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Views of Reality: Perceptions of Police Responses to Mentally Ill People

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VIEWS OF REALITY: PERCEPTIONS OF POLICE

RESPONSES TO MENTALLY ILL PEOPLE

by

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ABSTRACT

Society's views about mental illness can influence their views regarding police-response strategies used with the mentally ill. The purpose of this study is to analyze the question: does mental illness impact perceptions of delinquent behavior and police responses? It is important to understand the effects of these interactions to better assist those affected by mental illness and avoid uncertain risks/injuries to the police and citizens involved in an incident. Labeling theory suggests that people may come to identify and act in ways that reflect how others label them as well as come to define mentally ill individuals in accordance with the label. My interest in understanding how police label mentally ill individuals as either deviant (out-of-the-norm) or criminal because of their condition motivated me to explore what other people thought about this.

This study used survey analysis to collect data from 349 Facebook participants. Participants were randomly assigned to 1 of 2 scenarios (excerpt A and excerpt B). The only difference between these two scenarios is that excerpt B directly relates to mental illness while excerpt A does not mention mental illness.

In relation to labeling theory, I predict mental illness will impact the perception people have about how police may respond to situations involving the mentally ill. Further studies should expand this research to examine this connection more thoroughly. The broader implications of this research is that it could create awareness as to ways in which to improve police training tactics that could in turn result in better support between mental health services and law enforcement.

ACKNOWLEDGMENTS

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CHAPTER 1: INTRODUCTION

People, including police officers, tend to form positive or negative perspectives about diverse groups of people; with negative attitudes or perceptions most common. The current study aims to explore this phenomenon by focusing on how Facebook users perceive the interactions that take place between mentally ill individuals and law enforcement officers. The question comes down to whether having some type of mental disorder can affect the perception people may have about how police may respond to situations involving the mentally ill. According to labeling theory, by labeling someone as "deviant," this can drive them to engage in deviant behavior. Therefore, the response to the label is the influential factor rather than just the deviant act itself. When it comes to criminality, labeling theory argues that labels are applied by those with power to those without power. Those who have that power, such as the court system, police, and other officials use laws to determine those that are deviant or non-deviant. Labels among individuals may vary given the interpretation of these laws by those in power.

What is interesting about this theory is that deviance is not solely related to just criminal acts but really towards any behavior that is considered out of the norm given the social context. So, the behavior of someone that has a mental disability may be considered "deviant" if people perceive it violates typical social norms. The way in which an officer may respond to that label of "mentally ill" can influence their decision-making process in certain situations. So, based on this theory, it is hypothesized that the experimental group will view police response more negatively than the control group. In other words, the experimental group will not attribute as much measures such as victim blaming knowing the individual in the excerpt is mentally ill

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compared to the control group. Research discussed below indicates different ways in which people define mental illness, police-training models used to approach cases involving mentally ill individuals, and the results of these interactions.

CHAPTER 2: LITERATURE REVIEW

Definitions/Perspectives of Mental Illness

Not everyone views mental illness in the same way due to different experiences and beliefs. Decades ago, there was a controversy about the definition of mental illness and how to treat it. From the perspective of a psychoanalyst in the twentieth century, Szasz (1974) argued against labeling psychological conditions as mental "diseases." He also questioned the legitimacy of applying these labels to certain individuals. An example of this was Jean-Martin Charcot's (1825-1893) hysteria patients, which the author quoted, "Most of Charcot's hospitalized patients, whether those with or without organic neurological diseases-and, as we shall see, it was often extremely difficult to make this distinction at the time-were hospitalized not so much because they were sick but because they were poor, unwanted, or disturbing to others" (Szasz, 1974, p. 18). Szasz wanted to point out that deviance, or out-of-the-norm behavior, should not be labeled as a mental illness like in this case with hysteria. He believed the physical and mental aspect should have been separated.

In Dixit's (2005) study on the meaning of mental illness in a social framework compared to what is scientifically understood, he identified a variety of mental illness categories from the data collected from 36 engineers. Although the sample was small and lacked education diversity, the findings revealed that mental illness was still associated with criminal behavior and deviance (Dixit, 2005). According to the study, a mentally ill person was perceived as "different from normal human being," "distant from society," and "harming the society as a whole" (Dixit, 2005, p. 9). These attributions were stated in relation to the social definition of mental illness; however,

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the participants were able to differentiate between physical illness and mental illness in their writings where most believed that bodily sickness was easier to detect or cure while psychological illness was harder to cure and not as easy to identify (Dixit, 2005). This is similar to what Szasz (1974) was referring to in regard to the distinction between physical sickness and a true "illness" of the mind.

