medical clearance thing is a huge hurdle.

The above account suggests that Patrick does not perceive the individual in need of immediate treatment due to the observed the consumption of alcohol. Mental health professionals and CIT officers operate with a distinctive theory of trouble and interventional ideologies. CIT officers are conditioned to the ideology of discretion in evaluating sobriety and competence. Comparatively, mental health professionals are conditioned to an institutional ideology where any alcohol or drug consumption automatically results in a lack of inhibition and the source of the perceived trouble cannot be readily identified. These competing definitions of severe mental illness become the source of conflict between meeting the needs of the individual and meeting the needs and goals of the organization. The individual becomes stereotyped and identifies the client as ineligible for immediate mental health evaluation and treatment (Lipsky 1980).

Mental health professionals also acknowledged that they frequently deal with outside parties’ reactions to their decisions. At times they feel pressured or coerced to hospitalize as a result of outside pressures, namely from other official parties including physicians and officers. Mental health professionals argue that they constantly find
themselves in “power struggles” with other parties in how they identify and define severe mental distress.

Patrick Miller explained his contentions with emergency room physicians and his decision to deny a referral for hospitalization.

Physicians! It’s weird, cause we’ll go up against doctors, ya know, a social worker! And a doctor in ER can’t get someone in there. And there’s been times in the past where a doctor has tried to-well we’ve all gone through this- where a doctor thinks someone needs to be in there. He’ll tell us, ‘A guy did this-he overdosed last night he needs to be in the hospital!’ Well, you say, ‘contract him for safety, he’s got a supportive family, he wants to go home, he doesn’t meet the criteria – No, we’re not gonna do that.’ So we get in these power struggles, but the hospital will not take them from a doctor. They will not accept the referral unless we “okay” it.

It is only when a mental health professional recognizes an individual in severe mental distress that hospitalization becomes an appropriate response. The mental health professional identifies and subsequently conceptualizes the trouble as a bodily illness where immediate psychiatric intervention is needed to remedy the trouble (Emerson and Messinger 1977). If the individual in question is not perceived, at first, to be severely mentally disturbed, other outside parties can intervene and negotiate the definition of the trouble in attempt to facilitate a one-sided response.

Erin Kline explained her frustrations with competing definitions of severity between systems.

Yeah, and a lot of ER’s and cops think their crisis is the big one, ya know? Or this guy’s the really crazy one or you’re gonna let this person go? And how can you…We see this shit every day. We can’t lock everybody up that says they’re gonna kill themselves. There’s a lot of mentally ill people! (laughs) A lot that live in this town!

Erin’s statement suggests that the definition of severity is shaped by the availability of mental health resources and the anticipation of more severe mental health
crises. Differing perceptions of what constitutes “severe” mental distress has often been considered the progenitor of tension between these two systems. Like officers, mental health professionals and officers have specialized ideologies that dictates decisions and subsequent responsive actions. Situations where an officer may perceive an individual in severe mental distress and in need of clinical treatment, a mental health professional may perceive the same individual as a low priority for treatment or hospitalization. The definition of severity by the officer is reshaped and stereotyped by the mental health professional as commonplace where the individual in mental distress is ‘not worthy’ of in-patient mental health services and resources (Lipsky 1980).

Situations have also occurred where officers have admitted individuals to the crisis center they perceived as non-threatening but eventually became violent and caused injury to patients and staff. Officers have received resistance from mental health professionals for transporting individuals they recognize as “psychotic” to the crisis center, in lieu of requesting assistance from a mental health professional or transporting them to the emergency room for medical evaluation.

Cathy Mayes talked about her experience with officers misidentifying symptoms of an individual who was severely psychotic.

This was someone that again, ‘we [the cops] thought we could maintain this guy at the crisis centers.” The crisis center is not locked. We have no doctors. We can’t give anyone medicine. This kid had driven from Indiana. His dad said he had his first psychotic break and had just been diagnosed with schizophrenia. This kid had literally got in his car and was driving away from the voices which he referred to as “It.” He was here for a month before they shipped him back to Indiana. ‘Really, you guys think that’s appropriate – the crisis center (laughs)?’ Or jail diversion? That guy needed to go to the ER. So, I was there within an hour, crisis staff calling me saying this guy was nuts.
Cathy’s statement also suggests that officers regularly misidentify symptoms associated with acute mental illness. However, officers may be disillusioned as a result of the numerous failed attempts to hospitalize someone they perceived to be severely mentally ill but were only dismissed by mental health professionals. Consequently, officers may be apprehensive about requesting the assistance of a mental health professional for evaluation and instead use the services of the crisis center as a strategy to quickly pass the trouble to another interventionist and link the individual with the mental health services. However, these public service professionals often come at odds with other professionals and outside parties’ definitions of mental illness. Definitions of mental illness are contended with and negotiated in attempt to reconceptualize the trouble and impose a mitigating response that correlates with their professional beliefs and organizational interests.

