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Catherine Reed
“Sheriffs’ Use of Restraints
for Transports of Individuals
on ‘Involuntary Status’ to
Psychiatric Facilities for
Care”

ABSTRACT

This study explored what factors most influence Vermont sheriffs’ decision-making regarding the use of mechanical restraints for the transports of individuals on ‘involuntary status’ to psychiatric facilities for care. It also examined what initiatives contributed to a marked and progressively downward-trending statewide rate of restraint use since 2012.

Six county Sheriffs and 47 deputies from nine of 14 counties completed a mixed-methods survey that inquired about officer, departmental, policy, resource, and training factors. As each of Vermont’s Sheriffs sets his own departmental policy regarding use of restraints this study paid particular attention to how officers’ available level of discretion interacted with the other factors.

The major finding was that Sheriffs’ individual county policies influence deputies’ restraint practices more than all other factors, including state law. Those deputies whose sheriffs had a blanket policy of restraint use appeared less able to exercise their personal discretion than those whose sheriffs had policies of no-restraint use. Respondents were evenly split regarding support for a statewide sheriffs’ policy governing use of restraints.

A mental health van pilot project and specialized sheriffs mental health trainings led initiatives responsible for a marked decrease in the statewide use of restraints since 2012. Robust mental health and law enforcement collaboration has been crucial to this advancement in humane mental health transport practices.

“SHERIFFS’ USE OF RESTRAINTS FOR TRANSPORTS OF INDIVIDUALS ON
‘INVOLUNTARY STATUS TO PSYCHIATRIC FACILITIES FOR CARE”

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Catherine Reed

Smith College School for Social Work
Northampton, Massachusetts 01063

2014

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CHAPTER I

INTRODUCTION

Each year more than 100 individuals in Vermont who are experiencing mental health crisis are emergency-evaluated, placed in the involuntary care and custody of the Commissioner of the Department of Mental Health, and transported against their will to inpatient settings for care. Vermont sheriffs by state contract have historically performed the majority of the roughly 250 annual transports of individuals who refused to be voluntarily admitted to a psychiatric care facility. Until Vermont Statute §7511 of 18 VSA Chapter 179 was passed in 2004 promulgating requirements for humane transport, sheriffs routinely used mechanical restraints for all transports of individuals on ‘involuntary status’ as a matter of policy and protocol.

Statute §7511 requires the DMH Commissioner to ensure that individuals on ‘involuntary status’ are transported to and from inpatient settings “in a manner which: (1) prevents physical and psychological trauma; (2) respects the privacy of the individual; and (3) represents the least restrictive means necessary for the safety of the patient.” The Commissioner has the authority to designate who may authorize the method of transport of patients under DMH’s care and custody. Statute also stipulates, “When a professional decides an individual is in need of secure transport with mechanical restraints, the reasons for such determination shall be documented in writing. It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons subject to this chapter unless circumstances dictate that such methods are necessary” (Vermont DMH, 2011, p. 3).

The concern is that a full 10 years after this Vermont state law was passed several county Sheriffs continue to require deputies to use mechanical restraints for 100 percent of transports of individuals on ‘involuntary status’ as a matter of their own personal departmental policy. Not

withstanding Statute §7511, DMH reserves authority to each of Vermont's 14 county Sheriffs to make final determination regarding the use of restraints to ensure the safety of the public, the individual, and the officer. A majority of Sheriffs have used their discretion and mental health knowledge to develop progressive, flexible departmental policies and protocols consistent with public safety to achieve a marked decrease in restraint use statewide. In contrast, a few Sheriffs have used this discretion, intended to ensure safety with non-compliant individuals, to solidify a policy of 100 percent transport using restraints such that county policy effectively contravenes state law. This dichotomy highlights the paradox that if people in one county are not inherently more dangerous than those in another, why do some Sheriffs continue to transport 100 percent restrained when practice evidence from other counties demonstrates that a majority of patients can be safely transported without restraints?

My interest in this issue of "secure" transport originates with the case of a 13-year-old boy who was transported in 2010 by an officer to a hospital in full metal handcuffs and ankle shackles simply because that county Sheriff had a 100 percent policy of (hard) restraints and alternative transport was not available. The child (5'1 and 98 pounds) who needed a rapid trial of a mood stabilizer under medical supervision had fully cooperated with adults for nine hours while undergoing evaluation and awaiting transport. Because he arrived at the hospital like a criminal in full metal shackles and a waist chain, the first thing medical staff asked him was, "Who did *you* hurt?" His treatment and psychological wellbeing continued to devolve from there.

Research into how this criminal and traumatic treatment of a child in need of medical care could be allowed generated more questions than answers. How could law enforcement violate a state law on humane transport that had existed for seven years? Why was there almost

a decade lag between legislation and implementation? Did Sheriffs not have to comply with the DMH Commissioner's letter governing transport of children? Who holds them accountable? Shouldn't the individual's cooperation and presentation at transport time influence the decision regarding use of restraints? Why doesn't Vermont have a statewide policy and instead allow 14 Sheriffs to set their own departmental policies? Why do rates of "secure" transports (defined as involving the use of soft or metal restraints) vary widely among Vermont's 14 counties? Some counties transported 40 percent of children in restraints in 2010 while others had a 100 percent policy of restraint, and this disparity has increased over the past four years.

Reviewing statistics by county in "*Vermont 2011: Transportation of Individuals in the Custody of the Commissioner of Mental Health, Report to the Legislature on Act 180*" it stunned this researcher to realize that no matter how the youth had comported himself, it was a foregone conclusion that he would be transported in full metal restraints because of that individual county Sheriff's departmental policy. That is to say, it wasn't the youth's behavior and compliance that mattered, but what county he was in. As the boy recounted afterward, the officer who shackled him hand and foot told him, "It's our protocol."

This led to another question: what are the barriers and facilitators to achieving prompt, enduring reductions statewide in Vermont sheriffs' use of restraints for transports of individuals on 'involuntary status' to psychiatric facilities? Particularly over the last two years (2012–2014), Vermont law enforcement and DMH have collaborated to significantly reduce the overall rate of "secure" adult and youth transports statewide. In February 2014, 87% of all sheriffs' transports of individuals on 'involuntary status' were done without restraints and only 13% were restrained. However, some individual counties still have a 100 percent rate of restraint use. Why is this still the case?

Research has shown considerable variability among law enforcement personnel to criminalize the mentally ill based on officers' attitudes, beliefs, perceptions, and assumptions about them (Patch & Arrigo, 1999). It has demonstrated that the mentally ill are more likely to be victims of crime than to be perpetrators and are victimized at a higher rate than the rest of the population. In interactions with law enforcement they are four times more likely to be killed as a police officer (Cordner, 2006). A review of the literature in the next chapter will demonstrate that when an officer has a high level of discretion in his/her interaction with a person in mental health crisis, that officer's personal attitudes and beliefs significantly influence patient treatment and disposition. Patch & Arrigo state that, "Clearly officer attitudes and their use of discretion toward disordered individuals are embedded within the decision process" (1999, p. 33). This would logically extend to the specific practice of using restraints for transports.

Personal attitudes, officer style, resources, policies, training, and lived experience all contribute to individual Sheriff's decisions to use their discretionary power to either promote or discourage departmental policies and practices of using restraints for transports of individuals who are on 'involuntary status.' This research study attempts to identify which factors most influence officers' decisions about restraints and are potentially modifiable. A diverse range of respondent comments and views are presented with the hope that it will inspire a vigorous and collaborative discussion among Vermont Sheriffs and deputies.

This study explores what factors have most influenced sheriffs' decision-making such that the statewide rate of unrestrained transports started to exceed restrained transports for the first time in April 2012 and use of restraints continues to trend downward. The five factors that my mixed methods study explores emerged from a review of the research literature and DMH's initiatives over the past 10 years to reduce use of restraints since Vermont Representative Robert

Koch wrote that they were “anti-therapeutic, traumatic and unnecessarily coercive to achieve the objectives of patient and community safety” (Vermont Protection & Advocacy, Inc., 2006, p. 4). These five variables are: officer-centered factors, departmental factors, policy factors, resource factors, and training factors. Research and analysis was based on a comparison of respondents’ attitudes toward these particular variables as outlined in my questionnaire. Of particular interest was how officers’ attitudes towards, beliefs, and perceptions about individuals in mental health crisis, interacted with their level of discretion to influence decision-making regarding the use of restraints.

Finally, the survey asked participants if they thought that transporting individuals on ‘involuntary status’ to psychiatric facilities was a proper use of sheriffs’ resources and function and to what extent they would favor a statewide sheriffs’ policy regarding the use of restraints. Free-write boxes invited respondents to elaborate on their responses through written qualitative comments to bring up factors for consideration that the researcher may not have thought of. The intent of this study was to learn directly from officers the variables that influence their decision-making regarding use of restraints, with the hope of identifying modifiable barriers and initiating productive discussion about solutions.

Vermont sheriffs in close collaboration with DMH leaders have achieved an impressive inversion in the statewide rate of restraint use for involuntary transports over the last two years from 80% restrained to 80% unrestrained. Vermont is a national leader in this regard such that law enforcement in other states has begun to inquire about its new, emerging model of humane transport. This survey attempts to learn directly from sheriffs’ personnel the factors that most influence their decision-making regarding restraints for transports, and if use could be reduced by a final 15-20 percent. It also acknowledges the absolute need for officer discretion regarding

use of restraints to ensure the safety of all involved in situations where restraint use is legitimate and necessary.

For the purpose of clarity, “Sheriff(s)” is capitalized in the text when it refers specifically to any or all of the 14 Vermont county Sheriffs. Lower case “sheriffs” includes both Sheriffs and deputy sheriffs. “Transport Deputies” is an official title for those 25 deputies whose transport services are paid for by the state of Vermont; three counties have not been allocated “Transport Deputies.”

The methodology of this study, including the survey sample and procedures, is discussed in Chapter III, the findings are described in Chapter IV, and the discussion and conclusions are presented in Chapter V. A history of Vermont sheriffs’ transports of individuals on involuntary status using restraints, joint initiatives to make transports more humane, the interaction of officer attitudes and use of discretion, the impact of restraint use on patient willingness to attend follow-up outpatient treatment, and law enforcement culture change are discussed next in Chapter II, the Literature Review.

CHAPTER II

LITERATURE REVIEW

This chapter will summarize Vermont's history of law enforcement transportation of individuals on 'involuntary status' to psychiatric facilities to include efforts to make it more humane, discuss the theory of culture change, and review literature that suggests five variables that can influence sheriffs' decisions to use mechanical restraints. The variables include officer-centered factors, departmental factors, policy factors, training factors, and resource factors. As there is no extant literature that specifically studies law enforcement decision-making regarding use of restraints for transport of these individuals, it has been necessary to extrapolate from studies of general police behaviors and decision-making governing dispositions of the mentally ill. These suggest that an individual officer's attitudes towards the mentally ill, modified by the crucial element of level of discretion are more influential than all other variables in determining use of restraints when an alternative to traditional sheriff's transport is not available.