In relation to Dixit's (2005) study demonstrating that mental illness could be viewed as a form of social deviance, Lucksted and Drapalski (2015) argued how society's stigmatization can affect a person's self-concept if they have some kind of mental illness. Specifically, they discussed the effects that self-stigma can cause, such as a decreased sense of recovery, reluctance to participate in treatment, loss of hope, and other side-effects that are formed when people have negative connotations about mental illness (Lucksted & Drapalski, 2015). Comments or phrases that carry a certain stigma, such as those made by the students in Dixit's (2005) study that point out their difference in society, could be internalized and lead to more self-harm, according to Lucksted and Drapalski (2015). They suggested strategies to address this problem in ways that can prevent, reduce, or even remove self-stigma from the label, "mentally ill." An example of how societal stigmatization can manifest is apparent in Salzer's (2012) comparative study between college students with a mental illness and the general student population. With the use of surveys, responses from 449 mentally ill students were analyzed to assess their relationships and campus experiences compared to a sample of general students (Salzer, 2012). Just as the author hypothesized, findings indicated that students with a mental illness had less engagement on campus and poorer social relationships which resulted in lower graduation rates (Salzer,

2012). This study demonstrates how the stigma of mental illness can affect other aspects of people's lives, such as education and socialization.

Interestingly, another study by Rusch, Evans-Lacko, and Thornicroft (2012) demonstrated contradictory results in their research on the effects of public views towards people's attitudes and disclosure about mental illness. More specifically, their findings through survey data analysis showed positive attitudes when classifying major psychiatric disorders as mental illness and greater intentions to disclose; while revealing negative attitudes and fewer intentions to disclose to family/friends when classifying stress-related/behavior-related conditions as mental illness (Rusch, Evans-Lacko, & Thornicroft, 2012). Unlike Salzer's (2012) study where college students were affected negatively by the stigmatization of mental illness, Rusch et al.'s (2012) study supported the idea that a better understanding of mental illness can increase positive attitudes, therefore lessening the stigma of being mentally ill. Instead of assuming all mentally ill individuals are "crazy" and "unstable," improved knowledge of the definition was shown to help decrease negative typecasts.

Relative to stereotypes, which are likely to result from labeling, Meloy (2014) described several myths people typically associate with mass murder. Among the seven misconceptions about this type of murder, the second myth claims that these killers could be divided into "psychotics," "depressives," and "psychopaths" (Meloy, 2014). Meloy argued that mental disorders cannot be simply classified into one category because they range in complexity that sometimes overlap with other areas of psychology, such as a mix of both mental and personality disorders. When a person with a mental illness is automatically thought of as a "psychopath," people typically presume they are violent and dangerous. Monohan (1992) further questions this

relationship using epidemiological research. After examining some of the evidence that

researchers and the public have gathered from the association between violence and mental

illness, Monohan analyzes this by looking at it from two perspectives; violence among mentally

ill people and mental illness among people engaging in violent behavior. The first viewpoint

looked at the frequency of violence committed by mental patients before, during, and after being

hospitalized (Monahan, 1992). For the second perspective, Monahan (1992) used the example of

determining mental illness among people that are receiving the consequences for their violence

in places like jail and prison. With this in mind, the author asserts that there must be some form

of relationship between violence and mental illness.

Police-training Models and Approaches

Following the link between violence and mental illness, it's important to examine what

kinds of tactics the police use to respond to situations involving mentally ill people. Chappell and

O'Brian (2014) briefly examined how police response strategies have evolved over some time in

a way that has recently become more systematically analyzed through research. People realized

around the nineteen sixties that police interactions with the mentally ill could escalate to violent

and even deadly force if there was no proper approach to go by. Since then, various kinds of

policing models have emerged when police recognized that they had to cooperate with mental

health specialists in addition to the justice system for these kinds of cases (Chappell & O'Brian,

2014). One of the policing models that emerged was the Memphis Crisis Intervention Team

(MCIT) program, which essentially paired trained officers with mental health professionals to

improve encounters with mentally ill individuals (Chappell & O'Brian, 2014). According to

Martinez (2010), the first Crisis Intervention Team (CIT) model was created in Memphis, Tennessee during the nineteen eighties (p. 170). Steadman and Morrissette (2016), as well as other researchers, also confirm this in their studies. This helps explain where the current model originated from which nowadays, has become very widely used based on most research.

