LAW ENFORCEMENT OFFICERS' READINESS TO WORK WITH PEOPLE WHO ARE MENTALLY IMPAIRED

A Project

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by

Samedi Thach

Robynn Thomas

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by

Samedi Thach
Robynn Thomas

Approved by:

__________________________, Committee Chair
Dale Russell, Ed.D., LCSW

__________________________
Date

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Students: Samedi Thach
Robynn Thomas

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Division of Social Work
Abstract

of

LAW ENFORCEMENT OFFICERS’ READINESS TO WORK WITH PEOPLE WHO ARE MENTALLY IMPAIRED

by

Samedi Thach,
Robynn Thomas

There is increased interaction with law enforcement officers and people who have mental illnesses. Law enforcement officers’ interactions are often guided by poor training that can lead to a violent interaction with people who have a mental illness. Law enforcement agencies can benefit from having increased mental health training or developing specialized teams to handle calls involving people who have mental illnesses.

This study takes a meta-analysis approach to study law enforcement readiness to work with people with mental illnesses. Data on law enforcement officers’ contact with people who have mental illnesses, referrals, arrest and training hours will be analyzed.

The study shows that law enforcement officers are not prepared to work with people who have a mental illness due to inadequate training and knowledge base of all depositions available – leading to the criminalization of the mentally ill.

_______________________, Committee Chair
Dale Russell, Ed.D., LCSW

_______________________
Date

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Chapter 1
INTRODUCTION

According to the National Institute of Mental Health, approximately 26.2% of Americans have a mental illness. As a result, law enforcement officers are coming into increasing contact with people who have mental illnesses. These interactions are guided by training that is often inadequate. Many law enforcement agencies would benefit from having specialized teams to respond to calls about people suspected of having a mental illness; yet most do not invest the time to train officers and build specialized teams. Thus, most police officers must work with people with mental illnesses even if they feel their training is insufficient.

Poor training of law enforcement officers in this area can lead to a deprived knowledge base about the mentally ill, negative attitudes toward the population, and interactions that can end in arrest or violence. Unsatisfactory training can also hinder an officer’s ability to decide on the proper resolution to a situation involving a person with mental illness.

In addition to the effects on officers, there are lasting effects on the mentally ill population and family members with whom officers come into contact. Accompanying a lack of knowledge surrounding mental health, officers are often unaware of community resources that can help this population—resulting in many people with mental illnesses being arrested rather than being referred to a more suitable resource. In some cases, violence occurs that may lead to the death of the people with mental illnesses. Take the
case of Jeremey Lum who was arrested by Lathrop, California police officers on July 8, 2009. Jeremy was diagnosed with bipolar disorder and was going through a bipolar episode with hallucinations and paranoia when police officers approached him. Police officers claimed he was intoxicated due to his bizarre behaviors. Jeremy was taken to San Joaquin County Jail, held for seven hours and released without receiving a mental health evaluation or medication. He notified the officers that he had bipolar disorder and needed medication during his booking. Three days after Jeremy was released, his body was in the river behind the jail. Jeremy’s story is one of thousands that occur yearly as a result of the lack of knowledge the law enforcement system has situations involving with people with mental illnesses.

**Background of the Problem**

In cities with populations of 100,000 or more, approximately 7% of all police contacts with the public involve people with mental illnesses (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). These interactions can have several outcomes, which are determined by the officers. These outcomes include leaving the person with mental illness with a friend or family member, referring them to mental health services, taking them to an emergency department and arresting them (Cooper, Mclearen, & Zapf, 2004).

One study concluded that 55% of police departments do not utilize specialized response teams for calls involving people with mental illnesses (Deane et. al, 1999). Those departments that do have specialized response teams employ one of three identified approaches: a police-based specialized police response, a police-based

**Statement of the Research Problem**

The lack of sufficient training of law enforcement officers is associated with inappropriate outcomes for the mentally ill population with whom they come into contact. Officer deficiency in knowledge of mental illness, how to work with people with mental illnesses and available community resources sometimes leads to disastrous conclusions. Although some agencies have addressed this problem by supplemental training or specialized teams of responders, most have not.

**Purpose of the Study**

This study aims to identify the points of weakness in mental health training among law enforcement officers. The research focus is on the amount of training law enforcement officers receive about mental health and their knowledge of community resources based on type and frequency of treatment referral.

The study’s primary goal is to create awareness of the problem and generate additional studies that develop specific curriculum training for law enforcement on mental health. The secondary focus is to advocate for the creation of specialized Crisis Intervention Teams (CIT), collaboration among mental health workers and law enforcement officers and increase law enforcement training so that people with mental illnesses can receive appropriate help when encountering law enforcement.
Theoretical Framework

Criminal justice policies elicit certain attitudes, emotional responses and behaviors from both law enforcement officers and people with mental health problems (Jennings, Gover, & Piquero, 2011). A framework to consider when analyzing these interactions is the procedural justice theory. This theory is based on the idea of perceived fairness. Procedural justice involves the administration of justice and legal proceedings that are connected to due process along with fairness and transparency of decisions made. If parties see transparency and feel that they have input in the due process, the perception of the interaction is positive (Watson, Angell, Morabito, & Robinson, 2008).

Law enforcement officers have great power over their decisions when engaging with a person with a mental illness in the community. They can choose to make an arrest, defer to mental health agencies or leave the person in the community. These decisions are often made based upon law enforcement officers’ background and training in mental health. If a law enforcement officer views a person with a mental illness negatively, the perceived fair decision from the point of view of the law enforcement officer could be to arrest and act aggressively. On the other hand, if the law enforcement officer views mental illness as an illness that needs treatment, he or she may be more willing to de-escalate the situation or refer to a mental health agency or hospital.
Definition of Terms

For the purposes of this study, mental illness will be interpreted as a diagnosis on Axis I of the Diagnostic and Statistical Manual of Mental Disorders IV-TR, including psychotic disorders, mood disorders, dissociative disorders, cognitive disorders and substance related disorders. Law enforcement officers are defined as government employees whose duties are to prevent, investigate, apprehend or detain individuals suspected of breaking the law.

Assumptions

Meta-analysis combines data from different independent studies to determine a pattern. This study assumes that data used are exchangeable – studies used are comparable and results can be interpreted directly. All studies used, reported in detail that significant information could be retrieved about its effect. Samples from studies were independent.

Justification

The research from this study seeks to benefit people within the mentally ill population. The outcome of this study will inform law enforcement agencies and mental health agencies about the successes and failures of current interactions with people with mental illnesses. This research will further identify law enforcement officers’ most successful interventions with the mentally ill population.

This research will also reveal ways that social workers can facilitate better education and training for law enforcement agencies. It may also expose ways in which social workers can help strengthen the working relationships between community mental
health programs and law enforcement agencies, thus improving the care and quality of life for the mentally ill population.

**Limitations**

This research study does have some limitations. Information from previous studies has been combined. These studies do not focus on one particular location or type of law enforcement agency, making it difficult to generalize the results to local law enforcement agencies as the data from the studies were collected nationally. The previous studies have not always taken into account the differences between rural and urban law enforcement agencies and the populations they serve. Community resources differ from city to city and county to county, making it complex to determine how law enforcement officers should interact with people with mental illnesses in order to have a positive outcome.

**Statement of Collaboration**

Co-authors, Samedi Thach and Robynn Thomas, shared equal responsibilities for all chapters of this thesis. All chapters were written collaboratively and edited by each author.
Chapter 2

REVIEW OF THE LITERATURE

This section will review different characteristics of interactions between law enforcement officers and people with mental illnesses. These characteristics include possible reasons behind the growing number of interactions between these two populations. Major models of police interventions will be scrutinized alongside officer training for working on calls involving people with mental illnesses. The role of law enforcement officers in outcomes for people with mental illnesses with whom they come into contact will be discussed. Additionally, officer attitudes surrounding mental health problems will be reviewed. A review of the current literature has revealed themes regarding police interactions, the models most frequently used, and outcomes for people with mental illness, all of which will be explored in this section.

Themes

Police Officers as Gatekeepers

Law enforcement officers, firefighters and other rescue personnel work on the front lines with people with mental health problems. They are often called first responders or gatekeepers (Dorfman & Walker, 2007; Sellers, Sullivan, Veysey, & Shane, 2005; Steadman, Deane, Borum, & Morrissey, 2000). Many studies have concluded that while officers are often times the first to come into contact with a person in crisis due to a mental illness, sometimes they are the only contact and must rely on their training and knowledge of resources to determine a course of action (Dorfman &
Walker, 2007; Godfredson, Ogloff, Thomas, & Luebbers, 2010; Lamb, Weinberger & DeCuir, 2002).

Many interactions end with an intervention which is up to the officers’ discretion (Godfredson, Ogloff, Thomas, & Luebbers, 2010; Watson, Ottati, Morabito, Draine, Kerr, & Angell, 2009). When confronted with a situation involving a person with a mental illness, officers have a number of options on how to approach the situation. Depending on the severity of the situation, officers are likely to choose between an informal or formal approach. Options include releasing the person to a friend or family member, making a mental health referral, transporting the person to an emergency department, making an arrest and ignoring the situation (Wells & Schafer, 2006; Cooper, McLearen, & Zapf, 2004). In some situations, officers are aware that a crisis worker or a mental health worker should evaluate a person before any action is taken or a decision made, but because of a lack of community resources or the amount of work involved in obtaining an evaluation, the officer will choose arrest (Wells & Schafer, 2006).

