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## ALTERNATIVE APPROACHES TO POLICE INTERVENTIONS WHEN RESPONDING TO MENTAL HEALTH CRISES INCIDENTS

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ALTERNATIVE APPROACHES TO POLICE INTERVENTIONS WHEN  
RESPONDING TO MENTAL HEALTH CRISES INCIDENTS

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Karen Rivera Apolinar

May 2023

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Karen Rivera Apolinar  
May 2023

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## ABSTRACT

Purpose: This study explored mental health workers perspectives on alternative approaches in responding to mental health crises.

The study was carried out in Southern California, in collaboration with mental health workers who currently work or previously have worked in mental health. It adopted a post-positivists paradigm and data was gathered through individual interviews with mental health workers who have direct experience with mental health crisis response in the community and with the police. The twenty participants were men and women of various backgrounds, licensures, and ages.

The study found that the current approaches of addressing mental health crisis needs expansive revamping. The approaches from police were observed to be mostly negative and due to this line of work, not enough support and training is prioritized for mental health workers. Alternative key solutions were unfolded on the micro, mezzo, macro levels.

This study is important to find alternative approaches sensitive to the individual's needs. At the micro-level, knowledge gained from this study could assist agencies in understanding what additional resources and support mental health workers need to de-escalate crises. At the macro-level, mental health workers perspective of working with police, reallocating funds, program expansions, and help advocacy efforts on behalf of individuals with serious mental illness.

## DEDICATION

I dedicate this project to my family. My husband Isaac and daughter Samantha, who for the last 3 years have given me their unconditional love and support. They are the motivation for me to finish this master's programs. My parents Ricardo and Maria for being there for me. My sister Leslie for putting our differences aside and loving me. My soul sister Carolina for her empathy, praises, and kindness. Salome for her constant prayers. All my close friends and co-workers you know who you are for checking on me and giving me the push, I needed when I was so tired.

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## CHAPTER ONE

### ASSESSMENT

#### Introduction

Chapter one identifies and explains the research focus. The post-positivist paradigm that's used throughout the study. The literature review of this study is included and focuses on the prevalence of police encounters with the mentally ill, and alternative programs already in place that provide exemplary services to the mentally ill. This chapter contains theoretical positions and possible implications for micro and macro social work practice, and a summary.

#### Research Focus

In the US, 20% of adults and 49% of adolescents have a mental illness (National Institute of Mental Health [NIMH], 2021). People with mental illnesses are disproportionately represented in police encounters, with 1 in 10 police calls involving someone who is mentally ill (Fuller, 2015). Many cities and counties seeking alternative ways of responding to mental health crises have turned to mental health workers and emergency medical technicians. The issues is that many counties in southern California, have mental health workers alongside police when responding to mental health crisis, and the approaches can be intimidating for individuals. It's intimidating because of the approach of having mental health workers with police officers with guns showing up to a person experiencing a mental health crisis.

Alternative programs with a different approach throughout the U.S. use a team of mental health workers alongside emergency medical technicians as an alternative to police when responding to mental health crises and have shown promise. One exemplary program providing these services with great positive outcomes is the Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Oregon. Their services include mental health workers in the frontline assessing and providing appropriate services and transport for people who are intoxicated, mentally ill, or disoriented, as well as non-emergency medical care. (Eugene Police Crime Analysis Unit, 2020). This program for example is funded by their city police department, they coordinate the services to divert calls from police.

To expand programs ideas like the CAHOOTS to a larger scale in the U.S. including southern California, we need to better understand what the supports and resources are needed to integrate a successful program. Part of that is understanding the needs of the mental health workers, the involvement and funding of various communities' agencies, the training and approaches, and the support and collaboration of the team.

This study explored mental health workers in Southern, California, in collaboration with mental health professions who work or have worked in mental health perspectives on alternative approaches in responding to mental health crises. This study is important because it can help identify the appropriate

interventions, resources and supports needed to respond to a crisis when working with this population without police involvement.

### Paradigm and Rationale for Chosen Paradigm

This study employs a post-positivist perspective because of its objective approach. This paradigm assumes that qualitative data should be gathered in naturalistic settings. This paradigm was appropriate to develop an understanding of the scope of interventions needed for individuals experiencing a mental health crisis. To develop an understanding, the researchers gather the qualitative data by conducting interviews with experienced Southern California mental health workers, whose practice is relevant to the field of crisis work, allowing themes to emerge naturally. The analyzation of the data uses the “bottom-up” approach with a built theory regarding the mental health workers perspective of the current approach of law-enforcement teaming up with mental health workers in addressing crisis assessments in the communities of Southern California. Qualitative data functions best for this study because it captures mental health workers experiences in their own words, leading to a deeper understanding of the scope of the issue. The analysis of the data provides suggestions by the participants voicing needed changes in the approach when addressing mental health crisis.

### Literature Review

This literature review provides an overview of the prevalence of the nationwide issue of addressing mental illness in the U.S. population and the

prevalence of police handling encounters with the mentally ill. It also discusses the consequences of police involvement, and the causes of so many mental health crises in the community. Recent innovative programs already in place to replace police in mental health calls were also discussed, followed by a summary of the literature.

### Prevalence

In the U.S., the number of adults 18 years or older with any mental illness is 51.1 million, that is 20% of adults, and those with a serious mental illness is 13.1 million, approximately 5.2% of all adults (NIMH, 2021). Rates of any mental illness are higher among adolescents than adults. It is estimated that 49% of adolescents have any mental illness and 22% have a serious mental illness (NIMH, 2021). These statistics would increase if they included the dual diagnosis of substance use disorders, developmental disabilities, and those undiagnosed. Most recent data on the most common conditions of mental illnesses according to the National Alliance on Mental Illness (NAMI) is, Anxiety Disorders at 19.1%, Major Depressive Episodes at 8.4%, Posttraumatic Stress Disorder with 3.6% and Bipolar disorders at 2.8 % (NAMI, 2022). As a result of the pandemic the prevalence could have increased. The most common mental health encounters consist of situations where an individual, “presents with apparent mental health symptoms and/or behaviors that suggest the possibility of an imminent risk to themselves or others” (de Tribolet-Hardy et al., 2014). Data reinforces that the most common mental health encounters the most challenging for the police

(Rogan, 2011). Dealing with individuals that are experiencing symptoms of suicidal ideation, auditory visual hallucinations, delusions, confusion, outbursts, can be unpredictable. The police conventional ineffective approach styles when dealing with a mentally unstable individual can lead to escalations and unnecessary coercive tactical approaches (Brouwer, 2005). Research on police use of force showed that over-representation of mental illness disorders including mood and anxiety disorders, psychosis, schizophrenia, substance use disorder, and personality disorders have a high degree of comorbidity as compared to the general public prevalence (Short et al. 2010). The common mental health issues the police are called to address are at the expense of the mentally ill. People with mental illness are overrepresented in police encounters. Various studies found that overall, 25% of people with mental illness have been arrested, 10% of people receiving mental health care have the police involved in the process, and 1% of police dispatches involve people with mental disorders (Livingston, 2016). Adequate community mental health services at the hands of police may not be effective and need more tailored strategies when facing these complex encounters.

### Consequences

The police are viewed with an authoritarian style of approach to enforce the law and can potentially lead to a violent incident with people experiencing symptoms of mental illness (de Tribolet-Hardy et al., 2014). An article review of literature examining mental illness training programs for the police shows that current

issues in training police officers may not be adequately trained because organizations provide training without proper outcome measures of effectiveness, the focus of training is on changing attitudes not demonstrating that it relates to behavioral change, and a mental health training program given on a single occasion is not necessarily sufficient to improve interactions over the longer-term (Krameddine et al., 2015). Negative consequences of the police interactions with individual with mental illness have high statistics. According to Fuller (2015), “1 in 10 calls to police service are for the mentally ill, 1 in 2 are fatal police encounters, and 1 in 4 fatal police encounters end in death” (p.1). These statistics could include a person experiencing a mental health crisis and/or intoxicated, making it challenging for the police to engage with their unpredictable behavior, resulting in triggering the over-representation of the mentally ill in police encounters. This is backed up by studies, in five cases studied the common triggers of police incidents addressing mental health crisis was the presence of substance use (Short et al. 2003). These factors could be the reasoning of the police resorting to the use of force to resolve the volatile situations (Garner and Maxwell 2002, Police Complaints Authority 2003, Kesic et al. 2013a, 2013b). Other statistics highlight the likelihood of police encounters leading to injury or death. The National Violent Death Reporting System showed that in 17 states from 2009 to 2012 there were 812 fatalities, resulting from use of lethal force by on-duty law enforcement, and of those police encounters 22% of cases were mental health related (DeGue et al., 2016, Abstract section). The authors concluded that the



use of lethal force by police is deeply rooted in their policing and their obligation to mitigate immediate danger to the public and themselves.

Mentally ill people are also more likely to be incarcerated when police become involved. According to the Center for Behavioral Health Statistics, the mentally ill are overrepresented in jails and prisons with 14.5% for men and 31% for women in jails, and 6% to 14% for men and women in prisons (Watson & Wood, 2017). The mentally ill are in jails rather than being helped in the community. Taken together, the data suggests that police involvement with the mentally ill is problematic. According to Watson & Wood, police involvement with the mentally ill in the community often resort to arrests or use of force, and at times the situation does not meet criteria for a crisis but officers' approach with problem-solving informal role with intentions to deflect the presenting problem instead of addressing the need of the individual (Watson & Wood, 2017).