Watson and colleagues provide a more in-depth analysis on what the CIT model consists of, including its efficiency and application; which they refer to as a multi-level conceptualization of this model (Watson, Morabito, Draine, & Otatti, 2008). The CIT approach involves 40 hours of specialized training in mental health and legal matters for volunteer patrol officers to effectively assess cases involving mental illness (Compton, Broussard, Reed, Crisafio, & Watson, 2015; Watson et al. 2008; Watson et al. 2010). This way, police have prior skills in advance before responding to scenarios like a dispatch call for instance (Watson et al. 2008). Research also mentions de-escalation training as an example of a skill taught in the CIT model and that the program requires a specific mental health drop-off center to evaluate any person police officers bring in (Martinez, 2010; Steadman & Morrissette, 2016). Some of the benefits that come with this model, as Watson et al. (2008) described, are maintaining community safety, redirecting persons from jail, improving the individual identifying with mental illness, and other positive effects. From the conceptual stance of the implementation of the CIT, research suggests that it should be able to decrease the need for physical force by police, improve officer skills in encounters with mentally ill persons, decrease events of arrests, increase access to mental health treatment, and diminish the occurrence of injury to both the police and mentally ill person involved (Watson et al., 2008). The overall study suggests that with this conceptualization model

of the CIT and additional research on police interaction with mentally ill people, police-training

strategies can continue to improve and develop new approaches.

Furthermore, in their study of CIT effectiveness, Watson et al. (2010) wanted to analyze

one of the major purposes of this model, which is to divert mentally ill persons from the criminal

justice system. After gathering patrol officer's call outcomes data from different police districts

in Chicago, results showed that CIT trained officers directed a greater number of mentally ill

persons to mental health services compared to non-CIT trained officers (Watson et al., 2010).

Findings also proposed that these CIT trained officers were more likely to promote the direction

of mental health services when having positive views on mental health resources, especially with

prior experience or familiarity with mental illness. However, results did not show a decrease in

arrests after CIT implementation (Watson et al, 2010). The study admits that one reason for this

may be that since several officers acknowledged through interviews that they do not arrest

mentally ill people, the question is whether these volunteers perhaps felt some kind of inclination

based on their personal experience or understanding of mental illness that may had impelled

them to become CIT trained officers (Watson et al., 2010). The authors recognized that there is

room for improvement by giving an example such as increasing the accessibility of the mental

health system in order to enhance police-training tactics (Watson et al., 2010).

Along with the popular CIT model, Martinez (2010) also discusses two other major

models that police use to respond in cases involving mentally ill individuals as well as examples

of different U.S. police departments that have implemented some of these models. One approach

he discussed is the Mobile Crisis Team (MCT) model where a behavioral health expert assists

police officers at the scene; however, unlike the CIT model, officers do not make decisions

regarding the mentally ill person on their own but rather in collaboration with a clinician that works professionally with the police department. The other response plan is the Community Service Officer (CSO) model which involves a six week police-training program for applicants with previous experience in social work and after that, they help police at the scene with calls related to mental health. The difference between this model and the MCT, is that a CSO is an employee of the police department instead of just a mental health specialist. In general, the author speculates on whether or not these approaches are sufficient enough to provide police officers the skills they need to correctly aid individuals with a mental illness.

In order to get a better insight as to what police may think about the CIT program, Compton et al. (2015) gave two surveys to 171 sheriffs/chiefs and 353 police officers in Georgia with questions related to this model. One of their hypotheses was that CIT-trained officers would have less work burnout and more job satisfaction than non-CIT trained officers which their results did not confirm. According to the study, some of the problems of executing the CIT model that sheriffs and chiefs observed were that it was not easy for officers to take time away from typical work for training, the cost, inadequate access to mental health resources, and not having a bigger task force (Compton et al., 2015). Their findings did, however, support their other hypothesis that CIT-trained officers would be less likely to use force in response to a vignette where a man is described as having a psychotic disturbance. This shows how the CIT model can diminish officer's use of force in cases involving mental illness even if Watson's et al. (2010) study did not show any decrease on arrests. Taking into consideration what some of the officers thought about this program, researchers agree that their needs to be more research on how to better improve police-response tactics.