The specific focus and scope of this paper preclude study of the related issue of the impact of law enforcement's use of mechanical restraints on individuals who are involuntarily transported, both in terms of psychological and physical trauma, and subsequent willingness to engage in outpatient treatment. It is suggested that this is important follow-up research to fill a gap in the literature that has significant implications for practice. For this paper's discussion of why the issue of transport utilizing restraints matters, it has been necessary to extrapolate from studies on use of restraints in inpatient and emergency room settings to estimate the human and

financial costs. Also, while there are studies on law enforcement attitudes towards the mentally ill and the benefit of mental health training to change officers' behaviors, it is not known if this extends to reduced use of restraints for involuntary transports. This study attempts to expand the body of research by examining how five variables (officer-centered factors, departmental factors, policy factors, training factors, and resource factors) influence the decision-making of individual Vermont Sheriffs and deputy sheriffs to use restraints for transport of individuals on involuntary status. Particular attention is paid to how sheriffs' officer style and attitudes toward the mentally ill interact with their level of discretion to mitigate the influence of the other variables.

A History of Involuntary Transport

Each year about 100 individuals in mental health crisis in Vermont are placed in the involuntary care and custody of the Commissioner of the Department of Mental Health (DMH) and are transported against their will to inpatient settings. Historically, individuals who refused to be voluntarily admitted to a psychiatric facility, (i.e., those placed on "involuntary status"), were transported by sheriffs in mechanical restraints as a matter of routine policy and standard procedure. Each of Vermont's 14 county Sheriffs was given discretion to transport individuals according to his own personal restraint policy for safety reasons regardless of the individual's level of compliance at the time.

Sheriffs have traditionally performed this involuntary transport function since the Vermont Agency of Human Services contracted with all 14 county Sheriffs' departments to provide transportation for three populations with entirely different characteristics and needs: inmates in the custody of the Department of Corrections, individuals with mental illness in the custody of the Department of Mental Health, and children in the custody of the Department of Children and Families. Individuals in mental health crisis were routinely treated as dangerous

(like criminals) and as incapable of being consulted about preferences and making informed choices (like children). The majority of individuals transported by sheriffs have been prison inmates, and some sheriffs still consider mental health transports to be “prisoner transports.”

Legislation

While sheriffs were contracted to transport individuals on involuntary status to fulfill a need where there was no viable alternative, the Vermont Legislature was concerned that these vulnerable persons in need of care not be treated in the same manner as criminals. Therefore, in 2003 the legislature tasked DMH with evaluating options to reduce or eliminate sheriffs’ reliance on prisoner shackles for the transports of mentally ill patients, deeming them “anti-therapeutic, traumatic and unnecessarily coercive to achieve the objectives of patient and community safety” (Vermont Protection & Advocacy, Inc., 2007, p. 4).

Law Enforcement Policy

This was in contrast to all Vermont county sheriffs departments’ policies in 2004 that “restraints should always be used for all people transported” – “typically metal cuffs, and sometimes metal wrist-to-wrist restraints, and ankle hobbles. Some sheriffs’ departments used “Humane Restraints’ made of leather, nylon, or polyurethane” (Vermont Protection & Advocacy, Inc., 2007, p. 5). Sheriffs also used mechanical restraints for transports of mental health patients between hospitals.

Vermont Statute

In 2004, the Vermont Legislature in consultation with DMH passed Vermont Statute §7511 of 18 V.S.A., Chapter 179 to address this issue while still giving sheriffs final discretion regarding use of restraints to ensure the safety of the public, the individual, and the officer:

The Commissioner (of Mental Health) shall ensure that all reasonable and appropriate efforts consistent with public safety are made to transport or escort a person subject to this chapter to and from any inpatient setting, including escorts within a designated hospital or the Vermont State Hospital, in a manner which:

- (1) prevents physical and psychological trauma;
- (2) respects the privacy of individual; and
- (3) represents the least restrictive means.

Transportation Guidelines

In 2005, Vermont DMH issued specific Restraint and Involuntary Transportation Guidelines. These stated that a group of “involved professionals” would jointly make an assessment of the appropriate mode of transport and need for restraints, that patients should be provided choices regarding means of transport consistent with safety, and alternative transports by mental health professionals were preferred if safe and financially feasible. All officers who conducted hospital-to-hospital transfers were to receive training, unmarked cruisers and officers in plain clothes were preferred for privacy reasons, and non-metal restraints were the preferred option when “secure” transport with restraints was deemed necessary (Vermont Protection & Advocacy, Inc., 2007).

Transportation Information Checklist

DMH also promulgated a “Transportation Information Checklist” for use by Qualified Mental Health Professionals (QMHPs) in collaboration with emergency department medical personnel to recommend the mode of transport for individuals they evaluated. However, DMH reserved the ultimate decision on use of restraints to law enforcement if they were doing the transport. It is important to note that deputy sheriffs are subordinate in rank and have to do whatever their Sheriff directs them to do, regardless of medical team recommendation or their personal attitudes toward individuals in mental health crisis. That is to say, they cannot exercise discretion regarding use of restraints unless their county Sheriff delegates it to them. On the

other hand, mental health professionals at times recommend “secure” transport when there is no alternative to sheriff’s transport and some officers would prefer the individual go unrestrained. One Sheriff commented that mental health screeners often document low-risk behaviors when filling out DMH’s Involuntary Transportation Checklist, only to make a final recommendation of “secure transport” (defined as using cloth or metal restraints) because alternatives do not exist or are too costly. He suggested, that the QMHP assessment needs to be reviewed as to why they are articulating that the individual needs to be restrained.

Department of Mental Health Protocol for Children

In 2005, DMH also promulgated a special protocol for the transport of children to an involuntary hospital setting. This called for the “least restrictive” mode of transport that ensured safety, use of restraints only when deemed necessary by a Qualified Mental Health Professional, and non-metal restraints as the preferred option in those cases (provided by DMH to the sheriffs departments). It also encouraged a parent to ride with the child “when clinically indicated and feasible” (Vermont Protection & Advocacy, Inc., 2007, p. 6).

Amendment to Vermont Statute

A 2006 amendment to Statute §7511 established transport *without* restraints as the new state norm clearly articulating that, “It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons subject to this chapter unless circumstances dictate that such methods are necessary.” It further stipulated that, “When a designated professional decides that they are necessary for a secure transport, the reasons for such determination shall be documented in writing” (Vermont Protection & Advocacy, Inc., 2007, p. 7). DMH provides monitoring and oversight to ensure compliance, and requires sheriffs to document if restraints have been used before they are paid for the transports.

Commissioner's Policy Regarding Children

In 2006, the photograph of a seven-year-old child in mental health emergency being transported by sheriffs in metal shackles for transfer between two hospitals sparked a public outcry and an investigation by Vermont Disability Rights. In response, the Vermont DMH Commissioner issued the first of three memos over seven years specifying how children were to be transported. He stated that they should be transported by parents or guardians, ambulance, designated mental health agency, or by sheriffs in unmarked cars without restraints, and planned to expand this to include children 12 and under by July 1, 2008. A new requirement was that use of restraints on a child required authorization from the Commissioner or his representative *prior* to the transport. Initially it was difficult for DMH to enforce policy because of sheriffs' discretion. However, sheriffs have been following it over this last year with a marked decrease in the number of youth transported using restraints. The current DMH Commissioner wrote a third policy memo in fall 2013.

Law Enforcement Mental Health Training

In 2006, Vermont launched Act 80/Act 79 six-hour basic awareness training for law enforcement personnel titled, "Interacting With People Experiencing a Mental Health Crisis." By the end of 2011, over 780 active Vermont police officers had received training statewide. This included 33% of Sheriff's Department personnel. Sixty-eight of the 76 law enforcement departments in Vermont (or 90% of departments) sent officers to the training (Vermont Attorney General's Office, 2012).

As of the end of 2013, Vermont had trained 68% (853) of its full-time certified officers and 21% (76) of its part-time officers, for an overall percentage of "58%, which reflects a 13%

increase from 2011” (Vermont Attorney General’s Office, 2014, p. 3). The overall percentage of Sheriffs/deputy sheriffs who have received Act 80 Training is now 24%.

Vermont’s basic training on “Interacting with People Experiencing a Mental Health Crisis” teaches officers how to recognize mental health conditions and disorders, communicate with and de-escalate disordered individuals; maximize officer and individual safety, decrease civilian complaints and liability issues, and increase awareness of stereotypes and stigma. It also covers roles of mental health and law enforcement professionals, the Americans with Disabilities Act of 1990, and laws regarding treatment and voluntary/involuntary hospitalization procedures. While Act 80 does not mandate involuntary transport training, new regional joint mental health/law enforcement trainings that started in May 2013 have included it in the curriculum.

Sheriffs’ Training

In addition to basic training on “Interacting With People Experiencing a Mental Health Crisis,” Sheriffs and deputies have recently been receiving specialized training from DMH on “Building Rapport with People in Mental Health Crisis” and “Safe Transport Strategies.”

Crisis Intervention Team Training

Vermont is also initiating a Crisis Intervention Team (CIT) Pilot Program, which would include 40 hours of advanced training. Teller, Munetz, Gil, & Ritter (2006) conducted research that studied dispatch logs for two years before and four years after the start of a CIT program in Akron, Ohio and concluded that it has a positive impact on transports of mentally ill individuals: “Training has led to increased transport of persons who are experiencing a mental illness crisis to emergency evaluation and treatment facilities, and transport is more likely to be on a voluntary basis compared with officers who have not participated in training” (p. 5).

Soft Restraints

Vermont has also tried to make involuntary transports more humane by influencing the type of restraint used. Historically Vermont has used steel handcuffs and ankle shackles, and a waist chain as for criminals. In 2009, Vermont DMH issued a new policy that “soft restraints should be used during transport, for children and adults, unless there is an immediate reason presented for a sheriff to utilize metal shackles” (Vermont DMH, 2013, p.3, *Transportation of Individuals in the Custody of the Commissioner of Mental Health*). Soft restraints are made of canvas and Velcro and are typically used only on wrists, although they can be used on ankles, too. Vermont has a unique practice of applying hard restraints when needed to apply the soft ones, and then removing the hard restraints. DMH assisted in implementation of this policy by purchasing soft restraints for sheriffs departments. (Note: A small number of officers (3 = 6%) indicated in this survey that their sheriff’s department does not have enough soft restraints).

Catalysts for Change

The issue of humane transport of individuals on ‘involuntary status’ gained renewed attention and urgency when Tropical Storm Irene flooded and permanently closed the Vermont State Hospital in August 2011. Overnight, sheriffs had to relocate current patients and transport new ones to six designated hospitals and treatment facilities across the state instead of one. As one Sheriff commented, Tropical Storm Irene forced change as DMH and law enforcement had to collaborate in order to keep costs down.