### Causes

Criminalization of the mentally ill starts with the mental health system not being appropriately funded to help individuals obtain the proper care they need. Since 1960's, several pieces of legislation have cut funding for mental health. First, the Mental Health Act began federal support for mental health services in the United States stepping away from institutions towards community mental health centers programs (National Institute of Health [NIH], 2015). The California Lanterman Petris, Short (LPS) Act of 1967 changed the regulating of involuntary detention inside state hospitals but led to involuntary hospitalizations in the

community (Whitmer, 1980). This law gave rights and protections for the mentally ill to choose whether to receive treatment in the community. The repeal of the Mental Health Act in 1981 has resulted in decreased Medicaid coverage of mental health services from federal administration to state to allocate funds (Teplin, 1984). The federal support declined and resulted in less availability and access to mental health programs. The affordable Care Act of 2014 has provided coverage for all in California including mental health services (SAMHSA, 2014). Although its purpose was to reduce the impact of mental illness in the U.S, the Affordable Care Act (ACA) has gaps, inadequacies, and disparities, including a scarcity of mental health providers for more than 113 million fully insured individuals in the U.S. (Baumgartner et al., 2020). Incarcerated individuals are guaranteed the mental health services, “The implementation of the Patient Protection and Affordable Care Act (2010) has expanded access but falls well short of a guarantee. Thus, for many, jail and prison are the only places they are able to access psychiatric care” (Wood & Watson, 2017). The effects of these acts have resulted in less federal funding leading to a shortage of programs in the community for the mentally ill.

Due to the mental health services not adequately funded, the mentally ill were resorted to continually access emergency services like police calls in community, and emergency rooms (de Tribolet-Hardy et al., 2014). Federal and state budget cuts for mental health services have created a crisis in communities by creating barriers in decreasing the number of mental health beds available,

mental health programs, and the appropriate staff. From 2009 to 2011 California made the highest budget cut for mental health services, compared to other states in the U.S. totaling \$587.4 Million (Honberg et al., 2011). These state budget cuts cause less coverage for community outpatient MH, hospital-based care, psychiatric services, including cuts to medication coverage, and housing for thousands of adults and youth with SMI (Honberg et al., 2011). The budget cuts to vital mental health services cause a transfer of responsibilities to law enforcement, emergency rooms, homeless shelters, and correctional facilities, causing the taxpayer high costs (Honberg et al., 2011). The lack of essential intervention for mental health services causes individuals with mental illness suffer the consequences of diminished services they need, and consequently, create a revolving door in the mental health system. Communities are negatively impacted, “lack of services often fosters worsened conditions and adverse consequences that cost communities dearly” (Honberg et al., 2011).

Data suggests that police are not trained to successfully manage a mental health crisis. According to Tribolet-Hardy, Police address concerns in the general population with an authoritarian style and have a pre-existing bias against the mentally ill (de Tribolet-Hardy et al., 2014). Additionally, police are usually trained in problem solving, they do not know the patient’s history and they also face barriers to care. The many health emergency systems allocate police officers to the responsibility for the custody of health care patients, instead of addressing the issue of inadequate deliver of emergency care (Dupont & Cochran, 2000).

Police want an immediate resolution to someone experiencing mental illness symptoms and unable to control mental distress (de Tribolet-Hardy et al., 2014). According to Shepard, “The manner in which the police resolve a disturbance caused by a mentally ill individual rests heavily on the exigencies of the situation, such as the person’s behavior or degree of threat to self or others, and the resources available to the officer, such as responsible family members and accessible jails, mental health facilities, or detox centers” (Engel & Silver, 2001). This further explains that their trying to handle the situation regardless of the individual’s mental condition. The need for improvement in police response is needed.

### Existing Programs

Since the 1980’s mental health system’s transition from institutional to community care, there have been numerous interventions to address the police responding to mental health crises. A police department in Memphis created the Crisis Intervention Team (CIT) model after killing a mentally ill person. The CIT model was created in response to the negative police response to the mentally ill experiencing crisis in the community. The CIT purpose is to improve police response and safety to the mentally ill, but most importantly to divert from criminal justice systems to appropriate mental health systems (Watson & Wood, 2017). The CIT has become one of the most used programs to assist the front lines of mental health in different states (Watson & Fulambarker, 2012). Approaches vary state by state, but the CIT consists of specialized trained police

to collaborate with mental health service providers, emergency hospitals, and families to drop off individuals in need of emergency psychiatric treatment. Like CIT, In Orange County, California behavioral health clinicians, including social workers, conduct assessments with police present and determine if an individual needs hospitalization or redirection to other care (Orange County Health Care Agency, 2016). Studies of the CIT's impact conclude that although the program is somewhat effective, arrests of the mentally ill continue (Watson et al., 2009). Data on CIT efficacy is low due to identifying suitable candidates and no identifiable standardized measuring of the officer injury outcomes, some of the studies out there are based on self-reporting participants and the analysis of arrests made frequently was unable to show the increase or decrease effect of CIT to arrest persons with mental illness (Rogers & Binder, 2019). CIT can be more effective if highly trained professionals like mental health workers de-escalate, redirect persons with mental illness experiencing a crisis to the proper community-based programs to get them the help they need instead of being arrested (Watson et al., 2009).

Multiple municipalities have implemented a form of the CIT model and have modified approaches according to their jurisdiction need. In Orange County, California, police are paired with a Mental Health Workers to address any mental health crisis calls, and involuntary holds in the community (Orange County Health Care Agency, 2016). Police aid with ensuring the client is compliant for transportation to the local hospital E.R. The Los Angeles Police Department

implements a multi-layered approach that includes multiple mental health crisis response teams and follow-up and triage (Wood & Watson, 2016). In Minneapolis, police departments have an in-house mental health unit, and police teams aim to keep people out of jails and into one-stop shops for services. The persons with mental illness can obtain psychiatric services, counseling, and rehabilitation. This team believes in traditional police work and expands the mental health units with mental health workers (Roth, 2020).

An innovative program that uses person-centered interventions and mental health services linkages without police is a state program in Oregon. This program consists of a crisis response team called Crisis Assistance Helping Out On The Streets (Cahoots) (Beck et al., 2020). A team of mental health workers in collaboration with a team emergency medical technicians address the non-emergency calls of a behavioral health crisis in the community and directly intervene to de-escalate and handle the mental health crisis without police presence, which in turn helps police focus and do their job to serve and protect on crime-related matters (Beck et al., 2020). The Cahoots program “responded to 24,000 calls last year, which amounted to roughly 20 percent of all calls that went to the police. In less than 1 percent of those, Cahoots called the police for backup” (Roth, 2020, para 10-13). Between two cities of Eugene and Springfield CAHOOTS is funded about 2 percent of their police departments budgets. Staff are trained and experienced extensively, undergoing months of training, 40 hours of class and 600 hours of field training and then graduate to work for a team.

These trainings are incremental, ongoing, and specialized and focused on crisis incidents (Beck et al., 2020). The differences of programs from police responses to team responses changes dramatically. Numbers shows how many alternative programs can positively function better in addressing persons with mental illness in the community without the risk of criminalization.

### Conclusion

The overrepresentation of the Mentally ill in police encounters results from a lack of funding for mental health community resources. The police approach to mental health crises can have detrimental consequences on communities and individuals experiencing a mental health crisis, especially when police criminalize their behavior. Programs like Oregon State's Cahoots program suggest that mental health workers can process mental health assessments without police involvement. Some preliminary research indicates that CIT and Cahoots program are promising alternatives to traditional police interventions. However, research has yet to look at what makes these programs successful. If the goal is to expand programs like CIT and Cahoots to more locations, more research in this area is needed. This study will help fill part of that gap by exploring the resources and supports social workers need so that they can be a safe alternative to police in responding to mental health crises.

### Theoretical Orientation

Conflict theory was used to understand the problem focus. In social work, conflict theory has been used to described how elite classes benefit from social

control, competition among social groups, and structural inequality. According to Holmes, “The conflict perspective draws attention to conflict, inequality, and oppression in social life” (Holmes et al., 2007).

This theory assumes, “One would expect greater levels of state coercion in areas where inequality is most pronounced because inequality is an unnatural condition that must be maintained by force” (Jacobs & Britt, 1979). The conflict perspective was helpful in this study because “it shines a spotlight on how domination and oppression might be affecting human behaviors” (Hutchison & Charlesworth, 2014, p. 45). Mental health workers seek to encourage individuals towards societal change. When individuals are in vulnerable situations like a mental health crisis, they can seek the help they need and change their situation using mental health workers and local resources available to them. “The conflict perspective has become as useful for recommending particular strategies as for assisting in the assessment process” (Hutchison & Charlesworth, 2014). Concepts from the conflict perspective can further enhance the mobilization of power towards changing conflict-causing conditions and bring back community-oriented social work. Mental health workers don’t exert power like police, meaning they are anti-oppressive and seek to empower the MI. This will lead to less violence and less use of force when social workers, and not police, respond to mental health crises.

Contribution of Study to Micro and/or Macro Social Work Practice



This study aims to increase awareness of what a social worker needs to be a good alternative to police when responding to mental health crises. This study can help by exploring the resources and supports social workers need so that they can develop alternative approaches in responding to mental health crises. On the micro level, the potential contributions to the social work practice can be in the approaches when working to help mental health individuals that feel powerless during a crisis helping them and their families feel empowered to improve their situation. This study can provide further options for more in-depth ongoing training for social workers. Awareness of the bias police may have when working together and helping to advocate the client and for the role and importance of the role during the assessment.

On the macro level, this study aims to provide additional insight for grant writing to develop alternatives that reduce police involvement. Community Programs can make a case in grant writing for expanding crisis teams like Cahoots. Agencies and programs can become aware of their workers insight and make policy changes to the current procedures to implement different approaches for crisis assessments. Promote program expansions in law enforcement agencies and mental health agencies to integrate more social workers in police departments, or emergency medical technician in mental health agencies. Key considerations in budget demands like increase in the level of resources, integrate police departments in the budget to identify funding as this also can benefit their agency, and collaborations from agencies that are also part

of crises calls for continuity of care. Hospitals having more psychiatric beds available, ambulances with emergency medical technicians' available, and becoming aware of the essential components needed to respond simultaneously to mental health crisis calls. This study can contribute to the public's readiness to commit to resources and support of the local treatment of the persons with mental illness, for a better mental health system and provide adequate funding to strengthen the collaborations of social work programs.