**Negotiating Definitions of Mental Illness**

As explained in chapter three, differing interpretations of mental conditions has also caused conflict and strain between the systems. Where officers may perceive someone as “talking out of their head” and contemplating suicide, a mental health professional may perceive the person as being manipulative and exhibiting behavior that should not be automatically associated with mental acute illness. Mental health professionals explained that the individual’s deviant behavior might be a proxy for another underlying problem. The conflict is perceived and identified as deviance and not a mental illness. This ambivalence between officers and mental health professionals on
what constitutes someone with mental illness and in crisis has also caused conflict
between mental health professionals and CIT officer’s during actual crisis situations.

John Fritzer described his experience with a CIT-trained officer from the Wilson
University Police Department who had a differing prognosis of the individual in crisis.

My take on the individual pretty quickly was this was a severe character disorder
and he was being essentially manipulative. When you see somebody sitting on a
rail smiling and whatever - this looks like some other dynamic and so afterwards,
when we were kind of talking about it. I got into, kind of a big argument about
what was wrong with this individual [WU officer] and the WU officer was sort of
adamant that this was a person who was depressed, who was having marital
conflict and needed to be dealt with as a seriously depressed and stressed
individual. Well, what kind of people would do this, people who are extremely
manipulative, often narcissistic, sometimes borderline personality, and that’s and
that’s, everybody says, he’s a male character, he’s in the middle of a conflict with
his wife and this is about him. This is his narcissistic anger over… And so that’s
the only time we ever got into it.

John’s statement illustrates how definitions of mental illness are shaped from
expertise and particular experiences. The CIT officer conceptualizes the behavior of the
individual as severe mental distress because the individual was engaging in behavior that
was believed to be attributed to his state of mind rather than his moral character. John
perceived the same individual as morally competent and his behavior as intentional – not
symptomatic of a mental illness.

John then goes on to explain the death of the mentally distressed individual and
the CIT officer’s response to the death.

Well he died. I mean to this day, that individual [WU Officer] believes that this
was a seriously depressed individual. Really, he got very angry with me. One
time, I went over and wanted to talk about. I thought, the officer was in real
distress about this person’s passing and-and he just got yelling at me, ‘I learned
nothing from you!’ I said, ‘okay, whatever works for you,’ and it’s just different.
Similarly, Erin Kline commented on how officers attempt to negotiate particular definitions of mental illness with mental health professionals.

I know you hear about huge numbers of mentally ill in prison and I’m sure that happens and I know that happens at the jail. But I also see maybe, maybe officers thinking someone’s mentally ill where we would see them more as sociopaths or personality disorders or substance abuse, or than someone who is really psychotic and that needs to be in the hospital. And there’s that disagreement, sometimes we think someone needs to go to jail. The cops say, ‘no, he needs to go to the hospital he’s saying he’s gonna kill himself.’

Patrick Miller also explained how law enforcement officer have difficulty distinguishing between behaviors symptomatic of mental illness and actual criminal behavior.

I guess by definition and sometimes-sometimes cops and others just don’t pick up on it. So I guess it goes both ways where they may think someone’s really crazy and we might think someone’s just a criminal and there are other times where they may think someone’s fine and not want to bring them to us.

The above accounts suggest that mental health professionals still perceive that officers typically misidentify symptoms between different mental illnesses. CIT officers and mental health professionals both acknowledged that disputes were a common occurrence when negotiating the definition of the trouble and the direction of the responsive strategy.

Officers have also reported instances where other parties intervened in the troubleshooting and have influenced the definition and response of the trouble. The trouble of the individual is more likely to be labeled deviant if they are receiving resistance from outside parties or their jurisdiction is superseded by a superior authority. CIT officers are more inclined to perceive the individual in mental distress as a victim rather than a troublemaker. This suggests that they operate with a committed, one-sided
therapeutic stance towards the individual in crisis wherein a mental health response is the
most acceptable strategy to placate the conflict. However, competing definitions of
mental illness and pressure from outside parties can reconstitute the definition and change
the direction of the mitigating response.

Lieutenant Ashby reflected on an experience with a mentally ill university student
who was in the diversion program but the charges against the student were processed as a
result of pressure from an outside intervening party.