Steadman and Morrissette (2016) focused on this subject by asking how to go beyond CIT training to look for what needs to be done to make this model more effective. Even though Watson et al. (2008) discussed how the CIT approach should be decreasing events of arrests, the results from Watson's et al. (2010) study in Chicago proved otherwise. Instead of just concentrating on what strategies police need to use to deescalate a situation involving a mentally ill person to make appropriate decisions, Steadman and Morrissette (2016) argued that there should also be a focus on bettering the relationship between police and behavioral health providers. These specialists devise and apply crisis care services which are used to treat psychological symptoms. With law enforcement and mental health services working together more effectively, perhaps this could provide positive results for the community in general. Another example of how to enhance police-response strategies are given by Newcombe (2014) in his research on predictive policing. Some of the advantages discussed about this method through technology include: improved accuracy of profile matching, advanced predictions of times/places where crimes might occur as well as crime victims, and other valuable data. With better control over the policies behind technology used for predictive policing, this can be a very useful tool to obtain crime data analysis. If successful technology can provide information beforehand on whether or not criminal offenders have a mental illness, this can help police predict what to expect and therefore respond accordingly.

<u>Outcomes of Police Interactions with Mentally Ill Individuals</u>

As mentioned earlier in Monohan's (1992) study, they gave an example of how mental illness can be looked at among people in jails/prisons that are already receiving the outcome of their violent behavior. Lamb and Weinberger (1998) further discussed the number of mentally ill people that are imprisoned instead of receiving proper mental health treatment. They used data from different references to discover that the percentage of offenders in jails/prisons had poor functioning and chronic mental illness; and that a greater number of mentally ill offenders were arrested compared to the overall population. Considering that Watson's et al. (2010) more recent study showed that the CIT police-response model did not decrease arrests among mentally ill persons, this shows how a little more than a decade ago there was a large amount of mentally ill persons arrested and incarcerated than offenders that were not mentally ill (Lamb & Weinberger, 1998). So with or without the CIT program, arrests of mentally ill persons were and still are an issue.

Another study analyzed whether a number of certain factors such as previous violent encounters, substance abuse, and diagnosis of mental disorder had an effect on situations where police force was used (Kesic & Thomas, 2014). After analyzing over 4,000 police cases that involved force to determine what distinguished violent from non-violent behaviors, results indicated that amongst other characteristics, police perceptions of apparent mental illness was one influential factor that increased the likelihood of violent behavior against police when force was used (Kesic & Thomas, 2014), suggesting that violence in force situations may increase if police perceive an evident mental disorder.

In regard to arrests among mentally ill people, Mulvey and White (2014) questioned whether police force and suspect resistance were more likely to take place in arrest incidents

with mentally ill suspects. With data from interviews with 942 participants that were recently arrested by police in Arizona, results supported a link between increased resistance against police and mental illness (Mulvey and White, 2014). This demonstrated that police may respond to mentally ill suspects differently than other suspects as Kesic and Thomas's (2014) study pointed out through evidence that police force increased when a mental disorder was perceived. Schulenberg's (2016) research on the decision-making process of police when dealing with mentally ill offenders is another example that supports the notion that these persons receive higher rates of arrests, police contacts, and criminal charges for noncriminal behavior and minor offenses. Through observational data collected in Canada, findings showed a greater likelihood for mentally ill individuals to receive a citation. This may imply an inherent bias that reinforces criminalization of the mentally ill. Schulenberg also notes that with better collaboration between the criminal justice system and mental health resources, police decision-making strategies may improve.

Ultimately, researchers agree that there needs to be more research on ways to improve encounters between police and mentally ill individuals. Margolis and Shtull's (2012) research is an example on how the severity of mental illness on campus has raised awareness on what police strategies and information are needed to effectively respond to these situations. According to the study, "Although most people with mental illness are not violent, some individuals with mental illness do become agitated and act out dangerously, to themselves or officers, especially when alcohol and drugs are involved" (Margolis & Shtull, 2012, p. 318). Campus police officers must adapt to their environmental context in order to properly handle situations involving mental illness because of other factors like alcohol which are known to be popular on campus.