Another catalyst for change was an April 1, 2012 Associated Press article, “*Vermont Routinely Violates Law on Moving Mentally Ill,*” which reported that, “From 2007 to 2009, an average of 65 percent of patients were transported in restraints. In 2010 it crept up to 69 percent and last year to 72 percent.” The DMH Commissioner’s stated goal was to see within one year

(i.e., by April 2013), “at least 60 percent of Vermont’s transports of mental health patients done without law enforcement involvement or use of restraints” (Gram, 2012).

The Tipping Point

In January 2013, DMH reported to the legislature that, “Since April 2012, DMH has developed an aggressive implementation plan for changing the manner in which individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible” (Vermont DMH, 2013, p. 20, *Reforming Vermont’s Mental Health System*). The express purpose of this plan, which included new policies, sheriffs training, provision of soft restraints, analysis of transport patterns, oversight, financial incentives, a mental health van pilot project, and creation of a new multi-agency Involuntary Transportation Group, was to reduce trauma for the patient transported. Mental health and law enforcement collaboratively achieved a dramatic reduction in use of restraints for these involuntary transports between April 2012 and April 2013, going from 35% unrestrained to 85% unrestrained. Sheriff involvement, however, will be needed for the foreseeable future.

Reductions have also been achieved in the use of hard (i.e. metal versus cloth) restraints. A July 1, 2013 *New England Psychologist* article reported that use of metal restraints for adult involuntary transports (to include ambulance and mental health or hospital vehicles) stayed at 59 and 58 percent for 2010 and 2011. Notably, however, when “secure” transports by sheriffs were broken out of the larger statistic, their use of metal restraints was much higher, “73 percent of the time, up from the previous two years” (Berard, 2012). DMH first introduced soft restraints in 2009 and has since trained 100% of sheriff’s department personnel. In January 2014, only 11% of sheriffs’ transports used metal restraints (Vermont DMH – Research & Statistics Unit, 2013).

DMH reported to the Vermont legislature in January 2013 that, “The drop in secure transport is directly attributable to (one county’s mental health van) pilot as it responds to the entire northern tier of the state, an area where metal restraints continue to be used by (four county) Sheriffs as a matter of policy. All other Sheriffs have transitioned to soft or no restraints” (Vermont DMH, 2013, p. 22, *Reforming Vermont’s Mental Health System*).

Restraint Factors

Vermont DMH’s annual reports to the legislature on initiatives to reduce the use of restraints for the transport of individuals on ‘involuntary status’ suggest that DMH and sheriffs’ policies, Vermont statute, joint mental health and law enforcement trainings, resources (such as soft restraints), DMH oversight, data transparency (DMH statistics) and changing departmental culture (influenced by each sheriff) have all contributed to a decline in the use of restraints since 2004. The mental health van pilot project and sheriffs trainings have coincided with a sharp reduction in “secure” sheriffs’ transports from April 2012 to April 2014.

It would appear that the mental health van pilot that is run by retired deputy sheriffs trained in communication and de-escalation techniques to make restraints unnecessary in most cases, has dramatically reduced the statewide rate of restrained sheriffs’ transports because it offsets the extraordinary discretionary power that Sheriffs have wielded in four counties with 100% restrained transport rates. This researcher postulates that officer-centered factors (i.e., officer style and attitudes) and departmental factors (i.e., individual Sheriff’s policy) modified by level of discretion, influence restraint use more than resource, policy, training, and patient factors.

Officer Attitudes

Patch and Arrigo (1999) make a nod to macro-level policy, resource, and departmental factors as they impact outcomes of police interactions with the mentally ill. However, they feel that officer-centered factors, specifically officer attitudes and available discretion are overlooked and understudied with regard to how they significantly affect outcomes in situations regarding the mentally ill. They make the case that police officer style (which relates to attitudes) and type of police-citizen interaction (which affects level of discretion) have a major impact on individual police officer decisions to arrest, involuntarily commit, or ignore mentally ill persons. While the authors do not address officer utilization of restraints for subsequent transport of individuals on involuntary status, their logic would extend to this specific behavior as well. “We contend that these situational variables are significant relative to the issue of police discretion. They help us understand how the outcomes of *individual* interactions can be studied apart from the more policy or resource-oriented factors” (1999, p. 24).

Use of Discretion

Patch and Arrigo discuss four typologies of officers and how police officer style can impact the outcomes of individual officer-mentally ill citizen encounters due to use of discretion. They cite Broderick’s (1987) delineation of officers into four types (enforcers, idealists, realists, and optimists) based on the relative value that an individual officer places on social order versus due process of law. “Enforcers” value social order over due process; “idealists” value social order and due process of law equally; “realists” focus on what is most practical in a situation; and “optimists” value due process over social order. Using this typology, Patch & Arrigo (1999) posit that,

The enforcer would likely...arrest the individual, regardless of the discretion available...
The arrest may not be necessary, or even strictly legal; however, it satisfies the enforcer’s

sensibilities regarding “proper” behavior and the primacy of social order. At the same time, the arrest satisfies departmental superiors who require assurances that they will not be unavailable for extended periods. (1999, p. 32)

Applying this line of reasoning one can postulate that Vermont Sheriffs/deputy sheriffs may differentially use restraints to transport individuals on involuntary status based on their personal officer styles. If one were to substitute the word “restraint” for “arrest” it could be predicted that the enforcer would likely...restrain the individual regardless of the discretion available... The restraint may not be necessary, or even strictly legal; however it satisfies the enforcer’s sensibilities regarding “proper” behavior and the primacy of social order. At the same time, the restraint satisfies departmental superiors who require assurances that they will not be unavailable for extended periods.

A related situational variable that takes into account both officer-centered factors and departmental factors is the type of police-mentally ill citizen interaction, as the nature of the call and the entity to which the officer feels most directly accountable largely determine an officer’s available discretion.

Wilson (1968) delineated four distinct types of calls for police intervention based upon two factors: initiation of the call and function of the call. Initiation of the call is introduced by either police or the citizen. Function of the call fulfills either a social order or a law enforcement purpose. These factors, then, produce four distinct call types: (1) police-invoked law enforcement, (2) police-invoked order maintenance, (3) citizen-invoked law enforcement, and (4) citizen-invoked order maintenance. (Patch & Arrigo, 1999, p. 27)

In police-invoked order maintenance situations the officer makes the decision to initiate action instead of being prompted by a citizen, and is dealing with a socially disruptive situation rather than the violation of a law. This encounter with a mentally ill individual “has the greatest potential to be influenced by the officer’s personal attitudes or beliefs. This is due to the high amount of discretion available to the law enforcement agent” (Patch & Arrigo, 1999, p. 28).

In police-invoked law enforcement situations the officer similarly makes the decision to initiate action regarding violation of the law before it comes to the attention of his superiors, and is not concerned with having to satisfy an individual citizen:

There is still no one watching the police agent to see whether a situation is being handled in a prescribed fashion. In these instances, the officer acts freely and solves the problem in whatever way he or she deems appropriate based on his or her particular attitudes toward, perceptions of, and assumptions about the mentally ill. (Patch & Arrigo, (p. 28)

In citizen-invoked order maintenance situations the officer has to take a citizen's concerns into consideration, but does not have to take specific action because a law has not been violated. "Departmental influences are minimal as these are isolated events for which the officer may not plan or preempt" (Patch and Arrigo, 1999, p. 29).

In citizen-invoked law enforcement situations, the officer has the least discretion because a citizen's expectations need to be considered and the department has expectations that specific actions will be taken when a law has been violated.

Although it is the police officer who makes the particular intervention decision, departmental forces greatly constrict the available options. Consequently, the patrol officer typically chooses the path of least resistance in an effort to satisfy (almost) everyone: the complainant, departmental superiors, and the public. (Patch & Arrigo, 1999, p. 29)

In Vermont, DMH initiates calls to the 14 county sheriffs departments it contracts with to transport individuals who are on 'involuntary status' so officers aren't concerned about satisfying individual citizens. This process most resembles a police-invoked order maintenance situation, which has the greatest degree of discretion. The deputy sheriffs who conduct the transports are accountable first to the Sheriff for whom they work, and only secondarily to DMH. Each of the 14 county Sheriffs is granted an extraordinary degree of discretion regarding the use of restraints to ensure the safety of all involved and sets his personal policy for the department. The Sheriff may or may not authorize his deputies to use their own discretion in the field and deputies must

do what their Sheriff tells them to do even if it contravenes Vermont statute. Thus some counties have a policy of 100 percent transports using restraints, while other Sheriffs have a policy of no restraint use unless a deputy can articulate a valid reason and obtain approval.

Until the advent of the mental health van pilot project, individual Sheriff's discretionary use of restraints based on their personal attitudes and beliefs regarding the mentally ill trumped all other factors combined as it could be invoked for any reason in the name of safety. It also appears that training may not have changed the attitudes or practices of the Sheriffs of the four northern counties as they still have an almost 100 percent rate of transport using metal shackles. Patch & Arrigo (1999) state that, "Clearly, officer attitudes and their use of discretion toward disordered citizens are embedded within the decision-making process" (p.33). They speculate that, "Certain police precincts attract a certain kind of applicant, which in turn results in a police department populated by a particular type of officer. This police force would likely evince definite trends" (p. 33).

Although officers generally have stigmatized views of the mentally ill similar to those held by the public, it is widely believed that mental health training can modify officer attitudes and behaviors toward the mentally ill. Clayfield, Fletcher, & Grudzinskas (2011) developed a Mental Health Attitude Survey to assess officer attitudes toward this population and "to measure the effectiveness of mental health crisis training in improving police attitudes toward persons with mental illnesses" (p. 742). They point out that officers who lack knowledge and skills regarding mentally ill individuals can make improper decisions and may be more aggressive if they believe these individuals are unpredictable and pose an elevated risk. For this reason, this study of Vermont involuntary transports asks parallel questions about sheriffs' attitudes toward the mentally ill as they relate to use of restraints.

Clayfield et al. (2011) state that, “In most states officers have the discretion to determine what action to take when they encounter an emotionally disturbed person” and that, “In these instances, the officers act freely and solve the problem in whatever way they deem appropriate, on the basis of their particular attitudes toward, perceptions of, and assumptions about mental illness” (p. 743). Officers are frequently concerned that mentally ill persons are unpredictable and take up too much time. Clayfield et al. cite studies that conclude, “Despite these frustrations, police officers do accept such encounters with emotionally disturbed persons as part of their normal police role (p. 743). However, Patch and Arrigo (1999) found that this view may not extend to civil commitment: “Researchers note that officers do not believe that involuntary hospitalization is a proper use of their resources and function” (p. 30). Therefore, this Vermont survey specifically asks if Sheriffs/deputies believe that transport of individuals on involuntary status to psychiatric hospitals is a proper use of their resources and function.

Patients’ Experience of Restraint Use

Because law enforcement officers are guided by principles such as “protect and serve,” they view physical restraints differently from health professionals who are guided by principles such as “first do no harm.” Allen, Carpenter, Sheets, Miccio, & Ross (2003), concerned that restraints are overused and misapplied in psychiatric emergencies, studied what mental health consumers want and need, and how they experience the use of restraints. These findings could have implications for sheriffs when they make decisions on use of restraints for the transport of individuals on ‘involuntary status.’ Consumers who participated in the surveys and workshops “repeatedly stressed the importance of having staff treat them with respect, talk to them, listen to them, and involve them in treatment decisions” (p. 39).