### Summary

Chapter one described the research focus, what resources and support SW need to take on the role as an alternative to police in responding to mental health crises. It also described the rationale for using the post-positivist paradigm, explaining how this perspective will best accommodate the study. The literature review summarized the prevalence, causes, consequences of the study focus as well as alternative programs in place that address the issue. Next, this chapter described conflict theory, which will be the theoretical orientation for this study because it explores how law enforcement seek to maintain power. Chapter one ended with the study's potential contributions to macro and micro social work practice.

## CHAPTER TWO

### ENGAGEMENT

#### Introduction

Chapter two begins by describing the initial engagement stage. Then the logistics of the region where the study will take place as discussed. Engagement strategies for potential participants follow, then a discussion of the researcher's self-preparation. The following section identifies the diversity, ethical, and political issues of this study and one strategy to address each issue. This chapter concludes with a description of the role technology will play in the engagement stage of this study.

#### Research Site

This research study did not focus on a specific study site but instead recruited participants from a region of southern California. Multiple county sites have different mental health workers with various job classifications including unlicensed and licensed behavioral health clinicians, social workers, marriage family therapists and mental health specialists engaging with clients assessing a mental health crisis in the community. Certain Counties operate their agency staff by partnering mental health workers with police when going out in the community to address mental health related calls, known as crisis stabilizations. Other teams like the Psychiatric Emergency Response Teams (PERT) program place mental health workers in police departments to address mental health concerns in the community (Orange County Health Care Agency, 2016). Mental health workers

have received special training of the 5150/5585 Lanterman-Petris-Short (LPS) Act to conduct involuntary holds to those facing a mental health Crises in the community (Orange County Health Care Agency, 2016). Multiple county agency sites in Southern California servicing mental health crisis in communities are the Crisis Assessment Team (CAT), Outpatient clinics, Assertive Community Treatment (A.C.T.), and local mental health providers.

#### Engagement Strategies for Gatekeepers at Research Site

There were not any gatekeepers, as the researcher directly reached out to mental health workers who have worked or are currently working throughout various sites to directly serve individuals who have had a mental health crisis in the community. The strategy used for engaging the mental health workers for the study was a recruitment email explaining the benefits of this study and how it can provide actual data displaying the real experiences of mental health workers working with individuals who have experienced a mental health crisis in the community. See Attachment D. The researcher asked those mental health workers who would like to take the initiative and participate about how the study can be improved. This Allowed the workers to provide their input and gave them a sense of ownership over the study and increased their buy-in for the study.

#### Self-Preparation

A self-reflection journal was started at the beginning and used throughout the study. This journal recorded the process of gathering the data and kept a record of the data. It also included the researcher's reflections on participants'

responses to the study questions. The researcher has experience in the mental health work field, and the experience may present a bias in the type of questions that are asked and the interpretation of the responses. Since mental health workers were part of the questions developed and served as the gatekeepers to refine or refocus the questions' structure, and the area of focus evolved. A research journal was used in the self-preparation stage. Morris mentions that research journals consist of details like “the source, time, and the date of the data collected” (Morris, 2013, p. 782) as well as the interpretation of it. As the data was gathered for this research study, documentation of the researcher’s experiences and reflections were essential. Another strategy considered was practicing interviews with a friend or a family member to get comfortable asking unbiased interview questions.

### Diversity Issues

In this study, there was diversity among the mental health workers who do this type of mental health work and diversity in how the different programs approached addressing mental health crisis in the community. For example, outpatient program mental health workers work with the police sporadically and less often than the mental health workers working alongside police in law enforcement agencies. Some are used to working with police, some have little experience with them, and some just see police when they drop off individuals at hospital emergency rooms or a crisis stabilization unit. Some were workers that have worked collaboratively with other workers and have exposure and

experience in conducting mental health crisis in the community. Sampling mental health workers from different programs was important to ensure diverse experiences were represented. One way used was to allow various mental health workers who have worked, have the experience from different types of programs that have worked with police and have seen the approaches in different settings. To prevent unconscious bias, the researcher chose participants for this study with diverse cultural backgrounds, had an awareness of the participants cultural worldview, showed a positive attitude towards cultural differences, and knew the importance of cross-cultural views.

### Ethical Issues

The researcher submitted the study proposal to the university Institutional Review Board to ensure the study meets ethical standards. The primary ethical issue addressed in this study was the lack of confidentiality and anonymity. The participants were questioned and ensured the confidentiality of their identity was with anonymity due to their line of work, and this was addressed by letting the workers know that the only identification used were by gender and age ranges, and their names were replaced with pseudonyms. The researcher used informed consent and clearly explained the consent to all participants and described the purpose of this study. The researcher's role was discussed, and the contact with participants was strictly for research purposes throughout the study. The agency name and police officers encountered also remained anonymous in the study.

Non-identifiable information was added to the data in the study like titles and years of experience.

### Political Issues

A political issue in this study is that the researcher is confronting a controversial subject that is politically charged. Samuel Walker (2004) explains that police research is “heavily influenced by external politics” (p. 1). The subject of policing can strike a nerve with mental health workers especially those that partner with them and directly experience the approach police take. Some mental health workers may be concerned about sharing information that may reflect negatively on their agencies. To address this, the researcher used pseudonyms, was open with participants about their concerns, and ensured they are aware of the contractual terms of this study and the options to opt-out of disclosing information that may negatively reflect on them or their agencies.

### The Role of Technology in Engagement

For this post-positivism study, technology was used in recording and transcribing interviews with participants. The researcher emailed and messaged participants to schedule face-to-face interviews and to communicate with participants to clarify questions and answers as needed. Most importantly, the researcher build rapport and ensured mental health workers were involved throughout the study and knew of any changes necessary through email, phone, and messaging to ensure transparency.

### Summary

Chapter two started with describing the region where the study was conducted. It also explained how experienced mental health workers of many titles, would be the participants, and how their input was essential. Engagement strategies were described, including reaching out directly to mental health workers in different sites that have worked with the police to address mental health crises in the community and open to the feedback mental health workers so that they felt comfortable sharing. Self-preparation for the study included using self-reflection journals and research journals for data collection. Diversity, ethical, and political issues that came up were discussed, and the strategies to address them were described. Chapter two concluded with the role of technology would play in the study.



## CHAPTER THREE

### IMPLEMENTATION

#### Introduction

Chapter three describes the implementation stage of this study. This chapter consists of the description of the likely participants, the sampling strategy used, the instruments for data gathering, and the approach employed for data analysis. A summary concludes the chapter.

#### Study Participants

The study participants consist of 20 mental health workers that have titles consisting of Licensed Clinical Social Worker (LCSW), Masters Social Worker (MSW), Licensed Marriage Family Therapists (LMFT), Marriage Family Therapists, Mental Health Specialists (MHS), and Senior Social Workers (SSW). This study was inclusive of mental health workers that are 18+ years of age or older, all ethnicities, and genders. The characteristics of the participants included workers who have worked in the past or are currently or have worked in mental health in Southern California communities. The goal is to get mental health workers with various backgrounds and various levels of experience in the field. All participants had experience conducting mental health assessments and crisis interventions in the community that involved police officers.

#### Selection of Participants

The study utilized the post-positivist perspective, and the selection of participants was based on the Snowball approach. Snowball sampling recruit's

participants through networks and word of mouth which can identify other participants eligible for the study (Hernandez, PPT 2021). According to Morris, the snowball method is the best method for “understanding and utilizing the practitioners in relation to the study focus” (Morris, 2014, p. 2568). The sampling method was the best approach for this study because the researcher recruited participants that had the experience of working in the field of mental health and work collaboratively with agencies in the community like the police, or hospitals. Implementing the snowball sampling consisted of sending emails to a network of contacts in the social work field, identified if they met criteria based on experience needed in mental health, emailed them the recruitment email, and further asked practitioners to identify other mental health workers who are potential participants who have experience in mental health crisis and were willing to participate in the study.

### Data Gathering

Qualitative data was gathered by conducting individual interviews with mental health workers who serve the mental health population. Interviews were conducted via Zoom, due to the pandemic and the busy schedules of the mental health workers. Close caption was enabled and recorded at every interview. A structured set of questions were developed and were subject to change as the study progressed. (See Appendix A) To build rapport with mental health workers, the researcher began the interview with throwaway questions. To obtain the day-to-day field experience of mental health workers, the researcher included

descriptive, essential, and open-ended questions. The researcher questioned the mental health workers knowledge of the response services available to any individual experiencing a mental health crisis. It was essential for the mental health workers to understand assessing for a 72-hour mental health involuntary hold, often called 5150 under California Law, the experience of working with police, and their attitude towards what they need to be an alternative to police when dealing with mental health crisis. The interviewer explored how the mental health workers' training contributed to their job and their professional experience of placing involuntary holds or de-escalating a situation.

Additional questions were asked about what resources and support they needed to complete crises interventions in the community without police present. The interviewer inquired about the benefits and challenges of mental health workers responding to crisis assessments with or without police. The interviewer delved into mental health workers insight on what are the tools needed, the support from their employer, and what resources like trainings, access to, funding options, and collaborations with other agencies can be helpful for them to become alternatives to police. Throughout the interview follow-up questions included to ensure participants elaborate on their responses and to encourage clarification without encouraging answers.