Current Study

Although research has investigated different types of perspectives people may have about mental illness, there is a lack of understanding of how people believe police will or should respond to situations involving mental illness. The study intends to bridge this gap in the literature by using survey analysis to see people's perceptions of mental illness and how they believe police should and will respond given a short vignette of a confrontational scenario. While Kelsic (2014) demonstrated that police have a greater likelihood of violent behavior when mental illness is evident, limited research actually shows the effects of how people in general may believe police will respond if they recognize a mental illness or not.

Though research supports public views on mental illness affecting police-response training methods, the literature only revealed the effects of this from the police perspective. It's important to see the difference in the public's perceptions about delinquent behavior and in perceptions about police responses. The hope is that results from this study will advance knowledge about public opinion of mental illness and police involvement. Future research could examine how perceptions about mental illness impact perceptions of police response.

Since my research pertains to perceptions of delinquent behavior and police response, labeling theory is an appropriate approach for several reasons. Labeling theory suggests that by labeling someone as "deviant," this can drive them to engage in deviant behavior. Therefore, the response of the label is the influential factor rather than just the deviant act itself. When it comes to criminality, labeling theory argues that labels are applied by those with power to those without power. Those that have that power, such as the court system, police, and other officials, use laws

to determine those that are deviant or non-deviant. Labels among individuals may vary given the interpretation of these laws by those in power.

What is interesting about this theory is that deviance is not solely related to just criminal acts but really towards any behavior that is considered out of the norm given the social context. So, the behavior of someone that has a mental disability may be considered "deviant" if people perceive it violates typical social norms. The way in which an officer may respond to that label of "mentally ill" can influence their decision-making process in certain situations. This theory relates to my study in that people may or may not perceive that police would respond negatively towards someone that has been labeled deviant for their mental disability. It is evident that those with mental illness are different from the rest of society but the deciphering factor is whether police label these individuals as just deviant for their condition or criminal because of their condition.

Based on the labeling theory, it is hypothesized that there will be a relationship between mental illness, perceptions of delinquent behavior, and police responses because of society's stigmatized label. I predict that those participants that receive the excerpt with mental illness mentioned will have a more negative view about the delinquent behavior, and will have more negative perceptions about how police would respond than those participants who were not explicitly told mental illness was involved.

CHAPTER 3: METHODOLOGY

Data. The study used quantitative data. Initially, data were collected using a convenience

sample to gather respondents, but then respondents were randomly assigned to two conditions:

the experimental condition (excerpt B) and control condition (excerpt A). The experimental

group was manipulated by including a word directly related to mental illness in excerpt B. That

word was then omitted for the control group, excerpt A. Excerpt A reads: "A 20-year male is in

the middle of the street screaming. The neighbors call in a disturbance and the police arrive there

shortly after. The police are concerned he will hurt himself or others." Excerpt B reads: "A 20-

year old male with a *mental disorder* is in the middle of the street screaming. The neighbors call

in a disturbance and the police arrive there shortly after. The police are concerned he will hurt

himself or others."

Dependent Variables. The dependent variables are: victim blaming, law enforcement

response, scariness, dangerousness, delinquency, likely to benefit from counseling, and likely to

be directed to mental health services. A Likert scale between 1 and 7 is used to measure victim

blaming in the statements indicating that this individual is to blame for his issues. The same scale

is used to measure the likelihood of benefiting from counseling in the statement, "I think this

individual would likely benefit from counseling." A Likert scale is also used to measure

delinquency in the question that states, "This individual is a delinquent and should be treated as

such." A scale from 1 through 7 measures how scared participants would feel if they saw this

individual on the street. The same scale is used to measure sense of danger from this individual.

The question of running into trouble with the law on a scale from 1-5 measures law enforcement

response and was drawn from the AMIQ questionnaire where only the name "Bill" was switched

with "this individual" for the survey. The same likelihood scale is used to measure how likely participants think this individual will be directed to mental health services. The control variables include the demographic questions which pertain to age, race/ethnicity, and sex.

Method of Research. This study used online surveys sent through the Qualtrics website. There were a total of eleven survey questions, eight related to the excerpt and three related to demographic characteristics of the respondents. The main variables of interest were measured on a Likert scale and a similar 1-5 scale to measure participant's responses based on personal opinion, experience, or ideas.