Allen, et al. (2003) reported that restraint use traumatized patients and made them less likely to seek subsequent outpatient care. They found that, “Thirty-six (36%) of those surveyed had been placed in restraints at some time during a psychiatric crisis” (p. 47); 93% of those who saw others in restraints reported that it was “upsetting” or “terrifying;” and 49% remembered what had happened to them while in restraints “vividly and in detail.” “Sixty-seven percent (67%) reported that staff had not tried anything else before putting them in restraints” and 77% felt that “no one had listened to them or responded to their requests.” “Finally, 54% said that being in restraints had made them unwilling to seek out psychiatric care after this experience” (p. 48). Some also reported that medical staff responded to their being in restraints by displaying “a negative and unsympathetic attitude towards them (e.g., *the staff looked at me as if I was a criminal*)” (p. 49).

Fisher (1994) conducted an exhaustive review of the prior 22 years of research literature concerning use of restraints in hospitals. A primary finding was that the use of restraints “can have substantial deleterious physical and (more often) psychological effects on both patients and staff” (p. 1590). Another important finding was that, “Although the rate...of restraint can be influenced by clinical factors (such as patient age and symptoms), they can also be substantially influenced by nonclinical factors such as cultural biases, staff role perceptions, and the attitude of the hospital administration” (p. 1590).

Rakhmatullina, Taub, & Jacob (2013) reviewed current research literature (48 studies over the last 10 years) on the use of restraints with a particular emphasis on negative outcomes of morbidity/mortality in healthcare settings, primarily in the U.S. While in the last 20 years new regulations, education, and training have resulted in fewer cases of restraint, adverse outcomes still take place. Physical trauma ranged from skin abrasions to death, with restraint asphyxia

accounting for 40% of fatalities. Patients reported symptoms of psychological trauma such as distress, humiliation, dehumanization, isolation, shame, depression, and re-traumatization, especially in individuals with sexual abuse histories and Post Traumatic Stress Disorder. Staff likewise reported disturbing feelings of sadness, guilt, conflict, fear, and retribution. The authors conclude,

The importance of using restraints only as a last resort, improving data reporting, and implementing restraint reduction initiatives cannot be underestimated. Noteworthy, there are multiple studies proving benefits of restraint reduction initiatives that range from staff training to policy changes. The most outstanding is a Pennsylvania program that managed to eliminate the use of restraints completely in most of its hospitals using only existing staff, without additional funding or resources and reporting no increase in injuries. It appears that strong leadership, cultural shifts in perception of restraint use, data transparency and incentives for decreased restraint utilization could be key components of ensuring success of this program. (p. 11)

Sandhu, Mion, Khan, Ludwick, Claridge, Pile, Harrington, Winchell, & Dietrich (2010) also conducted a study in a medical setting that may have implications for sheriffs' decisions regarding use of restraints for transports of individuals on 'involuntary status.' They conducted an empirical, quantitative, cross-section factorial study to determine physician knowledge of regulations and effectiveness of using restraints, and how physician characteristics affect the likelihood of using restraints. They concluded that clinicians with greater age and experience were no less likely to order physical restraints than younger physicians (residents or fellows), whereas "higher appraisal of harm ($P < .001$), less knowledge regarding restraint ($P = .03$), and male sex ($P = .005$) were unique indicators for the likelihood of ordering restraints (p. 1272). The authors stated that education is imperative to reduce the rate of restraints.

The economic costs/savings of restraints could also be a potential factor engendering sheriff culture change regarding the conduct of "secure" transports of individuals who are on 'involuntary status.' Here again I have to extrapolate from a study done on eliminating physical

restraints in a medical setting because there is no extant research in a law enforcement setting. Lebel and Goldstein (2005) conducted an empirical, longitudinal, retrospective, quantitative study to evaluate the economic cost/savings of using restraints on an adolescent inpatient unit one year before and one year after an intervention to reduce or eliminate the use of restraints. Study results demonstrated a 91% decreased use of restraint from 3,991 to 373 episodes, and an associated 92% reduction in cost from \$1,466,740 to \$117,036. These gains coincided with a significant, measurable improvement in mental health outcomes. Staff also experienced fewer work-related injuries, less use of sick time, and decreased turnover.

Cordner (2006) speaks to the issue of which party is more at risk in a law enforcement encounter with an individual in mental health crisis – the officer or the citizen. Sheriffs’ beliefs about this issue can be a major factor that influences their decision to use restraints for transports of individuals on ‘involuntary status.’

Police interactions with people with mental illness can be dangerous, but usually are not. In the United States, 982 of 58,066 police officers assaulted in 2002, and 15 of 636 police officers feloniously killed from 1993 to 2002, had “mentally deranged” assailants. These represent one out of every 59 assaults on officers and one out of every 42 officers feloniously killed – relatively small portions of all officers assaulted and killed. (p. 3)

Cordner explicates that, “Encounters with police are more likely to be dangerous for people with mental illness than for the police...It is estimated that people with severe mental illness are four times more likely to be killed by police” (p. 3).

Implications for Follow-up Outpatient Treatment

Currier, Walsh & Lawrence (2011) conducted the only empirical, follow up, longitudinal, prospective and quantitative study published in a peer reviewed journal assessing the impact of using physical restraints in emergency departments on attendance at post-discharge outpatient psychiatric appointments. This study is crucial to my research because it is the empirical bridge

between the voluminous literature regarding the use of restraints in the hospital environment and the non-existent research about the impact of restraints that commences with sheriffs' transport of patients to an emergency department or inpatient facility.

Researchers "evaluated two groups of patients aged 18 or over: (1) 67 individuals who presented voluntarily or involuntarily (being brought in by the police) to the emergency department and who were physically restrained in the course of clinical care, and (2) a comparative group of 84 individuals who presented involuntarily but were not restrained" (Currier et al, 2011, p. 387). The primary finding of this study was that physically restraining a patient is associated with decreased likelihood of attending follow up outpatient appointments. The authors caution that, "association cannot demonstrate causation (but) our findings suggest there may be a direct benefit in reducing restraint for that subset of patients who can be managed through less aversive means" (p. 392). The researchers conclude from this study that, "Clinicians should consider all alternatives to physical restraint to minimize any needless deleterious impact on post-discharge treatment compliance after emergency department care" (p. 393).

A study limitation is that the authors never defined what "mental hygiene arrest" by the police constituted: restrained, unrestrained, or simply brought in to the emergency department involuntarily by the police (with use of restraints not specified). This could constitute a major omission, as physical restraint during police or sheriffs' transport could also significantly affect the individual's experience of the emergency department treatment and participation in follow-up outpatient treatment. One can reasonably speculate that if police bring an individual to an emergency department in restraints, the medical staff will consider the individual to be more dangerous and be more likely to use restraints in the clinical setting. Thus it can be posited that use of restraints by sheriffs for the transport of individuals on 'involuntary status' could impact

how the patients are treated at the hospital and contribute to unwillingness to attend follow-up outpatient appointments.

Culture Change

Vermont DMH's approach to reduce use of restraints for transports has been to partner with law enforcement in training, mental health van, soft restraints, and other initiatives to bring about voluntary culture change. Berard (2012) writes that, "Some mental health workers say that while DMH has given the mandate to transport by less-restrictive means – the department has neither the resources nor authority to enforce it, since the issue of involuntary transfer from hospitals includes federal regulations and regulations of local hospitals, ambulance companies, and sheriffs departments" (p. 1).

Wood (2004) has studied police culture as it affects law enforcement practices. She states that, "Issues of culture change typically plague advocates of policing reform...due to their defining capacity to exercise coercion, the police possess occupational sensibilities that tend to undermine new ways of thinking and acting." However, she states that, "A notable exception to this pessimism is found in the work of Janet Chan, who argues that cultural transformations can and do take place through iterative changes at the levels of "field" (structures) and "habitus" (practical dispositions) of the police" (p. 31).

Chan (2007) in an empirical, longitudinal, quantitative study of police recruits published in a peer-reviewed journal, "describes how officers make sense of reforms that have considerably altered the field of policing" (p. 323). This process of sense-making leads to shared values and understandings that contribute to evolving police culture and practice. Chan notes that police "try to make sense of uncertainties and disruptions and 'enact' their interpretations into the world to give it a sense of order" (p. 323). This observation can have implications for Sheriffs/deputies

who have not had the benefit of advanced mental health training and may therefore opt for more “secure” transport of individuals in mental health crisis as a way of dealing with fear caused by that uncertainty.

Paoline III (2003) identifies “three potential sources of variation” in police occupational culture (organizations, rank, and individual style) which create conditions for possible change. These differences “suggest cultural fragmentation” across police organizations and within police (or sheriffs) departments according to rank and style and based on individual experience (p. 204). Sheriffs’ culture is also fragmented in that senior personnel define the department’s style, set policy, and exercise their own discretion, whereas lower-ranking officers have to follow orders. Individual learned experience and officer style also contribute to “‘ideological differentiation,’ whereby subcultures reflect competing stances toward issues such as the nature of the work, the choice of the appropriate techniques, the correct stance towards outsiders, or the best way to treat particular clients” (p. 207). As departments “diversify demographically and philosophically,” overall “police culture thought” changes as well (p. 199).

Vermont’s 14 county sheriffs departments can be thought of as ideologically distinct subcultures whose beliefs and policies regarding ‘involuntary transport’ have been evolving and differentiating since 2004 when common practice was to use of restraints for all mental health transports. Some departments have developed more progressive policies, advanced trainings, and sophisticated techniques to communicate and build rapport with individuals on ‘involuntary status’ such that the majority of patients can be transported unrestrained consistent with safety.

The considerable variation in sheriffs’ departments’ restraint policies can be primarily attributed to individual Sheriff’s officer styles, attitudes, beliefs, and assumptions about the mentally ill, and how they choose to use their discretionary power. Schein (1992) states that,

“Organizational cultures are usually defined from the top of the organization down” (Paoline, 2003, p. 204). Thus some Sheriffs continue to mandate that deputies conduct 100 percent of involuntary transports using restraints, despite the individual merits of each case and practice evidence from other counties which have a 100 percent policy of no restraint unless a deputy can articulate a valid reason for their use.

Richerson & Boyd (2005) define “culture” in terms of cultural evolutionary theory as, “Information capable of affecting individuals’ behavior that they acquire from other members of their species through teaching, imitation, and other forms of social transmission” (Mesoudi, 2009, p. 929). According to social psychology, “The focus on information incorporates concepts relating to (social) cognition such as attitudes, beliefs, values, practices, opinions, schema, and representations” (p. 929). Flynn & Smith (2012) have researched how culture is acquired and spread through imitation. They show that, “like children, adults over-imitate. That is, adults faithfully imitate the behavior of a model even when this behavior is self-evidently of no instrumental value...(over)imitation appears to be a process so basic that it occurs even when contextual manipulations militate against it” (Kemmelmair & Kuhnen, 2012, p. 171). This observation could explain why some deputy sheriffs adhere to their Sheriff’s policy of routine use of restraints even when allowed to exercise discretion and despite practice evidence that demonstrates that restraints are unnecessary in the majority of cases and cause psychological trauma to the transported patient.