He was pretty sick so they were gonna’ pink slip him. Wasn’t gonna’, serve him,
wasn’t gonna’ file it or anything. Well, I leave from work and somebody goes out
at the chief’s request or directive and files that charge on him and gives a copy of
the charge to the kid. And I called the chief and he said let me check with the
associate dean of students or whatever. She had concerns that the parents didn’t
realize the true nature of this or some crap or another. So he calls me back and is
like, ‘we’re lettin’ the system run its course. I mean just, he goes to court, it they
gotta’ pay bond to get him out, they pay the bond, he was a student who made a
bad choice.’ I was like, ‘he’s not any student, chief, he’s a psychotic student.’
‘That’s not for us to determine.’

Lieutenant Ashby’s account illustrates how outside parties and the reactions of
others can intervene and reallocate blame. Lieutenant Ashby’s authority was superseded
by the chief of police, a party with more power, where the blame was reallocated on the
mentally-impaired individual making him a perpetrator and not a victim. Third parties
relative to that of the original party attempt to negotiate and impose their own solution to
the trouble by seeking more powerful troubleshooters who can effectually
reconceptualize the definition of the trouble and impose a response more aligned with
their own goals and desires (Emerson and Messinger 1977). The involvement of new
participants introduces new definitions of trouble which facilitate new conceptualizations
of the nature and causes of the trouble as well as appropriate remedies to mitigate them.
(Miller and Holstein 1993). In this case, the trouble was redefined and responded to in a way that meets the immediate interests of the intervening third party rather than that of the individual in mental distress.

The outside parties take sides and attempt to construct a definition of the trouble according to their own logic and seek intervention with a stance positioned on his or her side. Mental health professionals argued that if they receive enough resistance from the family members or initial parties to hospitalize, the mental health professional will be more inclined to take a therapeutic stance towards the individual and refer them to mental health services. Outside parties play a decisive role in determining the definition and facilitating further action towards the individual in distress. The activities and reactions of complainants and other troubleshooters are important factors in influencing how the problem of mental illness is defined and treated.

In summary, this chapter shows that through interaction with persons in mental distress, CIT officers identify a conflict symptomatic of a mental illness and attempt to isolate and remedy this behavior through the services of a mental health professional. However, public service professionals from both systems conflict with other parties and attempt to negotiate definitions of severity and mental illness. CIT officers are perceived as generalists who must quickly identify an ambiguous trouble. After the trouble is identified as a mental illness, the trouble is passed on to more specialized agents or mental health professionals where the ambiguous trouble is cautiously reevaluated and reconstituted. Public service professionals from each system as well as the reactions
from outside complainants have definitive roles in the conceptualizing the trouble and
determining the institutional network it enters (Emerson and Messinger 1977).
CHAPTER 6: CONCLUSION

CIT has played a pivotal role in the decriminalization of the mentally ill. The partnership between the law enforcement and mental health system has profoundly impacted the mental health community by diverting mentally distressed individuals away from the criminal justice system and towards community mental health services. In the past, officers had the role the gatekeepers to the mental health or criminal justice system. However, in the wake of deinstitutionalization and the relatively new collaboration between the law enforcement and mental health system, officers no longer retain this role. Mental health professionals have now become the primary gatekeepers to mental health resources. While officers have the authority to arrest, they lack the authority to hospitalize. Drawing on Lipsky’s (1980) classic work, CIT officers and mental health professionals are conceived as ‘street-level bureaucrats’ who are responsible for immediately implementing policy that is responsive to the citizens needs. However, these ‘official troubleshooters’ discretionary authority and capacity to implement particular responses is continually restricted by competing definitions of mental illness (Emerson and Messinger 1977). Consequently, these professionals must often negotiate definitions of severity and illness with public service professionals and other intervening parties to impose acceptable mitigating responses.

Throughout this study, I draw from Emerson and Messinger’s (1977) micropolitcs of trouble and Lipsky’s (1980) street-level bureaucracy perspective to illustrate the definitions of mental illness between CIT officers and mental health professionals. Furthermore, I examine how these definitions are shaped and, in turn, shape responsive
strategies. This research examines the processes involved in formulating definitions of mental illness among law enforcement and mental health professionals and how these definitions influence the strategies used for responding to individuals in mental distress.