Research Design. The research used a cross-sectional design. A link was dispersed throughout social media, specifically Facebook, that directed respondents to the survey. The advantages of this design are that the independent variable (mental illness) in the quasi group can be manipulated in order to make comparisons to the control group and social media is a convenient way to find participants. However, the disadvantage is that it measures data at one specific point in time and does not account for how views may change over time.

Population and sample. The study sample was 349 participants, 148 in the quasi group (Excerpt B) and 201 in the control group (Excerpt A). The population included anyone 18 or over. The quasi group (Excerpt B) respondents were compared with the control group (Excerpt A) respondents on all survey questions to see if differences exist.

CHAPTER 4: FINDINGS

Demographic statistics are displayed in Table 1. For the demographic statistics, the control group had a mean age of 27.01 (sd= 9.99) and the quasi group had a mean age of 26.14 (sd= 9.50). For the control group, 87 (43.3%) were male and 108 (53.7%) were female. Similarly, the quasi group had 60 (40.5%) male participants and 79 (53.4%) female participants. For the measure race, the control group had 149 (74.1%) White, 30 (14.9%) Hispanic, Latino, or Spanish origin, 3 (1.5%) Black or African American, 3 (1.5%) American Indian or Alaska Native, 3 (1.5%) Asian, and 13 (6.5%) other participants. The quasi group had 114 (77.0%) White, 18 (12,2%) Hispanic, Latino, or Spanish origin, 5 (3.4%) Black or African American, 0 American Indian or Alaska Native, 3 (2.0%) Asian, and 7 (4.7%) other participants.

Descriptive statistics for the dependent variables are displayed in Table 2. For the control group, there were 201 (57.6%) respondents that received the non-mental illness excerpt (control group) and 148 respondents (42.4 %) that received the mental illness excerpt (quasi group). For the measure of how dangerous participants perceived the individual, the control group had a mean of 3.98 (sd=1.45) and the quasi group had a mean of 3.90 (sd= 1.35). For the measure of how scared respondents perceived the individual, the control group had a mean of 4.26 (sd=1.61) and the quasi group had a mean of 4.19 (sd= 1.59). For the measure of how likely respondents perceived an officer would direct the individual to mental health services the control group had a mean of 3.03 (sd= 1.19) and the quasi group had a mean of 3.13 (sd= 1.22). For the measure of how likely respondents perceived the individual would get in trouble with the law, the control group had a mean of 2.37 (sd= 1.062) and the quasi group had a mean of 2.20 (sd= 1.046). The control group's mean score on the victim blaming scale was 2.75 (sd= 1.40) and the quasi

group's mean score was 2.37 (sd= 1.40). For the measure of how likely respondents perceived the individual would benefit from counseling, the control group scored a mean of 5.64m (sd= 1.30) and the quasi group scored a mean of 5.90 (sd= 1.19). The final variable measuring delinquency showed that individuals from the control group had a mean of 2.17 (sd= 1.13) and the quasi group had a mean of 2.03 (sd= 1.24).

According to the independent samples t-test, none of the seven dependent variables showed a significant difference in responses between the control and quasi groups. In general, adults did not perceive that mentally ill individuals were treated by law officers any different than those non-mentally ill individuals that display public disturbances. This suggests that regardless of whether mental illness is involved or not, there is no difference in perceptions of danger, scariness, delinquency, victim blaming, likelihood of officer directing to mental health services, likelihood of benefiting from counseling, or likelihood of individual getting in trouble with the law. It is important to distinguish mentally ill from non-mentally ill in these cases in order for police officers to respond with a different approach to mentally ill individuals that need assistance. These findings did not support my hypothesis in there being a relationship between mental illness and perceptions of delinquent behavior and police response. However, in relation to labeling theory, this examines the extent to which a label, such as "mental illness," can have an effect on social stigma. This label does not appear to create such a large impact when referring to a public commotion.