In addition to a lack of community resources and support during these interactions, situational factors influence officers’ dispositional decisions. Factors including whether the officer or agency answering knows the individual and suspicion of substance use aid officers in making their decisions (Cooper, McLearen, & Zapf, 2004; California Commission, 2002). If the individual is known to the officer or agency as a person with a mental illness, law enforcement officers are more likely to take an informal approach. It is difficult for law enforcement officers to make decisions when they are
unable to differentiate whether the person is mentally ill or under the influence of a substance because it affects the decision on how they will handle the case.

Factors intrinsic to the officers themselves also influence dispositional decisions. Officer trainings and attitudes surrounding mental health problems effect how they approach people with mental illnesses and how they are likely to handle these situations. Officers’ specific mental health trainings will be discussed further later in this section.

Increased Interactions

Law enforcement officers are coming into increasing contact with people with mental illnesses. Many of these individuals are receiving inadequate or no psychiatric treatment in the community (Lamb & Weinberger, 2005). Studies report that between 7% and 10% of all law enforcement interactions involve people with mental illnesses (Hails & Borum, 2003; Sellers, Sullivan, Veysey, & Shane, 2005; Watson et al. 2009). Law enforcement often encounters people with mental illnesses when they are called to transport them to the hospital or investigate a disturbance of some kind (Wachholz & Mullaly, 1993).

Of 126 officers surveyed, 40% reported working on calls involving a person with mental illness two times per month, 25% reported three or more interactions per month, and less than 10% reported that crime or violence was a reason for interaction with people with mental illness (Wells & Schafer, 2006). A meta-analysis of five studies and five cities concluded that interactions ranged between three and eight per month per officer (Wells & Schafer, 2006). A sample of 452 officers reported that 92% of the
sample answered at least one call involving a person with mental illness in the past month (Borum, Deane, Steadman, & Morrissey, 1998). This large number of dealings is reflective of law enforcement taking on a growing part in the treatment of people with mental illnesses and shows the relevance of further study within this area.

**Deinstitutionalization.**

Several studies explain that the contact between people with mental illnesses and law enforcement has, in part, been increasing since the 1960s – when a community model of treatment for mental illness was embraced (Green, 1997; Lamb, Weinberger, & DeCuir, 2002; Sellers, Sullivan, Veysey, & Shane, 2005). The goal of this deinstitutionalization was to move the focus for care of people with mental illnesses to the communities in which they live, provide more independent living environments and steer away from long-term psychiatric hospital settings (Krieg, 2001; Lamb & Bachrach, 2001). As a result, people with mental illnesses must navigate through different systems of mental and medical health, social services and housing that sometimes do not work effectively together (Wolff, 1998).

Unfortunately, an adequate level of care for deinstitutionalized individuals has never established. The United States does have a comprehensive plan to care for people with mental illness. When deinstitutionalization began, a housing plan was not created for people being released (Wachholz & Mullaly, 1993). Due to deinstitutionalization, it is suggested that 15% to 24% of the population of people with mental illness are in jail and 28% are homeless (Davis, Fulginiti, Kriegel & Brekke, 2012). There is a lack of
consistency of care that a person with a mental illness receives which often results in homelessness or reliance on police intervention to receive treatment.

**Decreased funding.**

A reduction of mental health spending has also contributed to more and more encounters between law enforcement and people with mental illnesses (Teplin, 2000). Discussions regarding reasons for increased interactions often include this decrease in funding as a key reason for rising numbers of arrests of people with mental illness and jail becoming a default place of treatment (Teplin, 2000). The necessity of financial investment has shifted from the mental health sector to law enforcement in terms of treating people in the jail or prison system and starting specialized response teams (Lamb & Weinberger, 2005; Teplin, 2000).

One reason explored as to why so few law enforcement agencies employ specialized response teams is financial constraints hindering the process of establishing a team (Tucker, Van Hasselt, & Russell, 2008). Not only are mental health agencies losing funding, but law enforcement agencies are also having the same problems. Although law enforcement officers are having more interaction with people with mental illnesses, law enforcement agencies sometimes do not see it as a priority in their departments. As a result, specialized response teams are not created and increased mental health training does not occur often.
Civil Commitment

Civil commitment is defined as a legal process in which a person with severe symptoms of mental illness can be court-ordered to receive treatment through either an inpatient or outpatient setting. The treatments mandated often have either a time requirement that the person with mental illness needs to fulfill, or are required to show that the person is no longer a danger to self or others. A person can be civilly committed if they are considered a danger to self or others, or gravely disabled. This process is also known as a 5150, and can lead up to a 72-hour hold. Definitions of meeting any one of those criteria vary from state to state which makes civilly committing a person with a mental illness difficult.

Strict civil commitment requirements increase police interaction with people with mental illnesses. Civil commitment statutes were revised in the 1970s’ and early 1980s’ due to constitutional changes that were placed to protect a person’s right to due process, create the least restrictive environment possible and refuse involuntary treatment (Patch & Arrigo, 1999). For example, in 1974, Donaldson v. O’Conner stated that a non-dangerous person has the right to refuse treatment if they can live safely in the community (Wachholz & Mullaly, 1993).

The idea of civil commitment serves two purposes: to protect the public and to get people with mental illnesses treatment. There is an argument that civil commitments do not have the ability to treat people with mental illnesses (Felthous, 2011). Even though
mental health treatment modalities have not been established to effectively treat mental illness across the board, it is more effective than arrest.

Teplin (2000) argues that when law enforcement officers encounter a person with a mental illness, there are only a few response options: transport the person to a mental hospital, arrest the person or deal with the person informally. Due to strict laws regarding hospitalizations, law enforcement officers view this option as difficult and limited. As a result, people with mental illnesses are often taken to jail rather than to a treatment center. Patch and Arrigo (1999) also argue that law enforcement officers do not view hospitalization as effective for person with mental illness. Law enforcement officers are also less likely to view that a person needs to be civilly committed than mental health professionals or family members (Husted & Nehemkis, 1995). As a result, law enforcement officers have a tendency to make less referrals for civil commitment and more for arrest.

**Officer Training**

Police work with people with mental illnesses is governed by two key ideas. These ideas consist of officers having the power and responsibility to care for the safety of the public, as well as serving as protection for disabled citizens –including those with mental illnesses (Teplin, 2000; Tucker, Van Hasselt, & Russell, 2008). Thorough training of law enforcement officers in regards to working with people with mental illnesses is vital. Training in the recognition of people with mental illnesses, de-escalation and available options in mental health cases is needed (Wells & Schafer, 2006).
As discussed previously, interactions between these two populations are increasing. Officers need to be trained to work in crisis situations where a person may be experiencing mental health symptoms. Half of law enforcement officers do not feel they have sufficient training in mental health or know what to do when encountering cases dealing with a person with a mental illness (Wells & Schafer, 2006).

Some communities have had the unfortunate experience of an officer using excessive force, sometimes deadly force, with a person experiencing mental health symptoms (Hails & Borum, 2003). This is traumatic not only for the person with the mental illness but also for the law enforcement officer and the community which they serve. Cases involving people with mental illnesses tend to require more of the officers’ time than other cases (Hails & Borum, 2003; Wells & Schafer, 2006). Unfortunately, law enforcement officers may not often have the time or the skills necessary to effectively work on a call involving a person with a mental illness.

According to one study that surveyed 84 law enforcement agencies across the United States that had more than 300 officers, new officer recruits receive between zero and 41 hours of training devoted to responding to calls involving people with mental illness (Hails & Borum, 2003). Many of the police agencies that responded to the questionnaire clarified that this training time also covered substance abuse, developmental disabilities, and supervision of unmanageable suspects (Hails & Borum, 2003). Essentially, officers are receiving mental health training that is grouped together with other problem areas.
Cases where it seems clear to officers that the situation is a result of drugs or alcohol may, to a mental health worker, seem to be the result of a severe mental illness and the two perceived causes will lead to different dispositions (Lamb, Weinberger, & DeCuir, 2002). Of 70 agencies, few reported that their training curriculum was a product of collaboration between the mental health system and the law enforcement agency (Hails & Borum, 2003).

Of those departments surveyed less than half acknowledged use of a specialized response program when working with people who are either known to have or are suspected of having a mental illness (Tucker, Van Hasselt, Vecchi, & Browning, 2011). This lack of proper training has not gone unnoticed by officers. One study reported that 80% of the officers surveyed from five agencies in Indiana believed that officer mental health training needed to be improved and 75% of those officers were willing to receive additional training (Wells & Schafer, 2006). These officers cited the major problems they faced were in identifying mental illness, knowing how to handle these people, and a lack of knowledge of options and resources (Wells & Schafer, 2006). Twenty-two percent of officers surveyed in Victoria, Australia reported not wanting more training in the area of mental illness (Godfredson, Ogloff, Thomas, & Luebbers, 2010).