### Phases of Data Collection

Data collection consisted of individual interviews. In the engagement phase the researcher used throw away questions to build rapport with

participants, went over the details of the informed consent ensuring consent, privacy, and confidentiality. The researcher addressed any questions the interviewee had regarding the study and answered them before the interview started. Next, the development of focus, the demographic information was collected like the participants gender, age, title, and years of experience. In the maintaining focus stage, the researcher used the structured questions that were developed beforehand. See Appendix A. Lastly, the termination stage, the end of the interview, the researcher thanked the interviewee for their time and provided them with a debriefing statement that included the process of the project and contact information if they had any questions.

#### Data Recording

To ensure accurate recording of the data collected in interviews, the researcher used a voice recorder to record audio. The researcher requested the interviewee's permission to use a closed captioning mechanism at the start of each interview. If the interviewee declines audio recording, the researcher resorted to taking thorough notes. In addition to the interview notes, research journals were used to record the progress and reflect on the interviews. Morris, (2014) mentions that documenting insights, feelings, and reactions without evaluating what was said at this point after the interview is essential.

#### Data Analysis Procedures

This chapter discussed the evaluation of the data collected from interviewing participants. The data analysis for this study consisted of a "bottom-

up” approach. Data analysis first introduced participants demographics information like titles and experience. Open codes were developed from the information and categorized to analyze common responses from the mental health workers. Axial coding was then applied to understand the relationship between the codes and the categories that emerged. The final section Included expert participants perspective on the needs of mental health workers and the level of micro, mezzo, and macro resources needed to better serve mental health crisis in the community and a personal conclusion and summary.

### Summary

Chapter three described the implementation stage of the research study. The Researcher recruited 20 participants from various study sites in Southern California. The interviews were conducted via zoom in the summer of 2022. Participants were selected with inclusivity in mind. The sampling strategy used was snowball method and utilized by a recruitment email and word of mouth. The data was gathered through the phases of data collection. Data was gathered through enabling and recorded with close captioning of the individual interviews via zoom. Finally, a bottom-up approach was utilized to analyze the data.

## CHAPTER FOUR

### EVALUATION

#### Introduction

Chapter four begins with participant demographics and experience. The evaluation of the data collected was through qualitative analysis. The analysis first uses open codes to categorize concepts, secondly axial coding shows the relationship between them. The third section is selective coding describing the implications of social work needs on the micro, mezzo, and macro level, the researcher's conclusion, and summary.

#### Demographics and Experience

There were five male, and fifteen female participants recruited from various counties in Southern California. Participants ages ranged from twenty-five to fifty-five. Ethnicities included but were not limited to Caucasian, Latinos, and Asian. Their professional titles and licensures included, License Clinical Social Workers (LCSW), Master's in social work (MSW), License Marriage Family Therapist (LMFT), Senior Social Worker (SSW), and Mental Health Specialists (MHS). The experience years of ten participants ranged from two to fourteen years of mental health work experience. Six participants had fifteen to twenty years and four participants had twenty plus years of mental health experience. Their experience work included working collaboratively and/or for community agencies providing mental health crisis services such as Crisis

Assessment Teams (CAT), adult and adolescent behavioral health clinics, recuperative care agencies, law-enforcement agencies, Medical hospitals, outpatient Clinics, Community mental health clinics, Crisis centers/programs, Assertive Community Treatment (ACT) programs, psychiatric hospitals, shelters, social services, crisis stabilization units, Emergency Medical Technicians, and Psychiatric Emergency and Response Team PERT Team.

<b>Demographics</b>			
<b>Gender</b>		<b>Race/Ethnicity</b>	
Male	5	White/Caucasian	8
Female	15	White/Mexican	5
<b>Age Range</b>		Chinese/ Malaysian	1
Ages 21-29	2	Korean	1
Ages 30-39	9	White/Hispanic	3
Ages 40-49	7	Latinx	2
Ages 50-59	2		
<b>Title</b>		<b>Experience (years)</b>	
LCSW	6	20+	4
MSW	4	15-20 years of experience	6
LMFT	7	2-14 years of experience	10
MH SW	1		
Senior Social Worker	1		
Mental Health Specialist	1		
<b>Work experience with agencies</b>			
<ul style="list-style-type: none"> <li>• Crisis Assessment Team (CAT)</li> <li>• Adult and adolescent behavioral health clinics               <ul style="list-style-type: none"> <li>• Recuperative care agencies</li> <li>• Law enforcement agencies</li> <li>• Medical/Psychiatric Hospitals</li> </ul> </li> <li>• Community MH/Outpatient clinics               <ul style="list-style-type: none"> <li>• Social services</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Crisis centers/programs</li> <li>• Assertive Community Treatment Programs               <ul style="list-style-type: none"> <li>• Shelters</li> </ul> </li> <li>• Crisis Stabilization Units</li> <li>• EMT's/Ambulance companies               <ul style="list-style-type: none"> <li>• PERT teams</li> </ul> </li> </ul>	

Figure 1. Table of Demographics

### Open Codes

The analysis of the transcripts identified nine open codes. These codes are experience with police, safety issues, trust issues, George Floyd effect, issues with the use of violence, safeguards for mental health workers,

coordination of care, system fails, the ideal team. Axial Codes-were the needed role of police, the need for highly skilled/lived-experienced mental health workers, interventions/resources needed, training needed. Lastly, researcher's conclusion and participants conclusion on Implications for the Micro, Mezzo, and Macro level.

### Experience With Police

Experience with police is defined as the participants description of working alongside police for crisis assessments in the community. Study participants tended to make various observations regarding this code. Some were positive but most were unfavorable. For example, RI1 stated, "When I started the work. It was a very collaborative approach with police. over the course of several years, it transitioned from collaborating to hands-off approach.", RI5 observations are, "negative that I've seen but I wouldn't necessarily say that's across the board. I've definitely had some great experiences with law enforcement". RI15 also stated, "It's kind, of a mixed bag but I've had pretty good experience when we're working as a team. The overview of statements tended to be negative responses and attitudes from police towards mental health workers, police responding poorly to clients, and lack of training and understanding in mental health. For example, RI1 declared, ". Police see us and the community that we service as a liability to them, and everybody's walking on eggshells". RI4 states, "Fatigued and the work becomes a burden to them", RI9 unnecessary deaths that happen when police are involved, it's not always their fault, but things escalate, and that's



how they are trained”, R15 states police “They made my job harder by doing the bare minimum”, and R110 stated “I've had situations where loved ones will tell me please don't call the police because he's a black man, or he's a Hispanic man, and it can easily escalate”. During the interviews, it became evident that minimal collaboration between mental health workers and police takes place during crisis assessments. The approach from police was unhelpful, reactive, unwilling to intervene, and insensitive during crisis situations.

### Safety Issues

Safety Issues is defined as the presence of police during a mental health crisis as a safety piece for mental health workers rather than safety risk for the community. The statements ranged from R11 stating “police are not collaborating with us anymore in the community which puts us at risk”, R14 revealed some of the responses from police when arriving to the scene, “that's your job to navigate the situation” and mental health workers responds, “it's not my job when it comes to safety, and I can support, and I can be present, but I need you to be here for safety reasons, there's other people here too and I need to keep this client safe”. R112 stated, “there are also times where you have PD for pre-caution and it turns out you actually do need them when the client tries to harm themselves”, R120 reported, “we know we're safe if something happens. If a client lunged at me, the cops would do something about it”. R117 said it best when she described having police for safety reasons, “For mental health crises, we want them there to keep us and the patient and the community safe, their purposes are for safety reasons,

they are the force that can hold the situation together, but it doesn't have to be in an aggressive or violent way”.

### Trust Issues

This code is defined as the lack of trust observed from the community to mental health workers approaching with police when conducting crisis assessments. RI1 explained the code when stating “It as a double-edged sword because when social workers show up to the community in crisis response, we are seen in cooperation with the police, and as part of that very system that has essentially either failed them or have disappointed them”. RI14 stated, “They're coming from a different perspective of being punitive”. This code was further elaborated with examples. RI20 stating how complicated it can get during a crisis assessment, “A lot of them standing off with arms crossed, saying “I'm not going to touch them, 4 policemen arrive just watching, you try to talk to them, and then that escalates tensions because there's now police everywhere”, further explaining that “We aren't seen as a team, but we're on the same team here. We're on the same end goal, but they see us beneath them, this is beneath their task, and not recognizing that this would go smoother if we could communicate together. If you don't cross your arms or make a snide remark, not have your hand on your gun, and how about we talk together and approach differently”.

RI16 states, “There's a stigma with law enforcement from our low-income disenfranchised communities, there's a lot of law enforcement abuse and distrust, therefore someone with a badge is going to change the environment”.

Mental health crisis work is challenging, and when their work is undermined by police, the challenge becomes a barrier.

### George Floyd Effect

The George Floyd Effect is the direct result of Floyd's murder and news of police behaviors such as police brutality went viral. Police held back on their assistance to mental health workers during a crisis to prevent even more backlash. The first participant, when asked on the approach of police. R11 reported, "The police arrived, and they refused to retrieve that individual, although that individual was deemed gravely disabled by various clinicians, deemed at risk to himself and the community. The police would not put hands on him, in reference to the concern of all the bad media (George Floyd Effect) they had been receiving, due to the mistreatment of people of color in the community by police officers". Another participant R18 reported, "significant social documented occurrences, related to police brutality changed the dynamic for the trajectory of getting law enforcement assisting us with mental health calls", R19 stated "It's hard to ask cops to take more training when they have a gun they resort to", and R113 stated, "Sometimes police can say inappropriate things, be insensitive, and get the client all riled up and angrier, and they're already in a rough situation". The lens changes when approaching a crisis from a law enforcement perspective and a mental health worker perspective. The approach that police have experience on is a more criminal nature and that has affected their treatment towards the mentally ill.