A cultural shift became apparent in how Vermont sheriffs transport individuals on ‘involuntary status’ in April 2013 when unrestrained transports started to exceed restrained transports for the first time. Law enforcement and mental health collaboration in new joint trainings, the success of the mental-health-van pilot project, soft restraint initiatives, and social

comparison between departments are mitigating the enormous influence of individual county Sheriff's personal attitudes and discretion. This study directly asked officers about variables that influence their decisions regarding use of restraints for involuntary transports to include their perceptions of the mentally ill, departmental policy, available level of discretion, and resource, policy, training, and patient factors. It invited officer comments about whether these transports are a proper use of sheriffs' resources and function, and asked if they would favor a statewide sheriffs' policy regarding the use of restraints.

CHAPTER III

METHODOLOGY

This study was designed to gain an understanding of what factors have contributed to a marked decrease in Vermont sheriffs' use of restraints for the transportation of individuals on 'involuntary status' to psychiatric facilities since April 2012. Five variables that the literature identifies as impacting police interactions with the mentally ill (i.e., officer, department, policy, training, and resource factors) were studied to determine if they influence sheriffs' decisions on using restraints for transports of individuals on involuntary status. By directly surveying all 14 Sheriffs and 25 state-funded Transport Deputies who primarily transport prisoners in Vermont's 14 counties, the study endeavored to be comprehensive and solicit firsthand the reasons for wide variation in restraint use for mental health transports. It also attempted to survey all the full-time "certified" deputies and part-time "on-call" deputies who are hired by each individual Sheriff to fulfill contracts with the towns for policing and courts for security, but who also perform mental health transports as needed.

The anonymous survey asked Sheriffs/deputy sheriffs what county they were employed by in order to determine the number/percentage of Vermont counties represented in the results. It was also possible to infer if individual officers' attitudes, restraint practices, and perception of their level of discretion were similar within a given county department and reflected the Sheriff's stance regarding the mentally ill and use of restraints for 'involuntary transports.' As each of Vermont's 14 county Sheriffs sets his own individual policy on use of restraints, this study paid

particular attention to how officers' available level of discretion modified the influence of the other five factors in decision-making.

A mixed-methods study was created to answer the following questions: (1) Why do the rates of "secure" transports by sheriffs' personnel (defined as involving the use of soft or metal restraints) vary widely among Vermont's 14 counties? (2) What factors most influence Vermont Sheriffs' and deputies' decisions regarding use of restraints for the transportation of individuals on 'involuntary status'? (3) How do Sheriffs' and deputies' rank, style, and personal attitudes toward the mentally ill influence their decision to use restraints? (4) To what extent do resources (i.e., staffing, vehicles, and time) impact Sheriffs' and deputies' decisions to use restraints? (5) Which policy most influences sheriffs' personnel decision-making regarding use of restraints: Vermont statute 7511 of 18 V.S.A., DMH policy guidelines, or individual Sheriffs' departmental policies? (6) How has training changed Sheriffs' and deputy sheriffs' attitudes and/or behaviors regarding transporting individuals who are on 'involuntary status' in restraints? (7) What do Sheriffs, and deputy sheriffs, view as barriers and facilitators to transporting individuals on 'involuntary status' without using restraints? (8) What percentage of Vermont Sheriffs and deputy sheriffs favor a statewide sheriffs' policy governing the use of restraints for transports of individuals on involuntary status?

Although originally a qualitative interview study was considered to identify factors that influence sheriffs' decisions to use restraints for involuntary transports, a review of the literature and 10 years of Vermont DMH's multifaceted efforts to reduce "secure" transports showed that most variables were likely already known. Therefore, a mixed-method survey was chosen to determine the extent to which each of the five variables influenced sheriffs' decisions regarding use of restraints. The survey also provided free-write spaces for qualitative comments to allow

participants to expand upon their answers and introduce additional factors and themes that the researcher may not have considered.

Although the survey instrument was not formally tested for reliability or validity it was reviewed by a professional in the social work field to ensure the language was appropriate, the directions and questions were clear and unambiguous, and the instrument maintained consistent focus. Survey questions about the influence of officer-centered, departmental, policy, training, and resource factors on sheriffs' decisions to use restraints were crafted to cite Vermont statute, policies, guidelines, trainings, and checklists by their specific names to increase validity. The President of the Vermont Sheriff's Association at this researcher's request reviewed the survey questions to ensure that they accurately reflected how the transportation process is conducted and would be understood the same way by all Vermont Sheriffs and deputy sheriffs. Many of these suggestions have been incorporated into the final version of the survey.

Sample

As Vermont sheriffs by mandate conduct the majority of transports of individuals who are designated as being in the care and custody of the Commissioner of Mental Health (i.e., on 'involuntary status') to psychiatric facilities, I planned to survey all 14 Vermont county Sheriffs and 25 state-funded Transport Deputies. Prior to launching the survey I learned that numerous full-time "certified" deputies and part-time "on-call" deputies are contracted and paid by the 14 individual Sheriffs to provide policing and security, and also conduct involuntary mental health transports as needed. Therefore, I expanded the sample to include these officers using the same qualification criteria as for the initial group.

This was a comprehensive and purposive sample rather than a sample of convenience as the President of the Vermont Sheriffs Association has an e-mail list of all Vermont sheriffs who

in turn have e-mail addresses for all their own deputies. The nature of my study supported the use of this sampling method since I was seeking specific data that could be supplied only by this group. I also sought to survey those few deputy sheriffs who are conducting a highly successful pilot project in alternative mental health transport using a specially modified van and specially trained deputies in plain clothes. My goal was to recruit all 14 Sheriffs and as many deputy sheriffs as possible, representing all of Vermont's 14 counties.

To be eligible to participate in the study individuals had to meet two criteria: 1) be a current Vermont Sheriff or deputy sheriff and 2) have within the last five years conducted involuntary transports of individuals who were in mental health crisis and in the care and custody of the Commissioner of the Vermont Department of Mental Health. To screen out non-eligible participants, all respondents were asked to confirm that they matched the above criteria at the beginning of the survey. The settings on the online survey required respondents to check an Informed Consent box acknowledging that they had read and understood the recruitment letter outlining the details of the study, its risks and benefits, and their voluntary participation, before they could start the actual survey. Eighty-seven officers accessed my anonymous online survey of which 53 qualified for and completed the survey for my study.

Recruitment

Prior to recruitment, a cover letter (Appendix A) describing the research study's purpose and methods was sent to the Executive Director of the Vermont Department of State's Attorneys and Sheriffs Association requesting approval to conduct the study using its members. A copy of the survey and Informed Consent were included so that the Executive Director would be fully informed of the anonymous and voluntary nature of the survey, protections, and questions being asked of his constituency. My cover letter explained that if my survey and Informed Consent

met with his approval, I would e-mail him the Survey Monkey link and ask that he distribute it through his membership e-mail list to include those deputy sheriffs who conduct transports for the Mental Health Van Pilot Project. The letter also stated that I would need to advise Smith College School for Social Work by January 21, 2014 if he had approved my study in order to proceed with the research.

I sent the materials by express registered mail on December 31, 2013. I followed up with a phone call on January 14, 2014, learned that my package had not been received, and faxed the materials to his office on the following day. On January 21, 2014 the Executive Director called to advise that he was going to defer the decision to Keith Clark, President of the Vermont Sheriffs Association. Keith Clark spoke with me about the survey later that same day and then e-mailed, “As the president of the Vermont Sheriffs’ Association you have our support on moving forward with the survey. Once the survey is complete I will disseminate it to all the Sheriffs.”

Ethics and Safeguards

The thesis proposal was submitted to the Human Subjects Review Board (HSRB) at Smith College School for Social Work to ensure that all possible measures were taken to maintain confidentiality; to maximize the benefits and minimize the risks of participating in the research; and to ensure that the principles of respect for persons, beneficence and justice were adhered to. Formal HSRB approval was received on January 24, 2014 (Appendix B).

Written Informed Consent (Appendix C) was obtained from each participant after outlining the study, potential risks and benefits, the voluntary nature of participating, ethical standards and measures taken to protect confidentiality, and the researcher’s contact information. The online survey was designed to be anonymous as the Survey Monkey website does not collect names or addresses of participants. The survey (Appendix D) did not ask for specific identifiable

information other than the county in which the individual worked. Demographic information such as the individual's age or number of years working in law enforcement was asked in terms of ranges so that the individuals would not be personally identifiable.

Given the small number of participants in my survey I disguised all information in my thesis, as individuals might be recognizable by a combination of demographic characteristics and the comments they provided. I intentionally did not mention any Vermont county by name. The online surveys were only accessible to the researcher by password and were downloaded as a file to a computer prior to removing the survey and associated files from Survey Monkey on May 25, 2014. After data analysis was completed the data were transferred to a memory stick and deleted from the computer. All survey data materials have been treated according to Federal regulations governing their storage and subsequent destruction.

Data Collection

My online survey consisted of four parts: (1) a demographics section that asked about age, gender, highest level of education completed, race/ethnicity, total years employed in law enforcement, county in which the individual was currently employed, the number of times that they had performed transports of individuals on 'involuntary status' within the last five years, and what specific mental health trainings they had received; (2) a resource section that asked about time, staffing, and availability of soft restraints and transport vehicles; (3) an officer-centered section that asked about individual style and personal attitudes, beliefs, values, and concerns regarding individuals in mental health crisis and these transports; (4) a departmental section that asked about departmental policy, rank/status, and available level of discretion; (5) a policy section that asked about Vermont statute, Department of Mental Health guidelines, and individual county Sheriff's policies; (6) a training section that asked about changes in attitudes,

skills, and confidence to do involuntary transports of individuals in mental health crisis using soft or no restraints; and (7) a table asking to what extent each of 22 items factored into Sheriffs' and deputy sheriffs' decisions regarding transports using mechanical restraints.

Survey sections 2-5 used a five-point Likert scale for each question followed by free comment boxes that invited respondents to elaborate on their responses and bring up factors for consideration that the researcher may not have thought of. Survey questions were developed based on (1) general factors identified in a review of the scholarly literature as influencing law enforcement's interactions with and dispositions of the mentally ill; and (2) specific factors that emerged from an analysis of 10 years of Vermont DMH's efforts to reduce the use of restraints for the transports of individuals on 'involuntary status.'

Data Analysis

Survey Monkey software assigned a unique identifying number to each respondent and the researcher reviewed the surveys for completeness. The survey responses were exported from Survey Monkey directly to an Excel file, which was then imported into the Statistical Package for the Social Sciences. The researcher created a codebook that assigned numbers to the response categories for each variable. A Smith College SSW statistical consultant ran frequency and descriptive statistics for all demographics and Likert Scale questions. The researcher then developed hypotheses and identified variables, which drove the choice of statistical tests. As the researcher was working with hypotheses of association and ordinal level of measurement, Pearson's correlation was used as the primary statistical test. Inferential statistics studied relationships between demographic statistics and Likert responses.

