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Commentary: Decision-Making by Front-Line Service Providers—Attitudinal or Contextual

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Research by Watson *et al.*[1] on police decision-making determined that prior knowledge of mental illness would have some impact on an officer's reaction to a mentally ill person if the person was in need of assistance, was a victim, or was a witness, although it would not make any difference in dealing with a suspect. The authors have attempted to explain their conclusions on the basis of labeling and attribution theories.

Is decision-making by front-line service providers influenced by prior knowledge that a potential service recipient is mentally ill and, if so, to what extent? What specific impact, positive or negative, would it have on the ultimate service provision, in view of the fact that all decision-making is inherently biased by educational, social, cultural, political, and regional persuasions? Is decision-making influenced by attitudes and beliefs toward the mentally ill? Is it also affected by contextual factors, as opposed to mere knowledge that a person is mentally ill?

Labeling theory focuses on the reaction of an individual or group of individuals and the subsequent effects of those reactions. Attribution theory explains how individuals interpret events as they occur and how that interpretation relates to thinking and behavior. When it is known that a person acts "weird" or "crazy," she or he is ostracized or isolated from society and potentially labeled as someone needing a different approach and interaction from the normal, or average, person. The very labeling of an individual as schizophrenic or psychotic evokes a stereotypical and stigmatizing representation, not only among the media but also among service providers and society at large. I argue that decision-making is heavily influenced by this stereotypical representation of the person labeled schizophrenic, and consequently the service provider acts in a predictable manner. Garfinkel[2] observed that jurors arrive at decisions on guilt or innocence of a defendant on certain situational cues and subsequently organize their thought processes during the trial to confirm the already-formed conclusions. Hence, an image of rational decision-making is projected. Similarly, I assert that a front-line service provider with prior knowledge has already formed a decision with regard to the person with mental illness based on his or her own cognitive schema of mental illness and, as a result, arrives at an action that confirms the decision.

In a larger clinical and service context, the findings of Watson *etal.*[1] have implications for how front-line service providers such as family service workers, probation and parole officers, correctional officers, and police officers behave toward the mentally ill at initial contact, if they have prior knowledge of the subject's illness and other " pejorative labels" depicting mental illness. The Epidemiological Catchment Area Study and World Health Organization have determined that approximately 20 percent of the general population suffers from identifiable mental disorders. Deinstitutionalization of the mentally ill has led to a large number of mentally ill homeless people who are subject to virtually no supervision or treatment and consequently come into contact with law enforcement officials and other service providers. Police officers and family service workers encounter people in

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domestic crises caused by violence, physical and sexual abuse, and neglect. Fifty percent of prisoners who have been in correctional facilities across the nation are returned to prison every year, and a significant factor contributing to their recidivism is mental illness, along with substance abuse, unemployment, and lack of social and family support. Correctional officers play a significant role in dealing with prisoners who are potentially suicidal. Suicide in prisons and jails is a major concern for mental health service providers and management.[3,4]

Accordingly, the decision-making by front-line service providers assumes greater magnitude, and thus, an improper decision may cause serious and dire consequences not only to the recipients of services but also to the system in general. A correctional officer who believes that all prisoners, regardless of mental illness, are manipulative, attention-seeking, and antisocial may miss an opportunity to intervene in crisis situations and to prevent an inmate from committing suicide. A child care worker may behave differently if she or he has prior knowledge that an alleged perpetrator of abuse was mentally ill. Police officers might not take a domestic violence situation seriously if the alleged victims, mostly women, are known to be mentally ill or might not give sufficient weight to a mentally ill witness in a felony situation. An officer might minimize or deny the gravity of the situation when arriving at the scene of domestic violence if he or she is guided by bias or preconceived notions about domestic violence and mental illness. Many battered women and adult victims of domestic violence suffer enormous negative legal consequences and lengthy incarceration for acts committed that could have been prevented.

Mental illness has been engulfed in community misperception, fear, and stigma. The stigma, defined as a mark of shame, disgrace, disapproval, and rejection, associated with the mentally ill precludes or limits them from obtaining adequate services necessary to improve their quality of life.[5] In addition, associating the mentally ill with violent crimes, irrational acts, socially deviant behavior, and dangerousness only helps to perpetuate stigmatizing and discriminatory practices against the mentally ill persons. [6]According to Arboleda-Florez, [6]the development of stigma has to be understood within three-dimensional axes that include: (1) the perspective of the stigmatizer and the stigmatized, (2) the perspective of identity from personal to group belongingness, and (3) the perspective of reaction of the stigmatizer and the stigmatized. The reaction can be measured in the cognitive, affective, and behavior levels. He further emphasized that by a process of association, all persons in an identified group—that is, all those who are mentally ill—are equally stigmatized, regardless of impairment or disability. Using this model, it is understandable that first-line providers would consider that all those who are mentally ill fit into one group with negative representations—thereby eliciting and/or confirming preformed reaction patterns.