### Issues With the Use of Violence

This code emerged while exploring participants attitudes, when working with police in the community and the use of violence, it was found that participants believed their ethics and values are misconstrued when working with police when approaching a mental health crisis. Mental health workers do not condone the use of violence and they are specifically trained in non-violent interventions to de-escalate situations. For example, RI5 states, “just because someone is being belligerent, mean, yelling, screaming, and angry doesn't necessarily reach the level of needing something to be done. You have self-determination”, RI17 states, “we always want to be hands-off. I don't want to touch anyone that doesn't want to be touched, especially in a crisis where they can become aggressive. I don't want a person to feel like they're restrained when you're assessing them. If they're needing restraints their probably needing medication and rest, but they don't need an intervention. Let's talk, hands off for our kind of functions”. RI9 explained, “With Police there's so many situations where somebody was killed because they were having a psychotic break, when maybe a social worker could have really talked the person down”. RI1 claimed, “As social workers, we show up with clipboards we don't show up with guns”. The purpose of professionals teaming up to help someone in need should not resort to the use of violence, there's options like non-violent, de-escalating, safety plan interventions to use before any sort of violence.

### Safeguards as Mental Health Professionals

This code was created because participants explained their concerns with the minimal safeguards of mental health workers. R13 pointed out that, “There are very little safeguards as mental health professionals for a person in psychosis to look at my public facing information. Technically, my classification is not protected as a mental health provider. For example, if I choose to hospitalize a person, they can always look up my information on the web and literally find where I work and live. Depending on your organization, there might not be some legal protections. If this client were to put a civil case against you that you restrained me against my rights and they're under a mental health condition that required hospitalization and crisis services”. R19 stated, “my immediate thought is the Crisis Assessment Team who just deals with new patients continually, they're hardly ever see the same person twice, unless they just happen to hospitalize the same sick individual over and over. Those clinicians who are meeting people for the first time, and who we may not have a lot of information on the danger if they went out as a group, Would that be helpful? Yes, but that ultimately still could lead to a need for somebody who's armed there. What we're doing is we're covering ourselves because we're hands off and we just have the training of non-violent beliefs and are trained differently”. R18 suggests, “Usually we rely on our instincts, and we go in groups of 2. We try our best to be safe. but I think equipping social workers to be safe, maybe having safe centers drop-in centers where social workers can meet homeless clients instead of the corner

locations that are community base spaces. a safe space for everybody that we can meet at, instead, of going to the riverbed, or going under a bridge that could be unsafe". RI14 declared that "in some situations, if there's a known history of violence, If there's a known weapon on the person or in the home. If the mental health crisis is that the client is actively making threats against somebody else. For me Personally, I would not even with 12 years of experience in the field. If that's the call that I got, I would not feel comfortable going to that home to do an assessment without police on standby". The safety of all workers should always be a concern for all agencies when providing mental health services. Having high safeguards in place is a must in this line of work.

### Coordination of Care

This open code explains the lack of collaboration from community agencies involved like the hospitals and providers in the care for the client. Participants provided the many obstacles involved when working with agencies in the community when providing crisis services in the community. For example, RI3 reported, "Very little does the hospital collaborate with the county, and vice versa. because of these safeguards we have for health information. But it's not HIPPA compliant when clearly, we're complying with coordinating client's care. It is a misconstrued concept between different agencies. Obviously, the continuity of care of a person doesn't matter". RI5 explained, "It's frustrating to have a client tell me they were hospitalized, and I had no idea why they were hospitalized, so they were discharged. and released, and no connection to a mental health

provider. Making it easier in cases where mental health crisis is a factor that public health information would be more readily distributed between workers or between agencies. There are some hospitals that I call to follow up on clients and I don't hear back for weeks on end, and I understand everybody's busy understaffed. A solution is making it easier for us as mental health workers to provide information to agencies involved. To overcome obstacles and have that cross-jurisdiction interaction with individuals". R19 provided insight, "It's such a fine art to know how to coordinate all of that. when the client is in crisis, and then you must call the cat team, ambulance, the police. call hospitals, that was more of a barrier than helpful for the county. the whole system needs to be revamped. It's never simple to do 5150's". R17 emphasized, "law enforcement and mental health agencies, but also rehab centers. Being in collaboration is a benefit, things get lost in communication. Having small networks, in a city, rehabs communicating with hospitals and crisis team and law enforcement, and everyone's in the same team. It would streamline things to make things faster, and to get appropriate care to the client faster". The coordination of care also needs to shift to provide the adequate support needed during and after the crisis assessment.

### System Fails

This open code was created because some of the participants provided insight on the challenges that they face in crisis work. They mentioned system fails and barriers that both mental health workers and clients face. These are barriers that clients face when trying to receive the services, and programs that

don't have the adequate resources, as a result make mental health worker's work harder. RI8 stated, "There's a lot of systems that fail, there are all these moving parts that all fail." And RI9 stated, "biggest issue is the amount of crisis workers that we have, it's not enough". RI10 also stated "A lot of people call these Crisis numbers to feel safe, to feel secure, and not having to deal with police, but police, still get called so what was the reason?". RI12 contributed to the subject by saying, "A lot of crisis happens with our homeless population. And Our system is not set up in a way where we are supporting them to succeed. They just fall back into the same cycles which inevitably lead to crisis".

Participant's responses paved the way for the open codes. After further analysis of the responses the open codes were labeled and categorized starting with positive and negative responses of experience with police, safety and trust issues that concern mental health workers when conducting crisis assessments in the community alongside police. The significant George Floyd effect resulting in police not providing the appropriate assistance and collaboration needed out in the field with mental health workers. Issues with the use of violence consisted of mental health workers not condoning violence and providing de-escalation options for addressing mental health crisis in the community. The concerns of mental health workers and the lack of safeguards for their line of work. The lack of agencies collaborating with mental health workers for the coordination of care when conducting crisis assessments in the community as it is not just mental health workers helping clients. Finally, the system fails that continue to negatively



affect the public creating a revolving door for them when accessing crisis services.

### Axial Coding

The axial coding shows how respondents linked the solutions to the issues they talked about in the open codes. Participants started to provide the necessities/changes needed for programs to better serve the communities during a mental health crisis. The researcher made the following axial coding to show the connection. Due to the negative behaviors of police that mental health workers experienced and the George Floyd effect, The role that police need to take when working with mental health workers emerged. Since the line of work of crisis assessment is unpredictable and requires careful coordination, the need for skilled/ lived experience, and training needed developed from the safety and trust issues. The ideal team was a direct result of participants providing the alternative approaches for crises assessments. Due to the unreliable system and the poor coordination of care, the axial code of interventions/resources needed emerged as the solutions. The diagram from Figure 2 below helps explain and connect the axial codes to open codes.

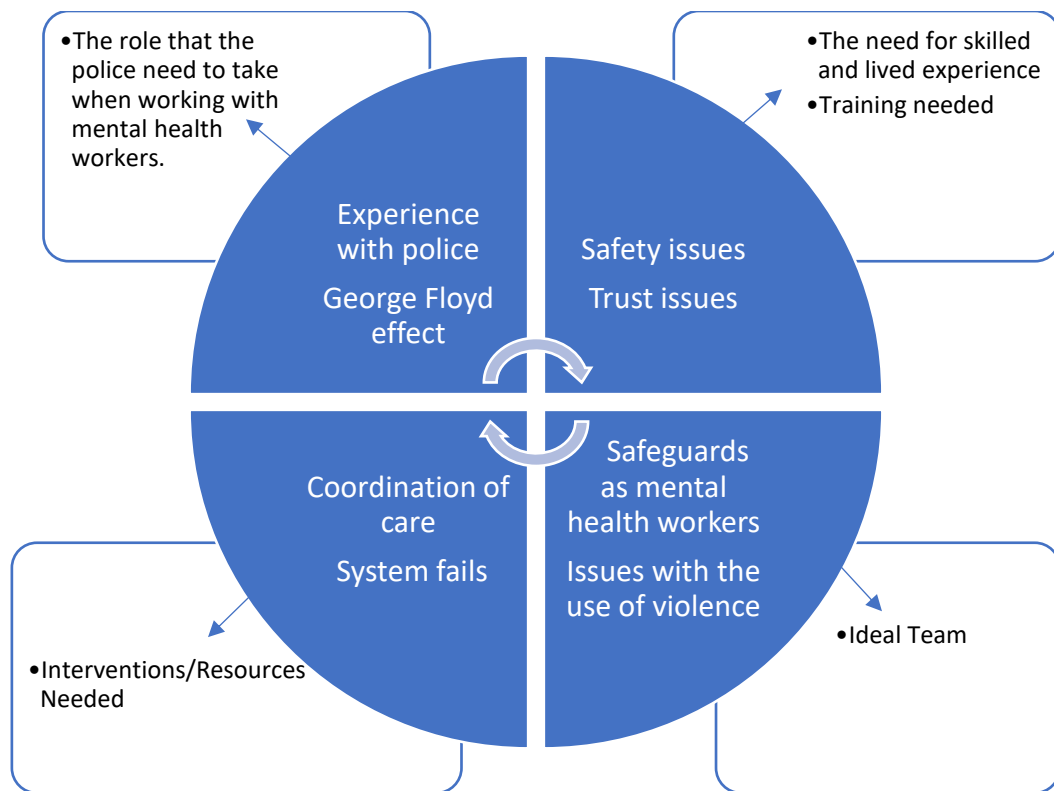


Figure 2. Connection of Axial Codes to Open Codes.

The Role That the Police Need to Take When Working With Mental Health Workers.