**Dispositions.**

As first responders, police officers play a significant role in the lives of people with mental illnesses. Adequate training relates not only to how officers communicate with people who are experiencing mental health symptoms but also to how they resolve
or end a case. Training to be able to differentiate between symptoms of substance use and active psychotic symptoms plays a vital role in the outcome for the person who is exhibiting the symptoms.

Law dictates that an officer has the power to intervene but it does not rule how an officer should act in specific situations (Teplin, 2000; Tucker, Van Hasselt, Vecchi, & Browning, 2011). The disposition an officer chooses to utilize is based not only on the situation but also on the severity of symptoms expressed by the person (Godfredson, Ogloff, Thomas, & Luebbers, 2010; Teplin, 2000). Dispositions differ slightly between studies; the following are a collection of dispositions law enforcement officers typically use when working cases involving people with mental illnesses:

_Arrest._

Research shows that officers typically resort to arresting a person with a mental illness in three types of situations: when the individual is thought to be inappropriate for hospitalization, when their behavior has exceeded community acceptance and it is thought that the individual would require further police intervention if nothing is done (Teplin, 2000; Tucker, Van Hasselt, & Russell, 2008). Based on these situations, officers are making arrests when they feel they have no other options. Law enforcement officers often resort to arrest because they feel that they have to act when handling a call with a person with mental illnesses (Patch & Arggio, 1999).

The rate of a person with mental illness being arrested is higher than those without mental illness (Wolff, 1998). Reported use of arrest in cases involving people
with mental illnesses varies from four percent to 21% of interactions ending with this type of disposition (Teplin, 2000; Lamb, Weinberger, & DeCuir, 2002; Wells & Schafer, 2006). Almost 60% of officers interviewed for a study where only four percent of cases ended in arrest thought that people with mental illness do not receive adequate mental health care while in the jail system (Wells & Schafer, 2006).

Another reason for law enforcement’s preference for arrest over hospitalization could be their frustration with the mental health system. Hospitalization stays may be too short to be effective and thus lead to repeated interaction with the same people with mental illnesses. There may also be a perception among law enforcement officers that there is a lack of effective community mental health treatment (Fisher, Normand, Dickey, Packer, Grudzinkas & Azeni, H, 2004).

**Hospitalization.**

Hospitalization as a treatment for people who have mental illnesses is used the least of all formal police disposition options (Teplin, 2000). Utilization is inhibited by the limited number of psychiatric beds available in communities as well as officers’ unwillingness or inability to wait long amounts of time for a doctor’s evaluation (Green, 1997; Teplin, 2000). As a result, 75% of law enforcement officers are not satisfied with the process of hospitalizing a person with mental illness (Wells & Schafer, 2006). To further complicate the process, hospitals are reluctant to admit a person with a mental illness if they are under the influence of alcohol or other drugs.
The numbers of cases that end in hospitalization vary widely from about 12% to 38% of people being hospitalized (Teplin, 2000; Wells & Schafer, 2006). Although the cases ending in hospitalizations are varied, Wells and Schafer’s (2006) study showed that 60% of law enforcement officers stated they feel these cases should end in hospitalization. The likelihood of arrest increases when the accessibility of hospitalization is decreased (Fisher, Normand, Dickey, Packer, Grudzinskas & Azeni, 2004).

A study on police linkage to mental health agencies found that of the cases involving a person with a mental illness, half of the individuals were not currently receiving mental health treatment (Van den rink, Broer, Tholen, Winthorst, Viser & Wiersma, 2012). According to the same study, law enforcement officers did not make a mental health referral in 58% of the cases of those people not receiving mental health services –suggesting that hospitalization is not the likeliest disposition taken by law enforcement officers.

*Resolve informally.*

According to numerous studies, officers choose to handle many mental health calls by resolving the situation informally (Lamb, Weinberger, & DeCuir, 2002; Teplin, 2000; Tucker, Van Hasselt, & Russell, 2008). Many communities have people with mental illnesses who are well known in the neighborhood by the residents and law enforcement alike. Officers may feel that they can diffuse situations with these better known people by methods such as talking them through a crisis or soothing them (Teplin,
2000). Some of these people have been labeled “troublemakers” and officers feel that intervention in these cases are not worth the trouble; and as a result, they have stopped trying to hospitalize or arrest them (Teplin, 2000). One study concluded that officers are somewhat more lenient when they know that someone has a mental illness (Watson et al., 2009). In one study where researchers observed officers’ interactions, about 20% of officers took no action with a person when they could have been justified in arresting the person (Green, 1997).

Officers who have more years of experience are more likely to resolve situations with people with mental illnesses informally and avoid arrests by relying on collaborations with mental health workers to find appropriate dispositions (Godfredson, Ogloff, Thomas, & Luebbers, 2010). In fact, most officers’ first choice is an informal resolution (Teplin, 2000). According to one set of data, 72% of cases are resolved informally (Teplin, 2000).

**Attitudes of Officers**

Calls involving people with mental illnesses are often viewed as not “real police work” (Wachholz & Mullaly, 1993). Watson, Corrigan, and Ottati (2004) conducted several studies regarding the attitudes of law enforcement officers towards people with mental illnesses. Watson et al. (2004) suggest that law enforcement officers tend to question the credibility of a person with mental illness, which leads to the possibility of the individual not being helped. The law enforcement officer may not believe what the person with a mental illness states and important evidence may be ignored. The authors
also suggest the perception of the level of dangerousness of a person with mental illness is greater among law enforcement officers. The assumption by law enforcement officers that a person with mental illness is dangerous can lead to violent outcomes.

Another Watson et al. (2004) study focuses on police knowledge on labeling a person with a mental illness. The authors suggest that an officer’s ability to label a mental illness along with their perception and attributions to the situations will affect the kind of assistance the person will receive. If the law enforcement officer believes that the person with a mental illness is responsible for their actions and feels anger towards the individual, officers are less likely to offer help and more likely to be more punitive.

**Intervention Models**

Law enforcement’s first-generation models for working with people with mental illnesses focused on training for officers (Hails & Borum, 2003). Research states that in-depth research into these specific trainings has not been done (Hails & Borum, 2003). Second-generation models also emphasize officer training but do not rely on it alone (Hails & Borum, 2003). These models include some type of specialized response for cases involving people with mental illnesses. The models of intervention need to include training on causes and nature of mental health, how to identify mental health calls, legal laws pertaining to mental health, de-escalation techniques and community resources for them to be effective. Agencies that have adopted programs with specialized responses generally fall into one of the following models:
Police-based specialized police response.

This model employs law enforcement officers who have had special mental health trainings. These officers act as liaisons to community mental health facilities (Borum, Deane, Steadman, & Morrissey, 1998). This type of response team was used by three percent to 11% of respondents (Hails & Borum, 2003).

Reuland (2010) argues for 10 elements considered needed for creation of an effective police-based specialized response team. The elements are:

1. Collaborative planning and implementation: Creating a multi-disciplinary team to determine guideline and implementation.
2. Program design: Creation of a committee to design the specialized police response team.
3. Specialized training among law enforcement personnel: Determination of specialized training needed for all parties involved.
4. Dispatcher protocols: Details procedures for dispatchers and call takers to describe information that needs to be gathered and when to direct to specialized response team.
5. Stabilization, observation and disposition: Focus on law enforcement’s ability to stabilize calls regarding people with mental illnesses.
6. Transportation and custodial transfer: Focus is on transporting person with mental illness in a safe and sensitive manner. Law enforcement officers will
also have knowledge which facility to transfer care of people with mental illnesses to.

7. Information exchange and confidentiality: Address the guidelines for the release of information to help law enforcement officers best work with people with mental illnesses but also protect the privacy of the individual.

8. Treatment, supports and services: Police-based programs will have the ability to connect people with mental illnesses to community mental health programs.

9. Organizational support: Details how law enforcement agencies will support specialized program and its personnel.

10. Program evaluation and sustainability: Collection of data to analyze success of program and needs for improvements.

Reuland (2010) provides a good guideline for creating community-involved police response teams that would be effective in law enforcement officers’ handling of dispatch calls of people with mental illnesses. Unfortunately, law enforcement agencies do not follow all the elements recommended to create a successful program because they require new policies, procedures and community collaboration.

_Crisis intervention teams (CIT)_.

Hails and Borum (2003) reported that 11% of agencies that responded to their questionnaire had a CIT in place. The CIT program has a low arrest rate, high utilization of patrol officers, rapid response time and high number of referrals for treatment (Hails & Borum, 2003; Steadman, Deane, Borum, & Morrissey, 2000; Watson et al., 2009). The
officers utilized in CIT programs are those who have been identified as having the most interest in working with people with mental illnesses, have high interpersonal skills, and the most agreeable attitudes. These officers are provided intensive training and are deployed to work as the officer in charge in situations involving people with mental illnesses (Hails & Borum, 2003).

The most effective CIT model in Memphis, Tennessee was the catalyst for similar models in Portland, Oregon; Albuquerque, New Mexico; and Seattle, Washington (Steadman, Deane, Borum, & Morrissey, 2000). This team consists of approximately 130 officers who rotate on-call shifts to provide coverage for any and all mental health disturbance calls. The officers, once choosing to become a team member, obtain a minimum of 40 hours of training. Officers’ training emphasized assessing for substance abuse, psychotropic medication, signs and symptoms of mental or physical illness and violence towards others or self were more likely to lead to transportation to mental health treatment centers (Ritter, Teller, Marcussen, Munetz, & Teasdale, 2011).