Qualitative analysis was used to analyze free-write comments in the survey for themes, concepts and relationships. Corbin and Strauss' constant comparative method was employed to

identify similarities and differences within the data. This mixed method was chosen to move from a simple ranking of the factors that influence sheriffs' use of restraints to a more complex explanation of their decision-making process and the mediating factor of their level of available discretion.

Marjorie Postal, Smith College School for Social Work's statistical consultant, provided the statistical analysis. The study analyzed individual Sheriffs' and deputy sheriffs' responses to survey questions to determine what factors most influenced their decision-making regarding use of restraints for the transportation of individuals on 'involuntary status.' It also explored how the influence of officers' personal attitudes in their decision-making was mitigated or amplified by their individual Sheriff's departmental policy and their available level of discretion. A table of 22 factors was ranked by both strength and frequency of response, and participants' qualitative comments were used to develop themes that explain the thought process behind their decisions.

CHAPTER IV

FINDINGS

This study investigated what factors most influence Vermont sheriffs' decision-making regarding the use of mechanical restraints for involuntary transports of individuals in the care and custody of the Commissioner of Mental Health to psychiatric facilities for care. It examined the influence of five variables that emerged from a review of the literature and 10 years of DMH initiatives to reduce use of restraints. The factors are: resource factors, officer-centered factors, departmental factors, policy factors and training factors. The study also investigated if patient factors (i.e., individual presentation and characteristics), influence sheriffs' decisions regarding restraint use.

Participants completed a survey (Appendix C) that asked to what extent the officers personally agreed or disagreed with each statement: strongly disagree, disagree, neutral, agree, or strongly agree. Resource-factor questions first inquired whether respondents thought these transports were a proper use of sheriffs' resources and function. Follow-on questions inquired about the amount of time these transports take and if county sheriffs departments are adequately staffed and have enough soft restraints and/or vehicles to conduct them. Additional questions asked if two officers available for a transport, or DMH financial incentives made it less likely restraints would be used. Finally, it offered a "check all that apply" list of reasons why officers don't use soft (i.e., cloth) instead of hard (i.e., metal) restraints.

Officer-centered factors focused on officers' attitudes about individuals in mental health crisis. Specifically, the survey asked if it is frightening to transport them whether or not they are in restraints, and if officers consider individuals in mental health crisis to be too unpredictable or dangerous to transport without restraints. As fright, unpredictability, and danger are all related to a concern about safety, respondents were asked if they would transport without restraints if they could ensure the transported individual's and their own safety. Participants were also asked how they view their personal officer style vis-à-vis the value each places on social order relative to due process of law. Finally, in an effort to tease out whether officers differentiate in how they transport patients versus criminals, each was asked if they have a responsibility to provide the best possible care when transporting individuals in mental health crisis.

Departmental-factor questions sought to explore the influence of individual county Sheriffs' policies on deputies' decision-making regarding use of restraints for these involuntary mental health transports. Respondents were asked to what extent they agreed or disagreed with the statement that his/her individual county Sheriff's policy was to "routinely" use restraints. A nearly identical question posed in reverse asked to what extent respondents agreed or disagreed that their individual county Sheriff's policy was to NOT use restraints unless clearly needed for safety. Three follow-on questions examined the key element of whether deputies can exercise personal discretion regarding use of restraints, if this is due to their junior rank/status, and if at times they are required to transport individuals in restraints when they would prefer not to.

Policy-factor questions explored officers' familiarity with Vermont State Law (Statute §7511 regarding "least restrictive means") and DMH Commissioner policy (memo regarding protocol for transports of children). The survey also asked to what extent respondents would favor a statewide sheriffs' policy regarding use of restraints for transports of individuals on

‘involuntary status.’ A ranking table at the end of the survey asked how much their decision making on use of restraints was influenced by their individual county Sheriff’s departmental policy, by Vermont State Law, and DMH Commissioner’s policy memo regarding children.

Training factor questions asked to what extent mental health training (of any kind) had made officers better able to communicate with and deescalate persons in mental health crisis, and increased officers’ confidence and skill to transport these individuals without any restraints. The survey also asked to what extent mental health training had changed their view of the transported individual from “prisoner” to “patient” and/or made them prefer soft over hard restraints.

Finally, to increase survey reliability through redundancy, rank the influence of all the variables in importance, and capture patient characteristics that also impact officers’ decision-making, respondents were asked to weight how much each of 22 variables in a table factor into their decision regarding use of mechanical restraints. The five main categories of factors were all addressed as well as patient variables, officer and patient safety, liability, reduced physical and psychological trauma for the person in mental health crisis, and empathy for the transported individual. Participants selected one of four provided responses: a lot, some, none, or don’t know.

This chapter will present the major study findings beginning with demographics of the sample. It will then provide statistical data describing the influence of each of the five original variables (i.e., resource factors, officer-oriented factors, departmental factors, policy factors and training factors) on officers’ decision-making regarding use of restraints. Statistical data will be reported as “valid percent” with missing values excluded as most officers responded to all of the questions. Additionally, what has been learned about the impact of the transported individual’s

presentation on officers' decisions to use restraints will be presented. Each dedicated section will incorporate officers' comments elaborating on their responses.

Demographics

This study is comprised of data from 53 respondents who met qualification criteria and completed most or all of the survey. Eighty-seven (87) officers initially accessed this survey from which 34 were removed: 15 were disqualified as they had not conducted an Involuntary Transport within the last five years; 3 were removed because they left the Transport question blank; 13 because they left the Informed Consent question blank, 2 because they responded "no" after reading the Consent document, and 1 who exited the survey after the Consent.

Of the 53 respondents, 11% (n=6) were Sheriffs out of a total of 14 Vermont county Sheriffs (a 43% response rate). (Note: Ten Sheriffs originally accessed the survey, but one had not transported in the last five years and three Sheriffs left the Informed Consent blank, exiting the survey). One of the 6 Sheriffs who took the survey completed only half of it; his responses have been included. Eighty-nine percent (n=47) of the final data sample was deputy sheriffs from nine out of 14 counties (representing 64% of Vermont counties). Three of the deputy sheriffs were not Transport Deputies.

The data sample consisted primarily of white males. One hundred percent (100%) of respondents identified their race/ethnicity as white/Caucasian, which correlates closely with 2013 U.S. Census Bureau statistics for Vermont (95% white). Eighty-nine percent (n=47) of the data sample of Sheriffs and deputy sheriffs identified as male and 11% (n = 6) as female, compared with 49% males and 51% females respectively in the Vermont population. All of Vermont's 14 elected county Sheriffs are white males.

The Sheriffs/deputy sheriffs who completed the survey ranged from 20 years of age to over 60, with greatest representation (26%) by those 60 or above. The age of all respondents was fairly evenly distributed with 19% being 20-29 years old, 13% being 30-39 years old, 23% being 40-49 years old, and 19% being 50-59 years old. Twenty-six percent (26%) had attained a high school degree, 45% reported having some college education, 21% had a bachelor's degree, and 8% had a master's degree or higher.

Almost half (45%) of respondents were fairly new to law enforcement with 10 years or fewer of experience, and half of those had been employed in law enforcement for only 1-5 years. Officers with a mid-range of experience (11-20 years) were less well represented (28%). The upper range (21-30 years) constituted 19%, while officers with the greatest law enforcement experience (31 years or more) constituted 8% of respondents.

Ninety-four percent (94%) of respondents reported that they conducted involuntary mental health transports as an "as-needed duty" while only 6% did them as their primary duty. A majority of respondents (64%) had done only 1-20 involuntary transports in the last five years (an average of <1-4 per year). Twenty-one percent (21%) had done 21-40 of these transports (an average of 4-8 per year). Two percent (2%) had done 41-50 transports (an average of 8-10 per year). Thirteen percent (13%) had performed more than 50 involuntary transports during the last five years (an average of more than 10 per year). Seventeen percent (17%) reported that on one or more occasions they had transported an individual and not known if the person was on 'involuntary status.'

Seventy-two percent (72%) of respondents reported having received Vermont Police Academy (Act 80) Training on "Interacting with People Experiencing a Mental Health Crisis" and 43% of officers said that this influenced their use of restraints "some" or "a lot." Forty-six

percent (46%) initially reported receiving Vermont Sheriffs Training by DMH on “Building Rapport with People in Mental Health Crisis” and 49% percent reported at the end of the survey that this training influenced their use of restraints “some” or “a lot.” (Note: Sheriffs training appears to have influenced the use of restraints by 100% of officers trained. One officer who initially answered that they hadn’t had this training apparently later remembered that they had.)

Table 1

Demographic Characteristics of the Respondents

n=53	Sheriffs Deputy Sheriffs	11% (n=6) 89% (n=47)
Age	20-29 30-39 40-49 50-59 60 or above	19% (n=10) 13% (n=7) 23% (n=12) 19% (n=10) 26% (n=14)
Gender	Male Female	89% (n=47) 11% (n=6)
Education	High School Some College Bachelor's Degree Master's Degree or Higher	26% (n=14) 45% (n=24) 21% (n=11) 8% (n=4)
Race	White/Caucasian	100% (n=53)
Year Employed in Law Enforcement	1-5 6-10 11-15 16-20 21-25 26-30 31 or more	23% (n=12) 23% (n=12) 15% (n=8) 13% (n=7) 7% (n=4) 11% (n=6) 8% (n=4)
Mental Health Trainings	VT Act 80 Training VT DMH Sheriffs Training	72% (n=36) 46% (n=24)
Involuntary Transports in last 5 Years	1-10 11-20 21-30 31-40 41-50 Over 50	43% (n=23) 21% (n=11) 13% (n=7) 8% (n=4) 2% (n=1) 13% (n=7)
Primary or As-Needed Duty	Primary Duty As-Needed	6% (n=3) 94% (n=50)

Resource Factors

More respondents (42%) felt that involuntary transport of individuals in the care and custody of the Vermont Commissioner of Mental Health is a proper use of sheriffs' resources and function than were neutral (37%), or felt it was not a proper use (21%). Sixty-two percent (62%) of respondents felt that their department was adequately staffed to perform this function; 17% were neutral; and 21% felt they were insufficiently staffed. Sixty-two percent (62%) felt that their department was adequately resourced (i.e., had enough soft restraints and/or vehicles) to handle these transports, 20% were neutral, and 18% felt they were not adequately resourced. Sheriffs' and deputies' beliefs that involuntary transports is not a proper use of their resources and function (21%) is highly correlated with their assessment that there is inadequate staffing (21%) to perform this duty. Twenty-nine percent (29%) felt that individuals in mental health crisis take up more than their share of sheriff transport time, while 40% were neutral, and 31% disagreed.