From all the themes of working with police, participants shed light on the needed role that police needed to take to better their approach when providing support to mental health workers on a crisis intervention. RI19 stated, “they need to go by the lead of the clinician”, RI16 stated, “while trying to provide support, they should do it in a way that does not involve physical restraints, its more impactful to see the person before the disorder or disability”. RI5 recommended, “trauma focused care would be helpful for law enforcement. Officers to be able to recognize, in this situation I can start from a 2, I don't always have to operate out

of a 10". R115 provided insight, "We have been trained in the clinical sense of mental health crisis, where the officer brings their experience and the legal aspects of the law. They can approach with communicating to mental health worker's, I understand some laws better than you, and I'm going to outline the things that we need to consider before approaching the situation". R117 affirmed that, "In a mental health crisis, We are the experts and police are there to follow our lead. Intervention is so different, and the skills that are needed in the moment are different than when dealing with an aggressor or in a shooting, where the police is the expert". R114 revealed an occasion when police took a better approach, "hands-off with our clients, but still helpful and responsive" all participants are aware that mental health workers are paired with police for safe-keeping purposes, but for police to be a resource for crisis, they need to understand the mental health worker's role when conducting a crisis assessment.

#### The Need for Skilled and Lived Experience

This Axial code was created based on the specialization of this work. Knowing that there are safety and trust issues when conducting crisis assessment, the participants explained how mental health workers need to have the adequate skills and lived experiences to better serve the communities. During the interviews, the participants were asked about the benefits of having mental health workers instead of police respond to mental health crisis. R14 stated, "Social workers go out in the field every single day without a weapon. There are situations that do happen, but more than not, they don't. I've been in situations

just one social worker in the field, but I've gotten myself out of that, and I'm continually aware of my surroundings, and so I never had an incident where I was in danger. I got myself out before it escalated. We know our limits, because we're so aware of body language, and tone. Yes, law enforcement may have that strength as well, but in a different way. They're ready to be proactive of something else, I'm not even considering getting that person to the ground. I'm considering how do I de-escalate or when do I need to leave?". RI5 continued with, "Obviously, education, gives you a different perspective. There's a certain type of person that goes into law enforcement, and there's a certain type of person that goes into mental health work, and so just that simple kind of demeanor can have a profound effect on interactions with clients". RI7 explained, "The benefits are that there are no weapons and the patient's sense of authority is different if they see a police officer come up to them, especially if they're having apparent paranoia, or delusional thoughts, that could be scary. If they see a person that's not in uniform that could be also more helpful for all the process". Then RI8 reinforced the difference, "a benefit in having mental health worker instead of law enforcement is that lots of our mental health workers are formally trained, that's their specialty. They spend years in school studying mental health and they have colleagues they can consult with. They have supervision with supervisors that have a career in that field. They have that support, ongoing education, they must maintain their license. They take classes so they're up to speed with what's new, how to treat clients, what is the new

medication out there. This is their specialty in every way. So, they by far are more equipped than a law enforcement officer to deal with the mentally ill, not to mention the paranoia from the clients when it comes to law enforcement. It's just better overall client care". Experienced workers, as R112 states can provide, "understanding more of the sensitivity that it takes to work with mental health clients, especially the ones in a crisis. R111 disclosed, "Having somebody listen to the concerns of the person that's upset, figuring out what will help with that, or fix it can bring more positive outcomes and keep that person from having to get into the system, especially if they've already been in the system". R114 stated the importance of having a skill set, "We are trained in mental health. we should be following evidence-based practices to keep the client safe. We're trained to be client-centered compared to the police, who are focused on the safety of everybody else". The lived experienced worker comes in with their specialty and through their experience they can navigate through hard situations when someone they don't know is going through a crisis. They can pick up on non-verbal cues, symptoms, assess and conclude that being mentally ill does not necessarily mean a threat to anyone.

### Ideal Team

This Axial code was created in connection to the lack of safeguards for mental health workers and the issues with the use of violence. An ideal team would consist of a joint effort of specifically trained collaborative workers pulling together to help accomplish the same goal of de-escalating, using non-violent

approaches, and providing the best possible care for mentally ill individuals. Participants provided insight on what the ideal team would look like when making crisis assessments in the community to benefit everyone involved. RI1 stated, “A team of people is important when these kinds of approaches are taken in the community, maybe like 2 or 3 people at a time, with different backgrounds, maybe somebody within the community. An emergency medical technician and a peer specialist and a social worker all together”. RI5 stated, “Dealing with The population in general the position in and of itself as a peacekeeper, not necessarily at the forefront. it's law and order but it's a dual position you must be the peacemaker and the person that understands they're needs. Everybody's not going to obey the law, sometimes you put yourself more at risk by not having a certain level of authority, understand it's a fine line. It's not just a matter of well be softer or toughness. Law enforcement need to be firm, direct, and to the point. But there must be that peacemaker component”. RI13 agreed that “A whole team going out that's so much better than what we have now, a team of more educated and experienced individuals working together is needed”. RI15 states, “have us part of the police department or law enforcement agency. You have clinicians that are hired there now, if at least they could be housed there and not on another agency, but their house together, and they work together. If they're an equal department. They'd be going to the same trainings”. RI19 then reinforced by stating, “What police departments have to do is have clinicians on their team full time”. The range of an ideal team varied from close collaborations, to having

a team involving various professions, and mental health workers being part of a police department to work as a team. Participants concluded with the benefits of having a skilled worker with all the abilities necessary team up in partnership with other professionals to improve the delivery of services while conducting mental health assessments in the community.

#### Interventions/Resources Needed

This Axial code is connected to the system fails and the poor coordination of care that has created gaps in crisis work. Interventions and resources needed was developed as participants naturally started to get creative on the most important interventions and resources needed to provide support to mental health workers and clients during a crisis, or aftercare. It's not just the mental health workers or the teams' approach that is needed. More collaborations by agencies involved need to provide the necessary resources. These possible interventions are suggested to prevent a revolving door in a failed system. For example, RI1 provided great interventions and resources when stating, "Sobering centers can appropriately and lawfully and ethically evaluate people, get them where they need to go and be safe whether it be a psychiatric hospital or sobering center, a few more days back in the communities and even a safety plan with family. Because we can allow somebody to sober up. Then evaluate them instead of just immediately. Evaluating them and saying, Okay, we're going to take your rights away. There should be a gap, a time-period of that. Somebody can be evaluated it shouldn't be right off the bat. Also, incentives for some people

that are struggling to get off the streets when they're in crisis". RI5 revealed, "Advocating, starting with the least restrictive kind of option. Trauma focused interventions, builds a lot of empathy and sympathy as you're taking away this person's rights. It's not just the mental health it's a substance use, the criminal sense that some of them may have experienced, all those things". RI6 stated, "a lot of these individuals are in crisis because they don't have sufficient resources. Maybe they're lacking housing and food. Sort of Maslow's hierarchy of needs, those things are not being met at the bottom of the hierarchy and somebody who has a mental health diagnosis, and they got kicked out, that could be the straw that broke the camel's back". RI13 provided insight, "Right Now, it's availability resources. My program is supposed to be once a week instead of every other week sessions, and we just don't have it because we're so impacted with clients. Clients can't find weekly therapy anywhere, at least community mental health weekly and on top of that getting into substance programs, and housing assistance. There's limited housing availability, there's limited substance abuse programs for this population". RI14 also stated, "Having more resources available when we're able to divert, outside agencies also collaborating, also in charge. The hospitals should have more of a responsibility. If no bed available, we're going to divert it there, and Instead of having them wait there for hours and hours to not getting assistance. More beds available in the hospitals, but also more beds available in crisis stabilization programs like Treehouse, a short-term crisis residential, Crisis Stabilization Unit (CSU), or even programs to detox". The



whole patient care consists of many layers, participants creatively provided attainable ideas of interventions and connections to resources and mental health worker's needs for this type of program to work. These quotes describe the ideas needed when developing programs that provide services to individuals in crisis. Participants provided those necessary interventions, because it's not just the mental health workers providing these crisis services but by all the programs involved.

### Training Needed

Training needed is an axial Code created also in relation to the open code of interventions/resources needed. Training is the one theme that the expert participants thought was the one of the most important needs for the services to work. They explained who should teach these trainings, what kind of extensive training for police is needed, and further training for mental health workers. RI1 stated, "trainings that allow people to immerse themselves within the community are important, it's so easy for us to focus on all the clinical pieces but forget that at the end of the day we are still working with human beings, and they all have a mind of their own. Getting people in the community in which you are providing interventions should be involved in spearheading some of these trainings, especially when you're getting familiar with a specific community of people. I also think peer specialists are important to spearhead these trainings". RI2 stated, "The various types of crisis interventions trainings. I think training on What to look out for with people that have mental health conditions, what mental health crisis

situations may look like and experienced mental health workers continuing to provide these services should lead these trainings especially for police". R14 declared, "The trainings needed would be w/ the intention, How can we work together? How can we make this better for the both of us? for law enforcement and mental health systems, showing the mutual benefit for both systems as well as the community". R15 states, "Law Enforcement should be more engaged in the type of trainings that we take as social workers. for us it's mandatory for them it's like no, you don't have to, but they're so involved, and they are not getting that type of training". R19 reassured that, "trainings should be taught by folks who have real life experiences and how to conduct appropriate assessments. Do scenarios about difficult situations, because most of them are going to be difficult. The majority of Scenarios have so many different layers to the situation. it's not just going to be somebody sitting there nicely saying, I'm going to swallow a bottle of pills if you don't put me in the hospital right now. There's a lot of moving parts going on, so having more trainings with real-life examples about how to approach these different problems as they come up, and how to monitor yourself in that moment because even though we're trained professionals, we can get nervous, anxious, and overwhelmed. Learning how to navigate through that". R10 suggested, "Cross-training, there should be an even-exchange. SWs are not going to carry weapons. PD, they're the ones with the weapons, so even-exchange in terms of training and what we may face in critical situations". R11 provided insight, "Many police departments, the training is very different, more of

a physical thing. little bit of aggression when you're dealing with extremely stressful situations anxiety is already high. being able to have classes that train law enforcement agents how to use your weapon or how to Detain a person but then how to listen to how they are, Why is this person upset? Maybe having classes on psychosocial issues- what's driven people to be on the streets and homeless. And the lack of resources and substance abuse issues. The Why, the why of it would probably help". Assessing individuals that you don't know their history or may not have rapport can be challenging when workers are busy assessing everything else like, body language, their current symptoms and diagnosis, coordination of care, and collaborations while also developing a safety plan. These quotes provided the best insight from the trained and experienced expert participants suggesting this is what's needed for workers to be properly trained to do this type of work.