One study of 112 officers working within a CIT model in four districts in Chicago, Illinois, concluded that CIT training facilitated a higher incidence of directing people with mental illness to mental health dispositions, but this did not result in a lower incidence of arrest compared to non-CIT rates (Watson et al., 2009).

**Mental-health-based specialized mental health response.**

This model relies on a traditional collaboration between law enforcement and a mobile crisis team (Borum, Deane, Steadman, & Morrissey, 1998). The mobile crisis
team functions independently of the police department and uses mental health workers to respond to crisis situations and act as consultants to officers in the field (Hails & Borum, 2003). About eight percent of law enforcement agencies employ this type of response model (Hails & Borum, 2003).

The goal of each of these response models is to reduce criminalization of people with mental illness and resolve crisis situations. Overall, it is reported that these interaction models reduce the arrest rate of mentally ill individuals by two percent to 13%, with an average of seven percent (Lamb, Weinberger, & DeCuir, 2002)

**Continuum of Care**

Officers report that they have difficulty working with the mental health system. One data set revealed that 97% of the officers surveyed believed it should be made easier for them to facilitate appropriate dispositions for people with mental illnesses (Wells & Schafer, 2006). Officers face barriers when attempting to place people they meet into hospitals or other appropriate settings. These barriers include: long wait times to access a clinician when a psychiatric evaluation is needed; hospital and residential facilities setting policies on not accepting people who have alcohol and drug problems; and histories of violent behavior (Lamb, Weinberger, & DeCuir, 2002; Teplin, 2000; Wells & Schafer, 2006).

Many studies revealed further the extent of officer frustration in regards to the mental health system and releasing people they feel are a threat to the community. Officers take these types of actions as a questioning of their judgment and feel frustrated
when extra time is taken to secure an appropriate disposition which is then quickly reversed by mental health workers or physicians (Lamb, Weinberger, & DeCuir, 2002).

In addition to the barriers discussed, many officers dislike the overall disposition options they have when working with people with mental illnesses (Green, 1997; Sellers, Sullivan, Veysey, & Shane, 2005). The disposition options they have come with too many drawbacks. One survey exposed that officers feel pressured from hospitals as well as law enforcement agencies to resolve situations informally (Green, 1997). This pressure works in tandem with the off-putting consequences of many dispositions such as long waits at the hospital or the unhappiness of the booking officer when arrest is obviously an inappropriate resolution (Green, 1997).

**Implications for Clients**

There are many implications of inadequate police training and inappropriate disposition decisions in the literature. One such implication is the criminalization of people with mental illnesses. The criminalization of the mentally ill is defined as the placing of a person with a mental illness in the criminal justice system rather than the mental health system (Aderibigbe, 1997).

Arresting people with mental illnesses leads to them being subjected to labels for the rest of their lives, which may result in arrests in later situations (Teplin, 2000). High arrest rates also lead to higher rates of mental illness within the criminal justice system. Approximately nine percent of male and 18% of female detainees in the United States prison system have mental disorders (Teplin, 2000). One article faults a lack of triage
training for officers for the criminalization of the mentally ill population (Lamb, Weinberger, & DeCuir, 2002). If officers were better able to assess crisis situations and how people with mental disorders react in those situations, perhaps certain symptoms such as back talk and pacing would not lead to as many arrests (Sellers, Sullivan, Veysey, & Shane, 2005).

Higher arrest rates also lead to more stigmatization for this population. Not only will they be labeled as mentally ill, which includes a great amount of stigma from the general population, they will also be labeled as criminals, which carries its own amount of stigma (Lamb & Weinberger, 2005).

**Need for Collaboration**

Law enforcement officers pose a significant and under identified influence in the lives of people with mental illness and, as such, efforts for more integrative treatment should be made (Tucker, Van Hessalt, & Russell, 2008). The successful Memphis CIT model relies heavily on collaboration with community mental health centers and organizations such as the National Alliance for Mental Illness (Tucker, Van Hessalt, Vecchi, & Browning, 2011). Thompson, Reuland and Souweine (2003) recommend other collaborative methods that some law enforcement agencies have tried and found to be effective:

1. Mental health professional can ride with law enforcement officers either in special teams or when there is a call suspected of including a person with mental illness.
2 Mandate 40 hours of training on mental health for all law enforcement officers in the department. A professional mental health worker should facilitate training.

3 Create county-based county teams to aid in calls of people with mental illnesses.

More open communication and collaborative efforts between law enforcement and the mental health system are needed in order to break down some of the barriers to better treatment (Lamb, Weinberger, and DeCuir, 2002). Thompson et al. (2003) suggest the sharing of information regarding people with mental illnesses between law enforcement agencies and mental health agencies to create an effective treatment plan.

This collaborative effort could begin with law enforcement agencies allowing for some cooperation with the mental health system in developing the curriculum for their trainings. Currently many training curriculums are prepared by the department or by the state agency responsible for training police officers; very few agencies have built partnerships with their local mental health organizations to develop and present lesson plans for officer mental health trainings (Hails & Borum, 2003; Wells & Schafer, 2006).

**Summary**

As the community continues to rely heavily on law enforcement to be the gatekeepers, we must reexamine policies and procedures to ensure the encounters they have with vulnerable communities are appropriate, especially among people with mental illnesses. With law enforcement’s increased interaction with people with mental illnesses
and decreased funding for mental health programs, law enforcement agencies must ensure their officers are equipped with the knowledge to handle dispatch calls involving a person with a mental illness.

Research shows that a majority of law enforcement agencies are not equipped to have their officers interact with the mentally ill. Law enforcement officers perceive civil commitments to be difficult and ineffective. In addition to this perception, various studies also concluded that law enforcement officers do not have adequate training on working with people with mental illnesses. As a result, people with mental illnesses are often taken to jail or prison and not referred to an appropriate mental health facility.

Studies indicate that there are several successful intervention models that law enforcement agencies are using across the United States. The three examined were police-based specialized police response teams, CIT and mental-health-based specialized mental health responses. All interventions require a continuum of care and need for collaboration between community stakeholders and law enforcement agencies.

If adequate training on mental health is provided to law enforcement officers, effective collaborative efforts are created and existing policy are continually examined, the impact on people with mental illnesses will be positive. It will result in higher rates of appropriate treatment and a smaller population of people with mental illnesses in the criminal justice system.
Chapter 3

METHODOLOGY

Study Objectives

This systematic review of literature aims to explore the interactions between law enforcement and people with mental illnesses, the models employed by police agencies, and the outcomes for people with mental illnesses who come into contact with law enforcement. The research utilized qualitative meta-analysis techniques to compare different models used by law enforcement agencies. Statistical analyses will be run through SPSS in order to compare arrest rates, incidents of violence, and specific statistics for each model of interaction. Specific factors include type of police interaction, referrals made after police contact and police training hours on mental health.

Study Design

This project takes an exploratory research design due to the nature of the question. An exploratory approach is appropriate because research on the readiness of law enforcement to handle cases involving people with mental illnesses is limited. More research is needed to gain a better understanding of the problem and to assess appropriate intervention models.

Meta-analysis is used to analyze data collected. Meta-analysis assumes that data used are exchangeable. This technique combines data from five different independent studies collected via Interuniversity Consortium for Political and Social Research (ICPSR) that have similar patterns. ICPSR studies used to obtain data were Census of
Law Enforcement Training from 2002 and 2006; Gender, Mental Illness, and Crime in the United States from 2004; Treatment Episode Data Set- Admissions from 2003; and Treatment Episode Data Set- Discharges from 2009.

**Sampling Procedures**

As stated above, five data sets will be used to examine law enforcement interaction with persons with mental illness. Data is collected through ICPSR’s online database. Data from previous studies used include: Census of Law Enforcement Training from 2002 and 2006; Gender, Mental Illness, and Crime in the United States from 2004; and Treatment Episode Data Set- Admissions from 2003; and Treatment Episode Data Set- Discharges from 2009.

Variables from the different studies were combined to determine the law enforcement interaction with people with mental illnesses. Variables from data sets used from studies were: demographics, development of training curriculum, training hours, Diagnostic and Statistical Manual of Mental Disorders Text-Revised IV diagnosis, arrest numbers, types of referral made, and source of referral.

**Data Collection Procedures**

Data was collected via ICPSR, which provides data sets from previous studies. Studies used were based on similarities in data collection and factors explored.

**Instruments**

ICPSR provides an online database of data from previous studies. All data used was obtained through ICPSR. Researchers searched for key words that generated studies
involving people with mental illnesses and law enforcement training. ICPSR provides datasets in SPSS and codebooks. Researchers read codebooks to determine relevant data to be combined among five studies used.

**Data Analysis**

Data collected from the five studies used via ICPSR were already available in SPSS format. Researchers generated new variables through combining and recoding the different studies in SPSS.