Watson *et al.*[1] aptly point out, by reviewing the relevant literature, other significant factors that cause negative and stereotypical representations, including belief about attributes of credibility, integrity, trustworthiness, competence, and responsibility-taking. Such personal attributes are necessary elements of being a good reporter or a credible witness. There seems to be a correlation between the extent of beliefs about these attributes and the emotional reaction one experiences and the course of action chosen. Sometimes, the officer's decision is not only a reflection of his or her anger, pity, or other emotional reaction, but also the recognition of a lack of resources in the community for appropriate disposition of the mentally ill. Dupont and Cochran[7] have eloquently identified several excessive barriers to care that affect an officer's decision as to how to respond. Among these are denial of admission to a local mental health agency, the requirement of an officer to make a subjective "diagnosis" and determination of level of impairment, the lack of a single point of entry, the lack of availability of centers for the treatment of those with dual diagnoses, tight municipal budgets, and turf battles between agencies.

Considering the stigma, society's attitude toward the mentally ill, and the common attributes applied to the mentally ill, it is understandable that police officers' behavior and decision-making about the mentally ill person who is in need of assistance, is a victim, or is a witness are affected by prior knowledge of the mentally ill individual. Although some decisions made by front-line providers are attitudinal in nature, many decisions are made after consideration of contextual factors. For instance, an officer who takes a bizarrely acting woman, who is claiming to be the President and is threatening her two inadequately dressed children with a tractor, from an open field in subfreezing temperature to a mental health agency

seems to be making a decision after considering all interrelated factors and circumstances as they occurred. The authors' finding that none of the attitudinal factors, officer factors, and prior knowledge are relevant in a potential felony situation or when determining dangerousness to others confirms the prevailing belief about law enforcement officials when making an arrest of a potential felon.

It is important to recognize the differences between decision-making by front-line service providers and those of clinicians and forensic specialists. Decision-making by clinicians and forensic specialists, such as psychologists and psychiatrists, is mostly based on a lengthy process that collects information about contextual and interrelationship factors. This process provides them with a checks-and-balances system to guard against biases. In most situations, clinicians and forensic experts have the advantage of time, as is not the case for front-line service providers, to conduct face-to-face interviews, gather collateral information, review relevant prior records, perform a standard clinical or forensic examination, and request appropriate tests from the service recipient before arriving at a decision. Contrary to the goal of a clinician in establishing a long-term therapeutic relationship, the front-line service provider's goal is to intervene at a point of crisis and to restore calm. The primary goal of the clinician is to provide therapy and treatment to the recipient. With regard to a forensic expert, the work is intensive, rigorous, and investigational in nature and is directed to address any psycholegal questions such as competency to stand trial, insanity defense, child custody, personal injury, or other matters that come before the court for resolution. Leading forensic experts caution against combining the roles of a therapist and forensic specialist.[8]

Although bias enters into the decision-making of clinicians, forensic psychologists, or forensic psychiatrists, since there is no "impartial expert,"[9] contextual factors enter into their decision-making. For instance, in a child custody case, conclusions and recommendations regarding the best interests of a child or children in divorce litigation are made on the totality and interrelationship of factors such as the physical and mental health of the parents; the wishes of the parents and the children; the stability of school, home, and community; and other statutory factors. The point is to consider all relevant factors in context. As such, a front-line service provider's observations, the nature and quality of his or her decisions, as well as the accuracy and thoroughness of documentation, are heavily relied on by both clinicians and forensic experts to address the aspects of the case that are relevant to their areas of decision-making.

The findings and conclusions of Watson *et al.*[1] highlight the need for action in two distinct areas: (1) dealing with stigma and attitude and (2) the training and education of front-line workers. The initial response of front-line service providers, including police officers, to a crisis tends to reflect the prevailing stigma and misinformation so common in society and the mass media.[7] Therefore, improving community attitudes by increasing knowledge and understanding about mental illness is an essential step in decreasing stigma. Arboleda-Florez[6] calls for governmental, social, institutional, clinical, service provider, consumer, organizational, and family level efforts for successful treatment and community management of the mentally ill. In these efforts, the front-line service providers are a key component. Consequently, training these individuals to make decisions free of prejudice, preformed attitudes, and stereotypical approaches, is of paramount importance.

The training of police, correctional officers, and child care workers should be a major goal of their respective agencies, to ensure unbiased and just decisions. Training of police officers to work with the mentally ill is not systematic across the nation, although select police organizations have instituted such training effectively. The Memphis model of the Crisis Intervention Team (CIT), born of a criminal incident, has been touted as the ideal model in dealing with crises involving the mentally ill. Although a few cities and towns have followed the same model, programs such as the CIT have not been universally established. In many departments of corrections, efforts are under way to educate the correctional officers systematically on how to identify high-risk, suicidal inmates and provide appropriate intervention. The New York State Mental Health Office, along with the New York State Commission of Corrections, Ulster County Mental Health Services, the New York State Division of Criminal Justice Services, and a state advisory committee[10] all worked together to develop a training program for identifying suicidal inmates. The training program focuses on recognizing warning signs, identifying signs and symptoms of mental illness and substance abuse, communicating with fellow correctional officers, and responding promptly to situations involving a men-

tal health crisis. Ongoing education is a significant administrative component in many county- and state-level service organizations, such as the Division of Child Welfare and Family Services.

In conclusion, Watson *et al.*[1] are to be commended for their empirical research on decision-making by police officers who come into contact with people who are mentally ill. It is to be hoped that their paper will stimulate studies on how other front-line workers reach decisions when they deal with their target populations. The authors have highlighted future areas for research, training and education, and policy decisions. Indeed, front-line service provider decision-making is influenced by attitude and bias; however, contextual and other interrelationship factors play a significant role.

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