Table 1: Demographic Statistics

Measure	N	Min.	Max.	Mean	Standard Deviation
Age	Group 0 = 178 Group 1 = 129	Group 0 = 18 Group 1 = 16	Group 0 = 65 Group 1= 74	Group 0=27.01 Group 1= 26.13	Group 0= 9.987 Group 1= 9.504

Measure	N	Male	Female	Other	Decline to State
Sex	Group 0 = 201 Group 1 = 148	Group 0 = 87 (43.3%) Group 1 = 60 (40.5%)	Group 0 = 108 (53.7%) Group 1= 79 (53.4%)	Group 0 = 4 (2.0%) Group 1= 4 (2.7%)	Group 0 = 2 (1.0%) Group 1= 4 (2.7%)

Measure	N	White	Hispanic, Latino, or Spanish Origin	Black or African American	American Indian or Alaska Native	Asian	Other
Race	Group 0 = 201 Group 1 = 148	Group 0 = 149 (74.1%) Group 1 = 114 (77.0%)	Group 0 = 30 (14.9%) Group 1= 18 (12.2%)	Group 0 = 3 (1.5%) Group 1= 5 (3.4%)	Group 0 = 3 (1.5%) Group 1= 0	Group 0 = 3 (1.5%) Group 1 = 3 (2.0%)	Group 0 = 13 (6.5%) Group 1 = 7 (4.7%)

Table 2 : Descriptive Statistics and Independent Samples T-test

Measure (Perceptions)	Mean	Standard Deviation	Sig. level	t (df)
How Dangerous	Group 0 = 3.9281 Group 1 = 3.8973	Group 0 = 1.44689 Group 1 = 1.35305	.449	.190 (297)
How Scared	Group 0 = 4.2559 Group 1 = 4.1862	Group 0 = 1.60808 Group 1 = 1.58984	.888	.371 (296)
How likely officer would direct to mental health services	Group 0 = 3.0327 Group 1 = 3.1293	Group 0 = 1.18886 Group 1 = 1.21786	.437	-.695 (298)
How likely individual would get in trouble with the law	Group 0 = 2.3709 Group 1 = 2.2041	Group 0 = 1.06217 Group 1 = 1.04645	.424	1.365 (296)
Victim blaming	Group 0 = 2.7467 Group 1 = 2.3699	Group 0 = 1.40080 Group 1 = 1.39957	.531	2.315 (294)
How likely to benefit from counseling	Group 0 = 5.6443 Group 1 = 5.9048	Group 0 = 1.29486 Group 1 = 1.17819	.394	-1.809 (294)
Delinquency	Group 0 = 2.1667 Group 1 = 2.0338	Group 0 = 1.25541 Group 1 = 1.23671	.811	.920 (296)

Some of the limitations the study has are that the participants may have assumed the excerpt was about mental illness prior to the survey questions. It also does not take into account other variables that may affect or influence participant's responses. While surveys tend to be reliable, they may not consider participants lying. Also, surveys help collect direct answers but it is possible that a more in-depth interview would have formed a better analysis of what participants felt about the topic. The findings did, however, show that the majority of the respondents gain their mental health information from experience such as family and friends.

Also, the study demonstrated that in regards to dangerous and scared levels, most participants averaged neutral.

Seeing as there was no significant relationship between the mental illness and dependent variables, a new questioned is formed of whether people should or shouldn't categorize mentally ill individuals separately when it comes to certain offences in order for police officers to better assist them. As mentioned in the literature review, Compton et al., 2015's study revealed that CIT-trained officers were not as likely to use force when described a man with some form of mental disorder; so, if by being able to identify whether an individual has a mental illness or not prior to the encounter, would police modify and adjust their skills to fit the circumstance? When it comes to labeling theory, Szasz (1974) argued that mental illness should not be categorized as "deviant" which is what the results of the current study suggests. Moreover, it showed that any sign of "out-of-norm" behavior should be responded to in the same way regardless if a mental illness is acknowledged or not. This is similar to what Szasz (1974) was questioning in regards to applying this label to certain individuals. So, the key factor that Szasz (1974) and this study emphasized is that any form of deviance that violates the social order of things, in this case a public disturbance, is what determines how people will interpret that behavior.

CHAPTER 5: CONCLUSION

This study did not reveal any significant difference in perceptions of adult people on how police officers respond to public disturbances that involve mentally ill individuals when compared to how they respond to non-mentally ill individuals. In regards to labeling theory, the label "mentally ill" may not have had an effect to perceptions of how police may respond or perceptions of delinquency but the label itself may still have an effect on how officers would react in a given situation. Therefore, future research could focus instead on how police officers perceive mental illness and how they perceive themselves as being prepared and equipped with the skills to manage confrontations with these individuals.