**Protection of Human Subjects**

Consent is assumed, because subjects would have given implied consent or informed consent before participating in previous studies. Informed consent does not need to be obtained as the study will not have contact with subjects. Current researchers will use studies for meta-analysis which have been peer reviewed in order to further assume proper consent was originally given to subjects. Subjects are anonymous through privacy protection of previous studies.

If identifiable information is established, it will be kept separate from data, on a different flash drive. Subjects will be coded numerically for analysis, furthering confidentiality.
Chapter 4

STUDY FINDINGS AND DISCUSSIONS

Background

Census of Law Enforcement Training, 2002 and 2006

This study analyzed data from the 2002 and 2006 Census of Law Enforcement Training Academies (CLETA). The principal investigator and funder was the United States Department of Justice. In both 2002 and 2006, CLETA mailed questionnaires to operating law enforcement training academies that provided basic law enforcement training across the United States. The studies excluded academies that only provide in-service training, correction and detention training or other special types of training. Data was collected on personnel, expenditures, facilities, curricular and trainees. The 2002 CLETA surveyed 626 law enforcement academies whereas the 2006 CLETA surveyed 648 academies.

For the purposes of this study, the variables that are being examined are demographics, certification requirements of the trainers, how curriculum is developed, training hours in cultural diversity and mental health (other specialized trainings).

Gender, Mental Illness, and Crime in the United States, 2004

The United States Department of Justice, Office of Justice Programs, National Institute of Justice funded this study. The principal investigator was Melissa Thompson of Portland State University. There were two purposes to the study:
1. Investigate the gendered effects of depression, drug use and treatment on crime.

2. Investigate the effects of interaction with the criminal justice system after depression and drug use.

The data from the study is derived from the 2004 National Household Survey on Drug Use and Health (NSDUH) that measured prevalence and correlations of drug use in the United States. NSDUH provides information on tobacco, alcohol, illicit drug, criminal activity and depression and other factors effecting Americans ages 12 and older. The NSDUH survey received 55,602 respondents. Data was collected through either computer-assisted self-interview or computer-assisted personal interview. The study had a response rate of 91%.

In addition to the variables collected through NSDUH, Thompson (2004) created 321 new variables. The author used the first 2,690 variables of NSDUH to create her 321 new variables for measurement.

This study will use data pertaining to demographics, arrest and treatment diagnosis.

**Treatment Episode Data Set-Admissions, 2003**

This study’s principle investigator and funders were the United States Department of Health and Human Services, Substance Abuse and Mental Health Service Administration.
The Treatment Episode Date Set-Discharge (TEDS-D) provides information on admissions to alcohol and drug-treatment facilities that report to state administrative data systems. TEDS-A provides information regarding length of stay, reason for obtaining treatment, prior treatment, primary source of referral, demographics, employment status, mental health diagnosis and substance use information.

Variables of demographics, referral source, referrals made and types of mental illness will be used in this meta-analysis study.

**Treatment Episode Data Set-Discharges, 2009**

This study’s principle investigator and funders were the United States Department of Health and Human Services, Substance Abuse and Mental Health Service Administration and Center for Behavioral Health Statistics and Quality.

The Treatment Episode Date Set-Discharge (TEDS-D) provides information on discharges from alcohol and drug-treatment facilities that report to state administrative data systems. TEDS-D provides information regarding length of stay, reason for leaving treatment, service setting at time of discharge, prior treatment, primary source of referral, demographics, employment status, mental health diagnosis and substance use information.

Variables of demographics, referral source, referrals made and types of mental illness will be used in this meta-analysis study.
Overall Findings

Census of Law Enforcement Training, 2002 and 2006

The 2002 and 2006 studies were combined to analyze types of training law enforcement officers received. For the purpose of this study, other specialized trainings and cultural diversity training will be analyzed for competency in the area of mental health. Analysis showed that 21.1% of law enforcement academies surveyed provided other specialized trainings. On the other hand, 97.5% of law enforcement academies provided cultural diversity training.

Gender, Mental Illness, and Crime in the United States, 2004

In the study of gender, mental illness and crime in the United States, 52% of those surveyed were female and 48% were male in the study. Of those surveyed 66.1% stated that they needed mental health treatment and did not receive it and was seen the emergency room in the last twelve months. Cross tabulation analysis showed that only 26.7% of those arrests in the study received any type of mental health treatment.

Treatment Episode Data Set, 2003 and 2009

Cross tabs chi square analysis showed statistically significant associations between: DSM diagnosis and principal referral; sex and principal referral; and type of criminal justice referral and psychiatric problem in addition to alcohol/drug problem—all at the p<0.05 level of confidence. These findings show that there is an association between the type of DSM diagnosis a person has, gender a person is, and the source from which treatment referrals come. There is also an association between the specific type of
criminal justice referral (court, parole, local law enforcement etc.) and whether a person has a psychiatric problem in addition to an alcohol/drug problem. Exact correlations were not calculated, because each of these factors is nominal in nature.

**Specific Findings**

**Frequencies and Descriptive Statistics**

*Census of Law Enforcement Training, 2002 and 2006.*

Data was analyzed by combining the censuses from 2002 and 2006; they were not analyzed separately due to the similarity of the dataset.

Cultural diversity training was developed based on different avenues. Chi-square test showed significance when cultural diversity training is based on a legislative or regulatory mandate, subject matter expert and academy staff input. Of law enforcement academies that provided cultural diversity training, 45.6% developed their curriculums due to legislative or regulatory mandate. This is a lower percentage than development of curriculums through subject matter expert (53.8%) or through academy staff input (67.9%).

Law enforcement academies were also surveyed on the certification of their specialized trainers. Of the academies that provided other specialized trainings, 60.6% did not require their trainers to have certification in the subject matter. Cross tabs showed that 72.5% of academies provided no specialized training and did not require certification from their trainers.
Treatment Episode Data Set, 2003 and 2009.

Descriptive statistics and frequencies were determined by first analyzing each data set individually and then combining data.

The 2003 data revealed the largest age group in treatment was 35-39 year-olds, which consisted of 15.2% of the overall. Referral sources were collected and analyzed. Sources included: self-referrals, 33.9%; alcohol and other drug care providers, 10.4%; healthcare providers, 7.2%; school, 1.2%; employer, .9%; community referrals, 9.9%; and criminal justice referrals, 36.4%.

For purposes of this study, concentration was on criminal justice referrals. State and federal courts represented 21.4% of referrals, probation 43.1%, and diversionary programs and prison each contributed 3.6% of referrals, and referrals from other legal entities (local law enforcement agencies, youth services, review boards) were 18.3%.

The data from 2003 also revealed that 35.7% of referrals had a DSM diagnosis and 13.5% had a psychological problem in addition to an alcohol and/or other drug problem.

The 2009 data revealed the largest age group in treatment was 25-29 year-olds, which made up 14.9% of the overall. Sources included: self-referrals, 32.9%; alcohol and other drug care providers, 10.5%; healthcare providers, 5.9%; school, 1.0%; employer, .9%; community referrals, 11.3%; and criminal justice referrals, 37.8%.

For purposes of this study, concentration was on criminal justice referrals. State and federal courts represented 24.5% of referrals, probation 41.5%, diversionary
programs 3.3%, prison 2.2%, and other legal entities (local law enforcement agencies, youth services, review boards) were 19.6% of referrals.

The data from 2009 also revealed that 34.1% of referrals had a DSM diagnosis and 29.0% had a psychological problem in addition to an alcohol and or other drug problem.

**Treatment Episode Data Set-Combined.**

Combined data resulted in 3,482,862 cases. The largest source of referrals were self-referrals, 33.4%. Primary criminal justice referrals consisted of state/federal courts, 23.2%; probation or parole, 42.2%; diversionary programs, 3.4%; prison, 2.8%; and other legal entities, 19.1%. Refer to Figure 4.1 for frequencies of each referral type. Results showed that 35% of cases carried a DSM diagnosis and 24.9% of cases involved psychiatric problems in addition to alcohol and other drug problems. Frequencies of each diagnosis are listed in Table 4.1.
Figure 4.1 Detailed Criminal Justice Referral and Gender
Table 4.1