Staffing levels were also a factor in some respondents' decisions to use/not use restraints for these transports. While 60% of respondents reported that the availability of two officers for a transport did *not* make it less likely that restraints would be used, (19% were neutral), nearly one quarter (21%) agreed or strongly agreed that having more than one officer made it less likely that restraints would be used. However, twenty-one (21%) of all respondents said that their Sheriff's department did not have adequate staff to handle these transports. One officer wrote that, "Two deputies should always be used for the safety of all those involved." Another commented that, "Regardless of the number of officers (although ALWAYS two by this department)...restraints WILL be used."

Only 11.5% of respondents reported that Vermont DMH financial incentives had reduced the use of restraints by their county Sheriff's department; 50% had a neutral response; and 38.5% disagreed. Asked later how much this factored into their decision regarding use of mechanical restraints, only 14% reported "a lot" or "some," while 80% reported "none" and 6% said "don't know."

One hundred percent (100%) of respondents reported having had training in how to use soft restraints. Participants were asked why, as Transport Deputies, they don't use soft restraints for these transports, and to "check all the reasons that apply." Fifty-three percent (53%) of respondents (n=28) reported that they do use soft restraints when a decision is made to perform a "secure" transport of an individual. Seventeen percent (17%), (i.e., six Sheriffs and three deputy sheriffs) stated that they were not Transport Deputies. Thirteen percent (13%) reported they did not use soft restraints for mental health transports of individuals on 'involuntary status' because their department had a policy of hard restraints; 13% because they take too long to put on; and 6% because their county Sheriff's department doesn't have enough soft restraints.

Officer-Centered Factors

Respondents were asked one question about themselves (officer style) and 7 questions about their attitudes and perceptions regarding individuals who are experiencing mental health crisis. On the question of officer style, the vast majority (85%) (n=39) indicated that they "value order maintenance and due process of law equally." A small number (9%) (n=4) reported that they "value neither due process nor social order but 'go along to get along.'" An even smaller number (6%) (n=3) reported that they "value social order at the expense of due process of law." The one Sheriff who answered this way was from a county with a policy of 100% restraints and hard restraints. This question of "officer style" came from a study by Broderick (1987) on police

typologies, elaborated on by Patch & Arrigo (1999) in terms of how it impacts individual officer-mentally ill citizen encounters. One Vermont Sheriff exited the survey mid-way after reading this question, and six deputies skipped it. (Note: These seven “missing values” or 13% of all respondents were not included in the above “valid percentages.”)

The overwhelming majority of officers surveyed (96%) (n=50) agreed or strongly agreed that, “I have a responsibility to provide the best possible care when transporting individuals in mental health crisis.” Only two respondents (4%) disagreed or strongly disagreed. Notably, a Sheriff who disagreed (not the aforementioned Sheriff) came from a county with a policy of 100% restraints and hard restraints (albeit soft restraints for mental health patients).

Eighty-five percent (85%) (n=34) of officers agreed or strongly agreed that they felt adequately trained to handle transports involving individuals in mental health crisis, while 8% gave a neutral response, and 7% disagreed. The percentage of officers who felt they were not adequately trained or gave a neutral response (15%) (n=8) correlates closely with the percent (14%) (n=7) who agreed that, “It is frightening to conduct these involuntary transports whether or not they are in restraints.” Twenty-nine percent (29%) (n=15) gave a “neutral” response to the question about fright, while 57% (n=29) disagreed or strongly disagreed.

A majority of respondents (56%) perceived individuals in mental health crisis as too unpredictable to transport without restraints, while 19% were neutral, and 25% disagreed or strongly disagreed. Fewer officers (37%) perceived individuals in mental health crisis as too dangerous to transport without restraints, while a significant percentage (38%) was undecided (“neutral”), and 25% disagreed or strongly disagreed. A majority of respondents (58%) agreed or strongly agreed that, “I would transport without restraints if I could ensure the individual’s and my own safety.” Thirteen percent (13%) gave neutral responses, and 29% disagreed or

strongly disagreed. One officer commented, “People as a whole are unpredictable and dangerous, then add a person in crisis, scared, it creates a situation that NO ONE can ensure.” Another held a different point of view, “In my experience mental health patients are cooperative when treated with dignity and respect.”

Table 2

“Individuals in Mental Health Crisis are too ... to transport without restraints.”

	Frightening	Unpredictable	Dangerous
Strongly Agree	0%	35%	15%
Agree	14%	21%	21%
Neutral	29%	19%	39%
Disagree	31%	19%	19%
Strongly Disagree	26%	6%	6%

A unique reason for one county Sheriff’s policy of restraint use which this researcher did not anticipate, had to do with officer-centered factors (i.e., age, physical strength, training, and patrol experience of the transport officers) and not patient factors (i.e., the presentation of the individual in mental health crisis):

Our department policy is to use restraints at all times, however this is due to the fact that many of our transport officers are older and not patrol officers. Often those of us who are patrol officers will look at the individual involved and, based on our advanced training and experience in the field, we may decide not to use the restraints.

Departmental Factors

Departmental questions asked about individual Sheriff's departmental policies regarding use of restraints for transports of individuals on 'involuntary status.' Fifty-six percent (56%) of respondents agreed or strongly agreed that their individual Sheriff's department's policy was to routinely use restraints for involuntary transports, 17% gave a neutral answer, and 27% disagreed or strongly disagreed. Asked a similar question in reverse, 32% agreed or strongly agreed that their Sheriff's department policy was to NOT use restraints unless clearly needed for safety, 12% were neutral, and 53% disagreed or strongly disagreed. A ranking table at the end of the survey found that 96% of respondents were influenced "a lot" or "some" by their Sheriff's individual departmental policy, only 61% by Vermont statute, and 54% by Vermont DMH Commissioner's policy regarding children.

A surprising finding suggested by the 12% neutral response to the above question was that a number of deputies didn't know what their individual Sheriff's departmental policy was regarding use of restraints for individuals on 'involuntary status.' Data analysis of response by county (Table 3) confirmed this. A uniform statewide Vermont sheriffs policy regarding use restraints for this type of transport could rectify this ambiguity.

Table 3

Deputies' Knowledge of Their Sheriff's Restraint Policy

“My Sheriff’s department policy is to routinely use restraints for involuntary transports.”

County	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
A (Unk)	0	0	0	1	0
B (Hard)	0	2	2	0	0
C (Soft)	0	1	0	0	0
D (Unk)	0	2	0	0	0
E (Hard)	0	1	0	0	0
F (Hard)*	1	1	0	0	0
G (Hard)	2	4	0	2	0
H (Hard)*	7	5	0	1	0
I (Soft)	1	0	6	3	7

Note: Sheriffs’ responses are included in the bold number count. An * signifies a general county policy of hard restraints but soft restraints for mental health transports.

Officer Discretion

Respondents were also asked about a crucial element that can mediate county Sheriffs’ individual policies: officer discretion. Only half of deputies (55%) surveyed agreed that they CAN exercise personal discretion regarding use of restraints for involuntary transports, 19% were neutral, and 26% disagreed. Thirteen percent (13%) of deputies said that they CANNOT exercise discretion regarding use of restraints due to their rank/junior status, 19% were neutral, and 68% disagreed. Six percent (6%) of deputies said that, “At times I am required to transport individuals in restraints when I would prefer not to,” 11% were neutral and 83% disagreed. As expected since they make their own policies, the Sheriffs (n=5) all responded that they CAN exercise personal discretion and are not required to transport individuals in restraints when they would prefer not to.

Policy Factors

Policy questions asked about officer awareness and influence of Vermont state law (Statute §7511 regarding “least restrictive means”), and external agency policy (specifically the DMH Commissioner’s memo regarding children) (Appendix F) on their decisions regarding use of restraints for involuntary transports. Seventeen percent (17%) of respondents reported that they were “very” familiar with Statute §7511, 33% that they were “moderately” familiar, 29% “slightly” familiar, and 21% were “not aware of statute.” Fourteen percent (14%) of respondents reported that the statute strongly influenced their use of restraints, 24% said moderately or slightly, 37% that it had no influence, and 25% that they were “not aware of the statute.” Asked the same question later about Statute §7511 18 V.S.A on a table that ranked factors with the added prompt “Least Restrictive Means,” 20% of officers reported that it factored “a lot” into their decision regarding use of mechanical restraints, 41% said “some,” 31% said “none,” and only 8% reported that they didn’t know. Of note, one of the survey respondents who reported spending 25% or more of his time doing these transports still stated “none” and commented, “Not able to pull Vermont statute out of my ass.”

Survey participants were also asked to what extent the Vermont DMH Commissioner’s 2007 policy memo (revised 2011 and 2013), (Appendix E), influenced their decision to NOT use restraints when transporting children. Fourteen percent (14%) reported it influenced their decision “strongly,” 28% “moderately” or “slightly,” 36% said it had no influence, and 21% indicated that they were “not aware of policy.” Asked the same question again at the end of the survey as part of a table that ranked the influence of many factors, 18% reported that it factored “a lot” into their decision regarding use of mechanical restraints, 36% said “some,” 30% “none” and 17% that they didn’t know.

As a concluding question on policies, survey participants were asked to what extent they would favor a statewide sheriffs policy regarding use of restraints for transport of individuals on ‘involuntary status.’ Respondents were evenly split on this question, with a marked percentage undecided. One third of officers (33.4%) were “strongly” or “slightly” in favor of a statewide policy, 33.3% were “neutral,” and 33.3% were “slightly” or “strongly” against. A slightly higher percentage (22%) reported that they “strongly favored” a statewide policy than were “strongly against” (18%).

Training Factors

Sixty-seven percent (67%) of survey participants reported that Vermont Basic Academy Training had influenced their use of restraints “some” or “a lot.” Seventy-two percent (72%) of officers said they’d had Vermont Police Academy (Act 80) Training on “Interacting with People Experiencing a Mental Health Crisis” and 44% of all respondents stated that this influenced their use of restraints “some” or “a lot.” Forty-six percent (46%) (n=24) of officers initially reported receiving Vermont Sheriff’s Training by DMH, “Building Rapport with People in Mental Health Crisis” at the beginning of the survey, and 49% (n=25) reported at the end of the survey that this training influenced their use of restraints “some” or “a lot.” (One individual apparently recalled later that they had in fact had the training. This training appears to have influenced restraint use by 100% of officers trained.)

Forty-four percent (44%) of all respondents reported that mental health training (of any kind) had “greatly” or “moderately” made them better able to communicate with and deescalate individuals in mental health crisis who they involuntarily transport. Thirty-seven percent (37%) said that it only helped “slightly,” 15% said that it had “no influence,” and 4% that they had not had mental health training.

In contrast, only 21% of respondents reported that mental health training (of any kind) had increased their confidence and skill “greatly” or “moderately” to conduct these involuntary transports without any restraints. Eleven percent (11%) reported that training had increased their confidence and skill “slightly,” while 64% reported no influence, and 4% said that they had not had mental health training. However, 100% of the officers who reported having had Vermont DMH Sheriff’s training said that it influenced their use of restraints “some” or “a lot.”