Axial Coding provided the modifications that could be implemented for agencies to collaborate successfully with a mutual goal to better serve the mentally ill in the community. The transformation of collaborative approaches such as non-violent and de-escalating when providing crisis interventions. The skilled trained teams of workers needed when conducting crisis assessments. The alliances needed between agencies involved such as hospitals, law-enforcement, ambulances, and mental health service providers to prevent the revolving door for the mentally ill.

Participants Conclusion on Implications for the Micro, Mezzo, and Macro Level

### Micro Level

On the Micro level the focus is on working with the individuals that are mentally ill, and how to better serve them during a crisis, this includes their present environment, their social support, and the agencies involved in the individual's life's. Participants provided quotes to understand what entails in serving the individuals during a crisis assessment from a micro perspective.

At the micro level, from the participants perspectives, R11 states, "Everybody must get involved, it becomes a traumatic experience for clients, we don't do enough to encourage people to seek help versus them being forced into involuntary help". R12 suggested that "There needs to be more linkages to services as opposed to giving them a flyer, giving them a number to call, but following up with them, that will fill in those gaps". R15 inputted, "There's too many actual cases and not enough people to respond to them, were losing people that are overwhelmed being overworked". R18 suggested, "More intensive de-escalation skills, having a set plan with a partner there to help in linkage to available services. Create a team that doesn't involve law enforcement, maybe like emergency medical technician's working alongside social workers. A lot of our clients are in the community. they're also facing medical issues like asthma attacks, And how are you going to help them? you could have some sort of community outreach team that's field based where patient's obtain intensive treatment. They must follow up with their workers. Not probation officers but their assigned social worker, this is what you do and have

some sort of incentive for them, and some assistance. Something way more intensive that's structured like probation". Working with this population requires a team approach as suggested by participants. Mental health workers, programs, agencies working collaboratively with mental health workers should start to work on the gaps missing in their work. The impacts can be significant for individuals with mental illness.

### Mezzo Level

At the Mezzo Level, The involvement of communities is crucial to reduce the stigma that impacts individuals negatively when dealing with mental health Crisis. People are already dealing with a lot when managing a mental illness, on top of that managing a mental health crisis is overwhelming. We as mental health workers need to see the involvement and support that needs to happen to help the individuals during that crucial episode they are going through.

Participants suggested that at the mezzo level, more community involvement, and families of individuals with mental illness. RI5 suggested, "More education needs to happen to educate them on what is and isn't appropriate, what can and cannot be done. All my clients were children at 1 point in time, so I think that's a component, educating families. Educating at a young age about mental health and the dangers of what it can turn to. As a community not stigmatizing these individuals, truly creating a safe space for them to be open and honest about what it is that they're going through, being preventive. When in my program, 10 hospitalizations later, 10 years struggling to manage the mental

health, because a lot of things come into play. It shouldn't just be put on us to do as mental health workers" RI8 stated, There needs to be more resources for families to educate about their mentally ill family members, and how to manage a crisis and how to navigate getting help for their families. RI4 stated, "Community engagement, seeing a better Presence within law enforcement and seeing them more engaged at community events". The quotes concluded that there's more that we as a community can do for each other by displaying more awareness of the mentally ill, erasing stigma, and educating families so that everybody can do their part in their community.

### Macro Level

At the Macro Level, the education, program policies, targeted funding, merging of programs are some of the systemic issues needed for the overall macro level practices to shift in a better direction. The rules and regulations, reorganization of funds, and involvement in policy are just some of the changes needed to improve in addressing a crisis.

Macro level suggestions from participants included, RI17 stating, "funding research. You can't even get employees if you don't have funding and then you can't train and get extra training without the funding. Mental health is overlooked in the medical health field". RI10 suggested, "Community organizations providing trainings and making them accessible for the community partners. Making sure who needs to know is trained and then extending it outwardly to other community members". RI11 stated, "Instead of putting money towards buying a huge-

armored truck, partnering with social workers. Hiring highly experienced professional social worker's, hire instead of 10 officers, hire 5 of them and 5 social workers' so that they work together, it's with ideas like that, you come up with better outcomes". RI20 stated, "a centralized system, sober centers". RI16 provided insight of progressive ideas from out of state law enforcement agencies that have partnerships with social workers, "They were very open to us, being the subject matter experts in how to deal with overdoses or mental health calls. So, they really relied on us to provide trainings or understanding of what to do, what not to do. They were very open to changing the way that they dealt with overdoses or substance use in the community. Instead of prosecuting or arresting somebody for possession they would give them the choice to come meet with us, or if they didn't want to, then go to the hospital to meet with us, we would get called and then we would show up in the field with them. Just kind of talk it through. They were open to harm reduction as a method of combating all the overdoses. Engaging with more progressive police departments, proving that it works and then trying to get the rest on board while we dismantle all the legislative things that make it impossible to remove them at the time and kind of looking at the overall, national systems change". RI4 proposed, "Social workers in policy, involved in the city councils and boards, where they can bring in more funding and help the community more". RI5 recommended, "Investing more time and effort and directing more money into education. More funding but purposeful and directed can be more beneficial".

Responding on the macro level has many layers, Participants suggested understanding how society views the mentally ill, providing accessibility to programs and services involved, major collaborations on a larger scale to ensure intensive services are provided specific to this population and prioritizing the changes in policy for the whole-person care by all agencies involved.

### Conclusion

Addressing crisis assessments in Southern California communities involves many entities such as law enforcement, emergency medical technicians, mental health workers, and hospitals to serve one individual. It appears as a team on the outside, but while conducting the assessment, mental health workers face many barriers. These barriers include law enforcement and their negative attitudes and bias behaviors, the lack of respect and needed collaboration to reach the same goal of helping these troubled individuals during a crisis. It's not that law enforcement is bad, and they don't do their job but it's their approach not only to the mental health worker but to the troubled individual, and that needs to change. There's also a safety risk to it, if we don't have police then we lack protection in case something does happen, if we do have police then there's a risk of the patient being negatively affected from police bias, or the situation escalating because of the police showing up with guns and not being adequately trained to de-escalate

Helping individuals with a mental illness dealing with a crisis involves meeting them where they are at. Some of them are adults and some are



adolescents, they could be housed, homeless, or even facing economic challenges, some are having a psychiatric episode and some of their behaviors could be alarming to others that are not aware of this person's struggles. Each situation is different and never the same. Mental health workers take care of many matters at hand not just the crisis. They have been conducting assessments, but they need help. This type of work is not easy to manage, certain skills come into place, especially skills of de-escalation combined with non-violent approaches, and figuring out how to transport them and place them.

A team of individuals from different professions need to work together in partnership, habitually for them to become one. Mental health workers hold many hats, but its time those hats come off, so they focus on doing their exemplary job to address a crisis. The need to be backed up by other professionals on all levels for them to be part of an ideal team that addresses all the issues at hand. Ideas of an ideal team is placing social workers to work directly in police departments, setting up a field team that works in teams with emergency medical technicians. A team that focuses primarily on the issues at hand. Education, on-going training, and experience is needed for this type of work.

To build this team, systematic changes need to happen. Interventions from outside agencies like hospitals, treatment centers, community providers need to collaborate to assist mental health workers in solving a crisis. This includes adding more professionals on the team, providing major funding, change in policies and procedures to facilitate the needed interventions, funding

and providing the needed training such as trauma focused for all professionals involved and education to reduce the stigma of mental health. It's crucial that these training are accessible for workers and families of the mentally ill.

Experienced mental health workers as the participants in this study shed light on the collaborations and approaches needing change, on whole patient care interventions needed, and the reorganization of the current system to provide a comprehensive collaborative approach for this type of work.

### Summary

This chapter discussed the evaluation of the data collected from interviewing participants. Data analysis first introduced participants demographics information including titles and experience. Open codes were developed from the information, then more in-depth axial codes that connected these codes together. The final section Included expert participants perspective on the needs of mental health workers and the level of micro, mezzo, and macro resources needed to better serve MH crisis in the community and a personal conclusion and summary.

## CHAPTER FIVE

### TERMINATION AND FOLLOW-UP

#### Introduction

This chapter explains the researcher's termination of the study and the connection between participants and the study's findings. The researcher will demonstrate the benefits of that connection. This chapter will also provide the dissemination plan for the study findings.

#### Termination of Study

The termination of the study consisted of giving participants a debriefing statement composed of a summary of the study focus, how the post-positivist paradigm will carry out the data gathered by participants and thanking each participant for their participation. The debriefing statement and the researchers' and supervisors' contact information are provided. At the end of each interview, the researcher informed each participant of the expected finalization and how they could access a copy of the study findings after May 2023.

#### Communication of Findings to Study Site and Study Participants

The study findings are publicized at the university scholar works (<https://scholarworks.lib.csusb.edu>). A final report will be drafted so that the key findings contribute to social work literature for the graduate studies and School of Social Work at the State University of San Bernardino. A thank you Email will be sent from the researcher to each participant, informing them of the completion and how to access it at their convenience online through the ScholarWorks link.