<table>
<thead>
<tr>
<th>DSM IV-TR Diagnosis</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO DIAGNOSIS</td>
<td>11385</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>ALCOHOL-INDUCED DISORDER</td>
<td>13812</td>
<td>1.1</td>
<td>2.1</td>
</tr>
<tr>
<td>SUBSTANCE-INDUCED DISORDER</td>
<td>21407</td>
<td>1.8</td>
<td>3.8</td>
</tr>
<tr>
<td>ALCOHOL INTOXICATION</td>
<td>109035</td>
<td>9</td>
<td>12.8</td>
</tr>
<tr>
<td>ALCOHOL DEPENDENCE</td>
<td>284086</td>
<td>23.3</td>
<td>36.1</td>
</tr>
<tr>
<td>OPIOID DEPENDENCE</td>
<td>189961</td>
<td>15.6</td>
<td>51.7</td>
</tr>
<tr>
<td>COCAINE DEPENDENCE</td>
<td>106124</td>
<td>8.7</td>
<td>60.4</td>
</tr>
<tr>
<td>CANNABIS DEPENDENCE</td>
<td>101880</td>
<td>8.4</td>
<td>68.8</td>
</tr>
<tr>
<td>OTHER SUBSTANCE DEPENDENCE</td>
<td>100615</td>
<td>8.3</td>
<td>77</td>
</tr>
<tr>
<td>ALCOHOL ABUSE</td>
<td>108246</td>
<td>8.9</td>
<td>85.9</td>
</tr>
<tr>
<td>CANNABIS ABUSE</td>
<td>68875</td>
<td>5.7</td>
<td>91.6</td>
</tr>
<tr>
<td>OTHER SUBSTANCE ABUSE</td>
<td>11766</td>
<td>1</td>
<td>92.5</td>
</tr>
<tr>
<td>OPIOID ABUSE</td>
<td>5455</td>
<td>0.4</td>
<td>93</td>
</tr>
<tr>
<td>COCAINE ABUSE</td>
<td>16896</td>
<td>1.4</td>
<td>94.4</td>
</tr>
<tr>
<td>ANXIETY DISORDERS</td>
<td>4480</td>
<td>0.4</td>
<td>94.8</td>
</tr>
<tr>
<td>DEPRESSIVE DISORDERS</td>
<td>15362</td>
<td>1.3</td>
<td>96</td>
</tr>
<tr>
<td>SCHIZOPHRENIA / OTHER PSYCHOTIC DISORDERS</td>
<td>6022</td>
<td>0.5</td>
<td>96.5</td>
</tr>
<tr>
<td>BIPOLAR DISORDERS</td>
<td>8099</td>
<td>0.7</td>
<td>97.2</td>
</tr>
<tr>
<td>ATTENTION DEFICIT / DISRUPTIVE BEHAVIOR DISORDERS</td>
<td>2860</td>
<td>0.2</td>
<td>97.4</td>
</tr>
<tr>
<td>OTHER MENTAL HEALTH CONDITION</td>
<td>8397</td>
<td>0.7</td>
<td>98.1</td>
</tr>
<tr>
<td>OTHER CONDITION</td>
<td>23203</td>
<td>1.9</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>1217966</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>MISSING/UNKNOWN/NOT COLLECTED/INVALID</td>
<td>2264896</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: 3482862

Cases were split by sex and showed data consisted of 31.4% female and 68.6% male. The most referrals for treatment for males came from criminal justice sources and for women referrals were mostly self-made. Approximately 75% of all criminal justice referrals made for treatment were for male individuals, and while women most highly...
self-referred to treatment, they made up only 32% of overall self-referrals. When reviewing criminal justice referrals both male (43.5%) and female (38.1%) referrals came largely from probation or parole sources. Twenty-one percent of males and 33.1% of females had been diagnosed with psychiatric problem in addition to an alcohol/drug problem.

Of those cases with a DSM diagnosis of alcohol dependence, 34.2% of referrals for treatment came from state or federal courts and 25.4% of referrals came from other legal entities such as local law enforcement. This group was comprised of 72.8% male and 27.2% female cases and the largest age group was from 40-44 years old, which consisted of 17.1% of alcohol dependent cases referred to treatment.

The cases that carried an anxiety disorder diagnosis were heavily referred to treatment through state and federal court systems, 46.7% of the time. Of these cases, 77.5% had an anxiety disorder as well as an alcohol/drug problem. The largest age group here was younger than alcohol dependence: the 25-29 year range consisted of 15.8% of referrals. This group was also more evenly distributed between males (47.7%) and females (52.2%).

The depressive disorders group was also highly referred through state and federal court system (45.6%) and through local law enforcement (24.4%). Of these cases, 77.1% had both a depressive disorder and an alcohol/drug problem. The 40-44 year old age group was most highly represented (15.4%) and was comprised of 47.1% males and 52.7% females.
Data was analyzed for the cases carrying a schizophrenia or another psychotic disorder diagnosis. The treatment referrals for this group came most frequently from other legal entities such as local law enforcement (40.6%), and 34.4% from state or federal court systems. A large number of these cases (76.7%) had a psychotic disorder diagnosis along with an alcohol/drug problem. The highest frequency of cases were in the 40-44 year old age group (17.8%), and consisted of more males (70.7%) than females (29.2%).

Treatment referrals for bipolar disorders also came heavily from state or federal court systems (41.1%) and from other legal entities such as local law enforcement (31.8%). A majority of these cases also had an alcohol or other drug problem in addition to the bipolar disorder diagnosis (75.9%). The 35-39 year old age group was most highly represented and was comprised of 44.9% males and 55% females.

Cross tabs analysis and chi square tests showed that there is a statistically significant association between DSM diagnosis and principal source of referral (refer to Table 4.2). Criminal justice referrals and alcohol dependence, anxiety disorders, depressive disorders, schizophrenia/psychotic disorders, and bipolar disorders were cross tabulated (refer to Table 4.3).
Table 4.2
*Chi-Square Test: DSM IV-TR Diagnosis and Criminal Justice Referral*

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>191458.437&lt;sup&gt;a&lt;/sup&gt;</td>
<td>120</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>1147155</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> 0 cells (0.0%) have expected count less than 5. The minimum expected count is 17.68.

Table 4.3
*Criminal Justice Referral*

<table>
<thead>
<tr>
<th>DSM IV-TR Diagnosis</th>
<th>Criminal Justice Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Dependence</td>
<td></td>
</tr>
<tr>
<td>% Diagnosed</td>
<td>39.70%</td>
</tr>
<tr>
<td>% of source referral</td>
<td>22.30%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
</tr>
<tr>
<td>% Diagnosed</td>
<td>19.00%</td>
</tr>
<tr>
<td>% of source referral</td>
<td>0.20%</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td></td>
</tr>
<tr>
<td>% Diagnosed</td>
<td>15.60%</td>
</tr>
<tr>
<td>% of source referral</td>
<td>0.50%</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td></td>
</tr>
<tr>
<td>% Diagnosed</td>
<td>11.30%</td>
</tr>
<tr>
<td>% of source referral</td>
<td>0.10%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td></td>
</tr>
<tr>
<td>% Diagnosed</td>
<td>15.30%</td>
</tr>
<tr>
<td>% of source referral</td>
<td>0.20%</td>
</tr>
</tbody>
</table>

A statistically significant association was found between sex and principal source of referral as well as $p < 0.05$, df=6. Females self-referred in 34.6% of cases but made up
10.8% of total referral cases. Males self-referred in similar rates (32.9%) and made up 22.6% of total referrals. Males were referred through criminal justice avenues in 40.6% of cases and made up 75.2% of all criminal justice referrals and 27.9% of total referrals to treatment. Female referrals to treatment came through criminal justice systems in 29.3% of cases and made up 24.8% of all criminal justice referrals and 9.2% of total referrals.

The association between specific criminal justice referrals and having a psychiatric problem in addition to an alcohol/drug problem was found to be significant at p< 0.05, df=5. Of the cases that had both a psychiatric and alcohol/drug problem, the most treatment referrals came through probation and parole (39.2%) which made up 8.2% of total referrals. Legal entities such as local law enforcement provided 18.6% of treatment referrals for this population, 3.9% of total referrals. In addition, diversionary programs contributed 4.4% of treatment referrals, only 0.09% of total referrals.

**Summary**

Law enforcement academies’ training showed that the development of cultural diversity curriculums varies widely depending on the academies. Analysis showed that of all ways curriculum is developed in academies, those that come from legislative or regulatory mandate, subject-matter experts or academy staff proves to be significant. Areas in specialized training also vary by academies. Only 28.8% of academies surveyed provided specialized training that required certification of their trainers.

In Treatment Episode Data Set-combined, the largest source of treatment referrals were self-referrals (33.4%). Primary criminal justice referrals consisted of: state/federal
courts, 23.2%; probation or parole, 42.2%; diversionary programs, 3.4%; prison, 2.8%; and other legal entities, 19.1%. It was found that different DSM diagnoses received treatment referrals from different criminal justice sources, but most highly from state and federal courts and legal entities such as local law enforcement. Strong associations were found between a person’s sex and their principal referral source; and specific criminal justice referrals and a psychiatric diagnosis, in addition to an alcohol and drug problem.
Chapter 5

DISCUSSION

Summary of Study

This study aimed to review law enforcement officers’ readiness to work with people who are mentally impaired. Factors such as police training hours, referrals made after contact, and rates of police interaction were assessed through meta-analysis techniques.

There is inconsistency in training across law enforcement academies in the United States. It is difficult to pinpoint the exact hours of pure mental health training received by law enforcement officers because it falls under the category of “other specialized training and cultural diversity”. Also, much of the mental health training offered, is presented alongside many other topics and is not given special attention. Not all law enforcement academies provide these types of trainings. If they do, the development of curriculum comes from a variety of sources.

Referral data that was available to the authors was limited to mental health or alcohol/drug treatment rather than all dispositions used by law enforcement agencies. Analyzing treatment referrals for individuals with mental illness showed that the most referrals to treatment came through self-referrals and criminal justice referrals. Criminal justice referrals came in the largest percentage from state and federal court systems. The exact details of these court referrals are unknown but they could have been the result of
mandated treatment in order to lessen or avoid any jail time. Probation and parole also contributed to a high percentage of treatment referrals.