Further studies could explore how well these training programs, such as the CIT model as discussed in the literature review, are successfully helping officers respond adequately. In doing so, this could better advance performance levels and improve police interactions with mentally ill individuals. This type of research could provide valuable insight that may result in changes or revisions of current law enforcement policies related to the management of encounters with mentally ill subjects. Also, this could help improve relations between police departments and mental health services in order to work together more efficiently to better assist people with mental illnesses. In furthering this knowledge, the public may become more aware as to the importance of differentiating between mentally ill and non-mentally ill individuals with the purpose of influencing a similar thought process in police officers.

APPENDIX: SURVEY

1) What is your age? _____

2) What is your sex?
   o Male
   o Female
   o Other
   o Decline to state

3) What is your race or origin?
   o White
   o Hispanic, Latino, or Spanish origin
   o Black or African American
   o American Indian or Alaska Native
   o Asian
   o Native Hawaiian or other Pacific Islander
   o Some other race or origin

The following excerpt will describe a scenario about a specific situation. Please choose the answer that best reflects your opinion.

Excerpt A: A 20-year male is in the middle of the street screaming. The neighbors call in a disturbance and the police arrive there shortly after. The police are concerned he will hurt himself or others.

1) On a scale of 1 to 7 (1=not at all dangerous to others and 5=extremely dangerous to others), how would you rate this individual's behavior?

   1 – Not at all Dangerous

   2

   3

   4

   5

   6

   7 – Extremely Dangerous

2) On a scale of 1-7(1=not at all scared and 5=extremely scared), how scared would you be if you saw this person on the street?

   1 – Not at all Scared

24

2

3

4

5

6

7   – Extremely Scared

3) How likely do you think it would be for responding officers to direct this individual to mental health services?

Very likely □ Quite likely □ Neutral □ Unlikely □ Very unlikely □

4) How likely do you think it would be for this individual to get in trouble with the law for his behavior?

Very likely □ Quite likely □ Neutral □ Unlikely □ Very unlikely □

Please rate your agreement to the following statements (1=strongly disagree, 7=strongly agree):

5)   I believe this individual is to blame for his problems.

1   2   3   4   5   6   7

6)   I think this individual would likely benefit from counseling.

1   2   3   4   5   6   7

7)   This individual is a delinquent and should be treated as such.

1   2   3   4   5   6   7

8)   Where has most of your mental information come from?

o Social Media
o Television
o Experience (Ex. Family member, friend, self)
o Other _____

_____

1) What is your age? _____

2) What is your sex?
   o Male
   o Female
   o Other
   o Decline to state

3) What is your race or origin?
   o White
   o Hispanic, Latino, or Spanish origin
   o Black or African American
   o American Indian or Alaska Native
   o Asian
   o Native Hawaiian or other Pacific Islander
   o Some other race or origin

The following excerpt will describe a scenario about a specific situation. Please choose the answer that best reflects your opinion.

Excerpt B: A 20-year old male with a mental disorder is in the middle of the street screaming. The neighbors call in a disturbance and the police arrive there shortly after. The police are concerned he will hurt himself or others.

1)   On a scale of 1 to 7 (1=not at all dangerous to others and 5=extremely dangerous to others), how would you rate this individual's behavior?

        1 – Not at all Dangerous

        2

        3

        4

        5

        6

        7 – Extremely Dangerous

2)   On a scale of 1-7(1=not at all scared and 5=extremely scared), how scared would you be if you saw this person in the street?

1 – Not at all Scared

2

3

4

5

6

7 – Extremely Scared

3)   How likely do you think it would be for responding officers to direct this individual to mental health services?

Very likely □ Quite likely □ Neutral □ Unlikely □ Very unlikely □

4)   How likely do you think it would be for this individual to get in trouble with the law for his behavior?

Very likely □ Quite likely □ Neutral □ Unlikely □ Very unlikely □

Please rate your agreement to the following statements (1=strongly disagree, 7=strongly agree):

5)   I believe this individual is to blame for his problems.

1   2   3   4   5   6   7

6)   I think this individual would likely benefit from counseling.

1   2   3   4   5   6   7

7)   This individual is a delinquent and should be treated as such.

1   2   3   4   5   6   7

8)   Where has most of your mental information come from?

o Social Media
o Television
o Experience (Ex. Family member, friend, self)
o Other _____

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