Having the study accessible gives them the convenience to review, pinpoint their contribution, and spark ideas about the contribution the findings have for mental health workers and the evolving approaches to the mental health crisis.

#### Ongoing Relationship with Study Participants

Since this study was recruited by word of mouth and all participants had experience working in this field, they will naturally be interested in the findings. Knowing this, the researcher will maintain contact with the site directors and the participants for any ideas, questions, and suggestions on how the study findings can be used in the future. This ongoing relationship will evolve into discussions, references, forming alliances, and gaining insight into how the results benefit their line of work. This study can even start conversations and task various programs, directors, and policymakers to make significant changes to the MH services provided to the public.

#### Dissemination Plan

In addition to the study being published on the Scholar works website after May 2023, the researcher will attempt to disseminate the study by reaching out to local county programs, law enforcement, and county officials that have the power to change local policy in mental health services. This effort to get the word out can be initiated by sending an inviting email requesting their time to review the study and to present the findings to their programs. Provide insight on how the findings came from experienced workers that work or have worked directly with these types of programs and what they had to say about them. Further, imply the need for better collaborations between law enforcement and mental health

experts. Introduce educational presentations to the administrative staff that shows the need for alternate functional approaches that lead towards a common goal of providing better mental health crisis services in the communities.

### Summary

The last chapter of termination and follow-up was detailed with a termination process of the study. The findings were made accessible through the research publication and where to access it. This chapter also included how the participants and the study site would benefit from an ongoing connection to the findings. This chapter concludes with the researcher's thorough dissemination plan.

APPENDIX A:  
INTERVIEW QUESTIONS

### **Demographics/throw Away questions**

Gender/Age?

Race/Ethnicity?

How long have you been or worked in the Mental Health (MH) field?

What is your title?

Tell me about your job as a mental health worker and what certifications are required to do the type of job you do?

What other agencies do you collaborate with to assist clients in crisis response?

### **Essential questions**

Have you ever worked with police in the field?

How would you describe your experiences in working with law enforcement officers while conducting a crisis assessment? Please provide examples.

Tell me about the benefits to have social workers instead of police respond to Mental health crisis?

Describe the challenges SW's face when working with police during a mental health crisis?

Tell me about the necessities/changes one would need for that type of program to happen and be successful?

### **Resources questions**

Tell me why police are a resource needed for crises response?

What resources at different levels (macro, mezzo, micro) are missing to fill in the gap of addressing crisis work?

How can community agencies collaborate more in crisis response to fill in the gaps?

What type of support do mental health workers need to better address crises response?

### **Training Questions**

What are the trainings needed for a best prepared professional doing this type of job?

Do you think police should/need these trainings as well?

Who should teach these training? what content should it contain? Should it be Hands on/off?

How often should police do these trainings?



APPENDIX B:  
INTERVIEW DEBRIEFING STATEMENT

This study you just completed was designed to investigate what resources and supports mental health workers need to serve as alternatives to police in responding to mental health crises. In this study we adopted a post-positivists paradigm and data was gathered through these individual interviews with mental health workers like you who have direct experience with mental health crises and with the police. We are particularly interested in the focus of what mental health worker's needs are and level of resources that they need to better serve mental health crisis in the community without the presence of police.

Thank you for your participation and for not discussing the contents of the question with others. If you have any questions about the study, please feel free to contact Karen Apolinar 760-562-3233 [007424619@coyote.csusb.edu](mailto:007424619@coyote.csusb.edu) or Professor **Teresa Morris** at [tmorris@csusb.edu](mailto:tmorris@csusb.edu). If you would like to obtain a copy of the group results of this study, please contact Professor **Teresa Morris** at [tmorris@csusb.edu](mailto:tmorris@csusb.edu) or +1 (909) 537-5000 after May 2023.

APPENDIX C:  
INFORMED CONSENT

### **Invitation to participate in a research study**

My name is Karen R. Apolinar, and I am a student at the California State University San Bernardino in the school of Social Work. I would like to invite you to take part in my research study being supervised by Dr. Teresa Morris. I am doing this study to understand more about what resources and supports Social Workers need to serve as alternatives to police in responding to mental health crises. Along with my research team, I want to help identify the resources and tools needed to de-escalate a crisis in communities when working with this population without police involvement.

### **What types of questions will I be asked?**

The interview will include questions about your experience working in the community to serve the mental health population in Orange County. We will delve into your insights on what are the essentials needed, the support from your employer, and what level of resources like trainings, access, funding options, and what is needed to further expand the collaborations with other agencies like hospitals, and crisis centers.

### **If you agree to participate**

If you agree to participate, I will conduct the interviews via zoom. I will record the interview with an audio recorder to ensure all information is transcribed. Due to the pandemic and your busy schedules, interviews are unavailable for face-to-face, and will have to be done via zoom online. Interview will take about 45 minutes. If more than 45 minutes is required for the interview, then multiple sessions can be scheduled.

### **Confidentiality, data storage, and future use of data**

Some of the questions may ask about your employer and working with police. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk. Your confidentiality is important due to your line of work, and to address this, your name can be replaced with pseudonyms. The interview information will be stored in an encrypted file on a password protected computer. If results of this study are published or presented, your name and other personally identifiable information will not be used. When the study is over, the audio recordings will be destroyed 3 years after the project has ended.

### **Who will see my research information?**

Only the members of my research team will be able to see your answers to the questions. My Advisor Dr. Morris will receive a summary of the study results that does not include any names or individual answers.

### **Participation in this research is, of course, completely voluntary**

Your participation is completely voluntary, and you do not have to answer any questions you do not wish to answer. You may skip or not answer any questions and can freely withdraw from participation at any time.

### **Risks**

There are risks in every study and to minimize them, all hard copies of the surveys will be stored and remain in a locked cabinet. Data extraction will occur at CSUSB and only non-identifiable data will be entered into a password protected excel spreadsheet. Data will be maintained on a password-protected laptop and will be transferred to a password protected computer in the PI's office at the conclusion of the study.

Participants are not required to answer all the questions and have the option to skip any questions that are uncomfortable to them. No participant will be reprimanded for choosing to skip a question. For this research, there will be no risks related to COVID-19, the interviews will be conducted via Zoom to mitigate any COVID-19 risks.

### **Benefits**

One important benefit is the increased awareness it can provide of what a social worker needs to be a good alternative. This study will help fill part of that gap by exploring the resources and supports social workers need so that they can be a safe alternative to police in responding to mental health crises. Another potential benefit is the public's readiness to commit to resources and support of the local treatment of the MI, for a better MH system, and provide adequate funding to strengthen the collaborations of SW programs.

### **Questions**

If you have any questions about this research, please don't hesitate to contact me. I can be reached at 760-562-3233 or [007424619@coyote.csusb.edu](mailto:007424619@coyote.csusb.edu)

## **Consent**

### **CONFIRMATION STATEMENT:**

- I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

I agree

APPENDIX D:  
RECRUITMENT EMAIL

Subject Line: Mental Health Workers can replace police in certain situations.

Subhead: Would you like to be in a study about whether mental health workers can replace police?

Body Copy:

Hi, my name is Karen Apolinar,

I am an MSW Student at California State University San Bernardino. I am a former Mental Health Specialist that directly worked for 5 years in crises interventions.

I am currently working on a new research study. I need your help.

I am doing a study to understand mental health workers perspectives on what resources and supports they need to be good alternatives to police.

This study is important because it will help ensure that mental health workers have the tools and support, they need to de-escalate a crisis without police involvement. This study will help understand what level of resources, essential components, program collaborations, and funding capacity that social workers need to be able to replace police in addressing mental health crisis in the community.

This research will:

- Help agencies understand what resources and support mental health workers need to help the community.
- Help counties identify the essential components needed to support crises intervention programs so that other counties can do the same.
- Help advocacy efforts on behalf of individuals with Serious Mental Illness.
- Provide input that will help argue for funding being reallocated for mental health.

Are you a Social Worker -MSW/MFT/MHW who has knowledge or work experience in any mental health program?

If YES, then CONGRATULATIONS you are what this study is looking for.

Please email me to give you more info to get started with the study.

Thank you for helping to improve the work of Mental Health Workers.

Best,

Karen Apolinar

California State University, San Bernardino



APPENDIX E:  
IRB APPROVAL LETTER

## **CSUSB INSTITUTIONAL REVIEW BOARD**

Administrative/Exempt Review Determination

Status: Determined Exempt

IRB-FY2022-185

Teresa Morris Karen Apolinar  
CSBS - Social Work  
California State University, San Bernardino  
5500 University Parkway  
San Bernardino, California 92407

Dear Teresa Morris Karen Apolinar:

Your application to use human subjects, titled "SOCIAL WORKERS AS AN ALTERNATIVE TO POLICE IN ADDRESSING MENTAL HEALTH CRISES" has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has weighed the risks and benefits of the study to ensure the protection of human participants.

This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses. Investigators should consider the changing COVID-19 circumstances based on current CDC, California Department of Public Health, and campus guidance and submit appropriate protocol modifications to the IRB as needed. CSUSB campus and affiliate health screenings should be completed for all campus human research related activities. Human research activities conducted at off-campus sites should follow CDC, California Department of Public Health, and local guidance. See CSUSB's [COVID-19 Prevention Plan](#) for more information regarding campus requirements.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- **Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.**
- **Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.**
- **Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.**
- **Submit a study closure through the Cayuse IRB submission system once your study has ended.**

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at [mgillesp@csusb.edu](mailto:mgillesp@csusb.edu). Please include your application approval number IRB-FY2022-185 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

*Nicole Dabbs*

Nicole Dabbs, Ph.D., IRB Chair  
CSUSB Institutional Review Board

ND/MG

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