These numbers were disturbing, as the review of literature discussed, because it gives credence to the criminalization of the mentally ill. If probation or parole is referring these individuals to treatment, it means that they are already in the criminal justice system and have perhaps fallen victim to high arrest rates. Diversionary programs, programs that can keep mentally ill individuals out of jails and prisons, were responsible for a very small percentage of overall referrals.

It could be considered promising that so many referrals to treatment come from criminal justice sources. It may lead one to think that law enforcement and court systems are aware of mental health resources and utilizing them. For the authors, this fact is disheartening. These large numbers of treatment referrals imply that there are large numbers of individuals with mental illnesses already in the criminal justice system, some of whom would have been better served through diversionary programs or mental health services in the beginning rather than being arrested or sent to court ordered treatment.

**Implications for Social Work**

This study implies much for social workers in the criminal justice system and the mental health system. Social workers should have a greater responsibility in developing competent mental health trainings for law enforcement officers. Presently, much of the curriculums are written by police officers and supervisors who do not have the same level of knowledge that social workers possess. This study showed that subject-matter experts,
which in the realm of mental health could and should include social workers, developed few training curriculums. Academies that used subject-matter experts to help develop training curriculums were also more likely to provide more specialized trainings beyond weapons management, vehicle use, and field training.

Beyond developing training materials and curriculum, social workers should take on the task of facilitating training as well. This study shows that training hours in mental health are lacking in law enforcement training academies. Having social workers fill this gap in training would be beneficial not only for people with mental illnesses that law enforcement officers encounter, but also for the officers themselves.

Social workers also have a responsibility to facilitate cooperation between law enforcement agencies and mental health treatment centers. Arrest is used as a disposition for people with mental illnesses encountering police officers because the officers do not know the available resources. Not only is facilitating conversations between treatment sites and local agencies essential, but so is enabling easy transitions and referrals for clients. More than 30% of the cases that received treatment responded that their treatment referral came from a criminal justice setting. Referrals to treatment should be a primary referral source during the first encounter and officers should not wait to make these referrals until arrest or civil commitment is imminent. The number of these referrals could increase if mental illness training hours were more widely available and collaborations between mental health and alcohol and/or drug service providers in the community and law enforcement were increased.
Furthermore, by working in direct practice with persons with mental illness and facilitating more effective law enforcement training, social workers have a duty to support this population at the macro level as well. Current policies at city, state, and the national level should be reviewed and analyzed in order to better facilitate effective outcomes for persons with mental illnesses who encounter law enforcement.

**Recommendations**

Research based solely on the model of interaction between law enforcement officers and people with mental illnesses is minimal and somewhat outdated. As such, this study explored relevant factors from studies detailing law enforcement training in mental health issues and types of referrals made in instances when mentally impaired people are encountered. In order for a more conclusive best practices discussion, more current research into interaction models is needed.

As previously discussed, police officers find working with people with mental illnesses challenging and often feel that they lack the necessary training. To remedy the uncertainty they feel, in-the-field training should be increased and reviewed periodically. Promising models such as the crisis intervention team (CIT), which provides training to every officer but also employs specialized teams that are dispatched to calls that are assumed to have a mental health component should be more closely studied and implemented. These models have the lowest arrest rates and highest number of referrals to appropriate mental health treatment centers, which helps to maintain adequate care for people with mental illness and keeps them out of the criminal justice system.
Further research into dispositions used by police officers and their contacts with the mentally ill population is needed. The authors were able to find only a few, outdated, studies that researched these dispositions. With changing laws and policies, it is worth the time to explore if law enforcement is using arrest, hospitalization, referral to mental health treatment, or other avenues most frequently in their encounters. In addition to reviewing current dispositions, reasons why officers chose these dispositions would also be useful in implementing more effective interaction models.

This further research could benefit the criminal justice system and even the healthcare system financially. If, by using more efficient contact models, law enforcement officers were able to keep some of these mentally ill contacts out of the jails, prisons, and emergency departments these entities would save unknown amounts of money by reducing the number of people in prison, lowering the number of correctional officers needed, and intensive mental health services would be less utilized in prisons if these people were being better served in their communities. If these individuals could instead be referred during first contact to appropriate mental health services or even diversionary programs they would also benefit in the long run. They would have the benefit of receiving appropriate mental health services in a setting more conducive to treatment than jail or prison would be.

Based on the review of literature, many law enforcement officers that were surveyed would be in favor of receiving increased hours of specialized training for working with people with mental illness. Additional research would reveal if it is more
advantageous to train all law enforcement officers or to equip agencies with specialized crisis teams who would work specifically with the mentally ill population. As discussed previously, these crisis team members could be carefully chosen law enforcement officers or community experts that work separately or in collaboration with one another.

**Limitations**

This study has a few limitations, many of which are regarding data. The data available for the study through the Interuniversity Consortium for Political and Social Research (ICPSR) was minimal and often available in unreadable formats. Several studies that were originally identified as containing relevant data and information were unusable because of unreadable data formats.

In addition, the authors had to settle for data sets different from originally intended. Data sets linked to studies that have researched specific law enforcement interaction styles and training programs in relationship to the mentally ill population are not available to the public to be used is such a way as to conduct this study. In addition, data used was collected nationally which makes it difficult to generalize to local populations. Because of this, local law enforcement agencies would need to be surveyed individually.

The methods of data collection for the studies of the synthesized quantitative data could have been more closely monitored. The methods of collection and factors of each study were taken into consideration but, if varied, did not automatically disqualify studies’ data sets.
All studies chosen were peer-reviewed to ensure a high quality of work. Meta-analysis is inherently dependent upon the original studies’ quality of results and information. While steps were taken to confirm the validity of original studies, this study could not improve upon any original data.

**Conclusion**

In conclusion the authors feel this topic needs more investigation, both into what other models are employed in working with mentally ill persons when coming into contact with them, and also the efficacy of these models in terms of outcomes for these individuals. The results showed that there are large numbers of treatment referrals for people with psychiatric and alcohol and other drug problems from criminal justice avenues, which if proper referrals or more advantageous referrals were made during first contact with law enforcement, could be lowered because less mentally ill individuals enter the criminal justice system. The results also showed large numbers of referrals coming specifically from parole and probation, leading the authors to believe that the criminalization of the mentally ill population is continuing and mental health services may be utilized much later than is ideal.

Increasing training for law enforcement officers, the gatekeepers as discussed in the review of literature, would give these front line workers a better understanding of what it means to have a mental illness and what kind of treatment is necessary. As a review of the literature revealed, some officers receive zero hours of mental health training before beginning to work. Ensuring these officers get basic mental health
training would increase the likelihood that more people with mental illness receive the treatment and support that is so vital to them.

Beyond increasing training, it is imperative to strengthen the communication between mental health service agencies and law enforcement agencies that share the same communities and likely, similar contacts. The authors postulate that if these bonds were strengthened, law enforcement officers would be more likely to reach out for recommendations as well as to refer to these agencies for immediate treatment rather than resorting to arrest or taking a person to an emergency department.
To: Samedi Thach & Robynn Thomas  Date: 12/13/2012

From: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “Law Enforcement Officers Readiness to Work with People Who Are Mentally Impaired.”

   _X_ approved as ___X__EXEMPT ___ MINIMAL RISK

Your human subjects approval number is: 12-13-036. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.
Professors: Maria Dinis, Jude Antonyappan, Teiahsha Bankhead, Serge Lee, Kisun Nam, Maura O’Keefe, Dale Russell, Francis Yuen
Cc: Russell
Appendix B

**ICPSR Study No.: 4255**

**Title: Census of Law Enforcement Training Academies, 2002: [United States]**

Alternate Title: CLETA02

Principal Investigator(s): United States Department of Justice. Bureau of Justice Statistics

U.S. Dept. of Justice, Bureau of Justice Statistics. CENSUS OF LAW ENFORCEMENT TRAINING ACADEMIES, 2002: [UNITED STATES]

Bibliographic Citation:


doi:10.3886/ICPSR04255.v1

**Scope of Study**

The 2002 Census of Law Enforcement Training Academies (CLETA02) was the first effort by the Bureau of Justice Statistics (BJS) to collect information from law enforcement training academies across the United States. The CLETA02 included all currently operating academies that provided basic law enforcement training. Academies that provided only in-service training, corrections/detention training, or other special types of training were excluded. Data were collected on personnel, expenditures, facilities, equipment, trainees, training curricula, and a variety of special topic areas. As of year-end 2002, a total of 626 law enforcement academies operating in the United States offered basic law enforcement training to individuals recruited or seeking to become law enforcement officers.

census data, law enforcement, police officers, police departments, police training

Subject Term(s):

Smallest Geographic Unit: city

Geographic Coverage: United States

Time Period: 2002

Date(s) of Collection: 2003 - 2004

Unit of Observation: Institutions
All currently operating academies that provided basic law enforcement training in the United States.