The data reveal that CIT officers and mental health professional define and understand mental illness differently which subsequently influence the type and nature of the responding strategies. First, CIT officers come to understand and define mental illness through hearing personal stories and experiences of mental health consumers and their families. These personal accounts assist in building empathy wherein officers regard mental illness as a multifaceted disease where the affronting behavior of someone in mental health crisis is a result of their illness and not their moral character. As a result, officers are more inclined to respond to the situation therapeutically rather than punitively. Comparatively, mental health professionals contend that individual responsibility must be accounted for with all mental illnesses and a distinction between criminal behavior and mental condition should be carefully defined.

Contrary to historical notions of officers’ authoritarian demeanor and mental health professionals’ sensitivity towards mental illness, the data illustrate CIT officers are reluctant to assign culpability to anyone exhibiting symptoms of distress and more inclined to respond therapeutically and link them with mental health resources. In comparison, mental health professionals are reluctant to exclusively attribute criminal behavior to an individual’s mental condition and more inclined to respond punitively to candid recalcitrance.
Second, contingent on how the mental distress is defined, CIT officers and mental health professionals employ different strategies to mitigate the crisis. Officers will typically “mercy book” the individual when they perceive no other options are available. If the history of the individual in mental distress is known, they will likely be diverted away from the criminal justice system and towards a judicially supervised treatment regimen. Comparatively, mental health professionals also seek to divert individuals away from in-patient hospital resources and will often contract individuals for safety and follow-up with them at a later date.

Third, admission to the mental health hospital only becomes a viable option only when the mental health professional conceptualizes the mental distress as severe. Consequently, CIT officers and mental health professionals and must often negotiate definitions of severity and mental illness in attempt to reconceptualize the perceived trouble and to justify a one-sided response that aligns with organizational interests. I conclude that how CIT officers and mental health professionals define and respond to mental illness is influenced by their own experiences, expertise and broader social forces (Lipsky 1980; Emerson and Messinger 1977).

Fourth, few studies have examined how “troubles” are negotiated between two different types of street-level bureaucrats. This study has argued that interactional and structural factors can both shape definitions and mitigating responses. Emerson and Messinger (1977) point out that broader economic, political and social interests or “macropolitics” influence how the trouble is identified and responded to (132). It could be argued that the economic downturn and lack of state funding for mental health
resources influence whether the trouble is conceptualized as a “crime” or a mental health “conflict” (Emerson and Messinger 1977). Specifically, economic interests can be overwhelmingly powerful determinants in influencing how troubles are identified, defined and treated. This study contributes to other literature on street-level bureaucrats and micropolitics by exploring the interdependent relationship between two types of public service professionals and how larger structural forces can influence whether behaviors and activities are defined and treated as a crime or the result of an uncontrollable mental condition.

In summary, the partnership between law enforcement and mental health system are an essential component to community-oriented policing. These public service professionals use their expertise and discretionary authority to deliver client services and, when necessary, facilitate punitive action. However, their discretionary authority to deliver services is often stymied due to broader structural forces. Specifically, micropolitics and macropolitics play a significant and influential role in how public professionals construct, respond to and negotiate specific social problems.

It is imperative that social science research continues to explore these perceptions of public service professionals and how they respond to crisis situations with the mentally ill at a ground level. The more scholars explore this avenue of research, a more informed, and lucid understanding will be discerned of how both systems interact and how these differences in definitions are shaped and influence responsive strategies when involved in crisis situations with the mentally ill.
While the current study has been limited in terms of methodology and analytic focus, the research suggests other avenues for further sociological inquiry. It might be interesting to explore the types of issues that become troublesome in different community settings. Research should examine how troubles are shaped by community factors. Specifically, researcher might explore how the operation of CIT programs are conditioned and influenced by local contexts (Spencer and McKinney 1997). In my data, institutional and economic constraints of the community influenced how mental illness was defined and responded to among public service professionals. Lastly, research should explore the processes of how behaviors associated with mental illness are classified among public service professionals. How do CIT professionals classify an individual’s behavior and actions based on evidence of mental illness and individual responsibility (Miller 1983).

In conclusion, the research of CIT indicates that the specialized training that officers undergo to become CIT certified has positive effect on their beliefs, attitudes and knowledge related to mentally ill persons. In general, CIT officers feel better prepared to manage encounters with individuals in mental distress and more likely to link them with the mental health resources. However, it may be interesting to more rigorously explore the discernable connection between the micropolitics and macropolitics of CIT officers and mental health professionals and how local contexts and structural forces influence definitions of mental distress and other social problems. As CIT becomes more formalized in jurisdictions and municipalities across the country, this phenomenon may
be explored more thoroughly in order to institute national standards and best practices for treating persons with mental illness.
REFERENCES