Universe:
Data Type: census/enumeration data

Methodology
Mode of Data Collection: mail questionnaire
Extent of Processing: Performed consistency checks.
Checked for undocumented or out-of-range codes.
ICPSR Study No.: 27262
Title: Census of State and Local Law Enforcement Training Academies, 2006

Alternate Title: CLETA 2006
Principal Investigator(s): United States Department of Justice. Bureau of Justice Statistics
United States Department of Justice. Office of Justice Programs. Bureau of Justice Statistics

Funding Agency:

Bibliographic Citation:
doi:10.3886/ICPSR27262.v1

Scope of Study
As of year-end 2006 a total of 648 state and local law enforcement academies were providing basic training to entry-level recruits in the United States. State agencies approved 98 percent of these academies. This data collection describes the academies in terms of their personnel, expenditures, facilities, curricula, and trainees using data from the 2006 Census of State and Local Law Enforcement Training Academies (CLETA) sponsored by the Bureau of Justice Statistics (BJS). The 2006 CLETA, like the initial 2002 study, collected data from all state and local academies that provided basic law enforcement training. Academies that provided only in-service training, corrections and detention training, or other special types of training were excluded. Federal training academies were also excluded.

census data, law enforcement, law enforcement agencies, police departments, police officers, police recruits, police training

Subject Term(s):
Geographic Coverage: United States
Time Period: • 2006
Date(s) of Collection: • 2006 - 2007
Unit of Observation: law enforcement training academy
All state and local academies that provided basic law enforcement training.

Universe:
Data Type: census/enumeration data
survey data

Methodology
Purpose of the Study: n/a
A master list of law enforcement training academies operating in the United States was compiled from a variety of sources, including professional associations, state law enforcement training organizations, and existing BJS law enforcement data collections. An initial screening verified telephone number, mailing address, and other academy contact information. The survey instrument was subsequently mailed to 734 academies. After the initial mailing, 13 additional academies were added, resulting in a total of 747 academies receiving the survey. During the course of survey administration, 99 academies were determined to be out of scope because they did not conduct basic law enforcement training during the study reference period. Of the 648 academies finally determined to be eligible to receive the survey, all but one responded to all (or nearly all) of the questions. A majority (54.3 percent) of the responses were received by mail. About a third (34.2 percent) were submitted electronically through the survey website, and 11.4 percent were transmitted by fax.

Data were from all state and local law enforcement academies that provided basic law enforcement training. Academies that provided only in-service training, corrections and detention training, or other special types of training were excluded. Federal training academies were also excluded.

Data Source: self-enumerated forms
Mode of Data Collection: mail questionnaire
web-based survey
Appendix D

**ICPSR Study No.: 4257**

**Title: Treatment Episode Data Set- Admissions, 2003**

**Introduction**

This codebook is for the Treatment Episode Data Set – Admissions (TEDS-A) for admissions to substance abuse treatment occurring in 2003. TEDS-A provides demographic and substance abuse characteristics of admissions to alcohol or drug treatment in facilities that report to individual state administrative data systems.

The TEDS system is comprised of two major components, the Admissions Data Set and the Discharges Data Set. The TEDS-Admissions (TEDS-A) file is an established program; data were first reported for TEDS-A in 1992. The TEDS-D began more recently, with the first data reported in 2000. TEDS includes treatment data that are routinely collected by states to monitor their individual substance abuse treatment systems. Selected data items from the individual state data files are converted to a standardized format that is consistent across states. These standardized data constitute TEDS.

The TEDS-A is comprised of a Minimum Data Set collected by all states, and a Supplemental Data Set collected by some states. The Minimum Data Set consists of 19 items that include:

- Demographic information;
- Primary, secondary, and tertiary substances used by the subject, and their route of administration, frequency of use, and age at first use;
- Source of referral to treatment;
- Number of prior treatment episodes; and
- Service type, including planned use of medication-assisted (i.e., with methadone or buprenorphine) opioid therapy.

The 15 Supplemental Data Set items include psychiatric, social, and economic measures. A full list of the variables can be viewed in the Variable Information and Frequency sections of this codebook.

This codebook provides background and descriptive information for the TEDS-A public-use
files, limitations of the data, and frequencies. References are available detailing the data collected in each state with the TEDS data elements, including state-by-state descriptions of exceptions or anomalies in reporting practices. Users may refer to the TEDS Crosswalks available from SAMHSA. The crosswalks are frequently updated as new information becomes available.

Since 1992, the Office of Applied Studies (OAS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS) has funded and been responsible for TEDS. It coordinates and manages the collection of TEDS data from the states. In 2010, the OAS was renamed to the Center for Behavioral Health Statistics and Quality (CBHSQ). The unit of analysis is treatment admissions to state-licensed or certified substance abuse treatment centers that receive federal public funding.

Descriptive and analytical reports from TEDS are developed by CBHSQ to provide national and state-level data on the number and types of clients treated and the characteristics of facilities providing services.

**Data Collection**
The “Treatment Episode Data Set State Instruction Manual – Admissions Data” is available from the SAMHSA Web site and provides complete instructions on how the TEDS-A data are processed and submitted by the states.

**Confidentiality Protection**
Several measures were taken to protect the confidentiality of the TEDS-A records. Variables that potentially identify an individual in their raw form underwent routine top- or bottom-coding in order to prevent high and low codes from distinguishing a respondent’s record. For example, AGE as a continuous variable has the potential to identify both the youngest and oldest participants in a public release file. Hence, AGE was recoded into 11 categories for the public use file to reduce disclosure risk. The lowest category for age combines the ages of 12-14. Similarly, ages of 55 and older were top-coded. All the variables recoded are documented in Appendix B.

Disclosure analysis is used to identify records that remained unique after routine measures were taken to protect confidentiality. Disclosure analysis is used to discern combinations of indirect identifiers that potentially link an individual to a record.
Particular attention was given to the analytic importance of geographic data and of subgroup populations. Consequently, data swapping was applied to the TEDS in order to satisfy stringent confidentiality standards while preserving the analytic value of the public-use file.

The original location of a record in TEDS-A cannot be known for certain due to the use of data swapping. This method has several benefits over other disclosure protection options: (1) the overall impact to the data is typically small; (2) nearly all of the data are left intact; (3) data for special populations (e.g., minorities, pregnant women) are no more impacted than other data; (4) the procedures typically do not affect any analytic uses of the file; and (5) the procedures allow greater detail to remain on the public use file (e.g., the original ethnicity codes).
**ICPSR Study No.: 33621**
**Title: Treatment Episode Data Set -- Discharges (TEDS-D), 2009**
Alternate Title: TEDS-D, 2009
Principal Investigator(s):
Series: Treatment Episode Data Set - Discharges (TEDS-D) Series
Funding Agency:
Bibliographic Citation:
Health Statistics and Quality. Treatment Episode Data Set -- Discharges (TEDS-D), 2009. ICPSR33621-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2012-10-25. doi:10.3886/ICPSR33621.v1

**Scope of Study**
The Treatment Episode Data Set -- Discharges (TEDS-D) is an administrative data system providing descriptive information about discharge from alcohol or drug treatment in facilities that report to Individual state administrative data systems. TEDS-D is part of a reporting system that was originally designed to provide annual data on the number and characteristics of persons admitted to public and private substance abuse treatment programs receiving public funding. The TEDS -- Admissions (TEDS-A) component began in 1992, and the TEDS-D component began reporting data in 2000. The unit of analysis is treatment discharges.
Variables unique to TEDS-D are the length of stay, reason for leaving treatment, and service setting at time of discharge. TEDS-D also provides many of the same variables that are reported in the admissions data.
This includes information on number of prior treatments, primary source of referral, gender, race, ethnicity, education, employment status, substance(s) abused, route of administration, frequency of use, age at first use, and whether methadone was prescribed in treatment.

- ICPSR 33621 -

Supplemental variables include: diagnosis codes, presence of psychiatric problems, living arrangements, source of income, health insurance, expected source of payment, pregnancy and veteran status, marital status, detailed not in labor force codes, detailed criminal justice referral codes, days waiting to enter treatment, and the number of arrests in the 30 days prior to admissions.

Substances abused include alcohol, cocaine and crack, marijuana and hashish, heroin, nonprescription methadone, other opiates and synthetics, PCP, other hallucinogens, methamphetamine, other amphetamines, other stimulants, benzodiazepines, other non-benzodiazepine tranquilizers, barbiturates, other non-barbiturate sedatives or hypnotics, inhalants, over-the-counter medications, and other substances.

Created variables include total number of substances reported, intravenous drug use (IDU), and flags for any mention of specific substances.

The public-use files were created using the data that were current as of October 2011 (the October 10, 2011, extract).

alcohol abuse, drug abuse, drug treatment, health care services, health insurance, intervention, mental health, substance abuse, substance abuse treatment, treatment programs

Subject Term(s):
Smallest Geographic Unit: Core-Based Statistical Area (CBSA)
Geographic Coverage: United States
Time Period: • 2009
Date(s) of Collection: • 2009
Unit of Observation: treatment discharges

Treatment discharges from substance abuse treatment programs in the United States receiving public funds. State substance abuse agencies Universe: are requested to provide TEDS-D data on all publicly- and privately-funded clients in treatment programs receiving any public funds. There are some instances, however, in which information is provided
only for clients whose treatment is funded through public monies. Data Type: administrative records data.
REFERENCES