Twenty-one percent (21%) of officers reported that mental health training had changed their view of involuntary transports from ‘prisoner transport’ to ‘patient transport’ “greatly” or “moderately,” 11% said “slightly,” 64% reported no influence, and 4% had not had any mental health training. One officer stated, “I did not view mental health transports the same as prisoner transports prior to any mental health training.” Survey results showed identical percentages for responses about the extent to which training had made officers prefer soft over hard restraints.

Soft Restraints

Nine out of 14 counties (64%) are represented in these survey results as either a county Sheriff, deputies, or both responded. Of the six county Sheriffs who participated in my survey, four reported that they have a departmental policy of hard restraints for transports of individual on ‘involuntary status,’ and two that they have a departmental policy of soft restraints. Deputies from three other counties reported that their Sheriffs have departmental policies of soft restraints. The total was five counties (55%) with policies of soft restraints, and four counties (45%) with policies of hard restraints for these transports.

The survey asked respondents the reasons why as Transport Deputies they DON’T use SOFT restraints for these transports and provided six possible responses asking that they “mark all that apply.” A free-write space was also provided for qualitative comments to allow them to

expand upon their responses and introduce additional factors and themes that the researcher may not have considered.

Table 4

Reasons that Transport Deputies DON'T use SOFT Restraints

N/A (I do use soft restraints)	53%	n=28
N/A (I'm not a transport deputy)	17%	n=9
They take too long to put on	13%	n=7
My department has a policy of hard restraints	13%	n=7
My dept. doesn't have enough soft restraints	6%	n=3

Several deputies (n=5) provided an unanticipated reason for why they don't use soft restraints, i.e., that they're not as reliable and/or safe as hard restraints. One commented, "The only reason I prefer the use of hard restraints is the fact that it is more difficult to slip out of hard restraints. Another elaborated, "Soft restraints are liable to be cut or slipped; are often unsafe to apply when a person is actively combative." A third stated, "I don't use soft restraints because they are not safe for subject, public, or Officer!" Other officers also expressed concerns about their reliability and liability:

I believe that mental health patients are inherently unpredictable and the use of soft restraints is a liability for the deputies and the patient. I have witnessed firsthand mental health patients slip out of what is considered properly applied soft restraints.

If 'they don't work' or 'they fall off' was an option, I would have chosen that. Almost every time I have used soft restraints, the patient hands them to me in a big pile when we arrive at our destination."

(Note: The valid issue of effectiveness aside, this last comment would seem to suggest that if “almost every time” mental health patients hand the soft restraints to the officer at the end of the transport, the restraints may not have been needed in the first place.)

Other officers (n=4) focused on the transported individual’s behavior as a reason that they sometimes don’t use soft restraints: “Use of soft restraints is determined by the history and current state of the patient.” Two officers noted patient variability: “Depending on the person’s action shall dictate soft/hard restraints” and “Depends on the individual. Individuals who are out of control or displaying conduct warranting a higher level of restraints WILL be transported in hard restraints.” One officer indicated that he has a policy of no restraints as his starting point and then bypasses the mid-range option of soft restraints if the patient’s behavior escalates:

I always will start transports without any restraints. If they choose to escalate, I can put them in metal restraints quicker and easier than in nylon. You cannot make a mass policy because each patient is different. A patient who is ok today might be different two months from now. There is no textbook answer. You have to have the knowledge and experience to make a good decision on how the transport will be conducted to keep both the patient and you safe at that moment in time.

A deputy from a Vermont county with a policy of 100% restrained transports and hard restraints noted that their starting point is soft restraints for mental health patients and then they move to hard restraints if the circumstances dictate:

It is our department policy to use restraints on all transports. For mental health transport, it is our policy to use soft restraints unless the Transport Deputies determine it would be safer for the deputies and the transport to use hard restraints.

Deputies who primarily do security ride-along on ambulance transports of patients in mental health crisis stated that they are influenced by and often defer to physicians, nurses, and EMTs regarding the use of restraints. One stated that, “Most of the transports that I have been on, the medical staff has the patient in soft restraints.” Other deputies describe collaborating closely with medical personnel in the decision-making process:

The decision to use restraints is dependent on several factors. As a Transport Deputy, the first person I speak to is the attending physician. That person will give you input as to the necessity of using restraints. Nurses also give input. A brief discussion with the patient can give an idea of the person's attitude and frame of mind. Since we usually transport with the rescue squad, they influence the decision on the use of restraints.

In my experience most involuntary Mental Health transports initiate from local ER where patient often has been administered calming medications. Often ambulance is transport vehicle with EMS on board in back with patient and myself. Decision to restrain is decided by deputy and medical personnel (including EMS). If department vehicle is used, two deputies always assigned. I have not transported mental health patient in departmental vehicle without restraints.

Rapport

Participants were asked, "From a departmental perspective how much time is necessary to build rapport with an individual who is experiencing mental health crisis before conducting a transport?" A majority of officers (n=20) emphasized how extremely variable this is and stated that, "It varies" or "Depends." Sixty-five percent of these (n=13) went on to say that it depends on "the individual," while (n=3) said "the case," (n=2) said "the degree of crisis" and (n=2) said "previous history with the subject." Numerical time estimates ranged from "0" minutes (which suggests that the one officer feels it is unnecessary to build rapport) to as much as "1-2 hours." Another officer stated, "Sometimes it is instant, sometimes it just doesn't happen. Every case is EXTREMELY different."

Interestingly, while "rapport" is defined in the dictionary as a close and harmonious relationship between two people marked by good communication, a majority of officers cited only patient factors in the time/rapport equation and appeared not to consider their own impact on the dynamic. Most identified patient variables such as the individual's "condition," "cognitive level," "willingness to build rapport," "mental state at time of transport," and "understanding of why the officer is there." Fewer respondents stated that the amount of time needed to establish rapport prior to transport depended on officer-centered factors, such as "attitude of the officers

and EMTs” and “common sense and patience of officers.” Just one deputy commented that the amount of time needed to build rapport depended on the interaction between both the “person and deputy involved” as influenced by their relational roles. Another officer also viewed others parties’ behaviors as influential, stating that the amount of time needed to build rapport with a person in mental health crisis depends on “how much they have been escalated by whoever we are taking them from.” One officer stated pragmatically that the amount of time needed to build rapport is “as much time as it takes to make transport safe for all parties,” which in the words of another officer is, “No time limit.”

Table 5

Time Needed to Build Rapport

Up to 10 minutes	24.5%	n=13
Up to 15 minutes	7.5 %	n= 4
Up to 20 minutes	5.7 %	n= 3
Up to 30 minutes	7.5 %	n= 4
Up to 45 minutes	1.9 %	n= 1
Up to 1 hour	5.7 %	n= 3
Up to 2 hours	1.9 %	n= 1
Varies/depends	34.0%	n=18
Missing	11.3%	n= 6

Patient Characteristics

While the literature identifies officer attitudes, resources, department characteristics, policy, and training as factors that influence officers’ decision-making regarding disposition of individuals in mental health crisis, patient factors have been largely omitted from the equation. A survey table in this study asked officers to rate how much 22 items factor into their decision regarding use of mechanical restraints for the transports of individuals on “involuntary status.” Significantly, responses showed that patient characteristics and officer concerns about clients’ wellbeing beyond simple physical safety ranked high among the five known categories of factors in terms of influencing officers’ decisions regarding use of mechanical restraints.

Table 6

How Much Patient Factors Influence Officer Decisions Regarding Use of Mechanical Restraints

(Ranking out of 22 varied factors)	“A lot” or “Some”
#1 Safety of the Individual	100%
#3 History of Prior Transport of the Individual	98%
#5 Presentation of Individual at Transport Time	96%
#6 Presentation of Individual at Initial Encounter	92%
#7 Reduced Physical or Psychological Trauma for the Individual	78%
#10 Age of the Individual (child or elderly)	63%
#13 Empathy for the Individual in Mental Health Crisis	57%

Statistical Tests

Statistical tests were run to explore the relationship between officers' assessments that their Sheriffs departments are adequately resourced, and responses that transport of individuals who are on 'involuntary status' is a proper use of sheriffs' resources and function. A Pearson correlation was run by resource variables (i.e., staffing, time, and vehicles and soft restraints). There was a significant positive correlation between adequate staffing ($r=.468$, $p=.000$, two-tailed) and belief that this was a proper function. This suggests that the more officers agree that staffing is adequate, the more they agree that transport of individuals who are on 'involuntary status' is a proper use of sheriffs' resources and function. A Pearson correlation regarding time approached significance ($r=.269$, $p=.056$, two tailed). This negative correlation suggests that the more officers agree that transports of individuals on 'involuntary status' take too much time, the less they agree that this is a proper use of sheriffs' resources and function.

Statistical tests also sought to explore the relationship between perceiving that mental health patients are "dangerous" and/or "unpredictable" and responses that these transports are a proper use of sheriffs' resources and function. Pearson correlations were run and no significant correlation was found, although qualitative analysis (see Chapter V Discussion) demonstrated that some officers felt very strongly that if an individual in mental health crisis is not dangerous sheriffs should not be conducting the transport.

Pearson correlations were run to determine if there was a correlation between total years employed in law enforcement and officer perceptions that individuals in mental health crisis are frightening, unpredictable, or dangerous. No significant correlations were found. Then T-tests were run comparing the mean response to "frightening," "dangerous," and "unpredictable" by officers with 1-5 years of experience as compared to those with six or more years of experience.

No significant correlations were found. Similarly, Pearson correlations and T-tests were run to determine if officers who had conducted ≤ 20 involuntary transports over the last five years considered individuals in mental health crisis to be too frightening, unpredictable, or dangerous to transport without transports more than those who had conducted greater than 20 transports. No significant differences were found.

A Pearson correlation was run to determine if there is a correlation between officer age and perception that individuals experiencing mental health crisis are too dangerous to transport without restraints and no correlation was found. A t-test was also run to determine if there was a difference in mean response to danger between officers aged 20-29 years-old and officers aged 40 years or above. No significant difference was found.

A Pearson correlation was run and there was a significant positive correlation ($r=.363$, $p=.009$, two-tailed) between officers' belief that mental health patients are unpredictable and the perception that they are frightening. This suggests that the more officers agree that individuals in mental health crisis are too unpredictable to transport without restraints, the more they agree that it is frightening to transport them "whether or not they are in restraints." A related Pearson correlation was run, which found a significant positive correlation in the strong range ($r=.848$, $p=.000$, two-tailed) between officers' belief that mental health patients are unpredictable and their perception that they are too dangerous to transport without restraints.

A Pearson correlation was run to determine if there was a relationship between officers' answers to the statements: "My Sheriff's department's policy is to routinely use restraints for all transports" and "My Sheriff's department's policy is to NOT use restraints unless clearly needed for safety." A significant strong negative (i.e. inverse) correlation was found ($r=.842$, $p=.000$). To further tease out whether the restraint policies were for the purpose of safety, the test was run

another way. Two category variables were created for each, where 1 = “disagree” or “disagree strongly,” and 2 = “agree” or “agree strongly,” with neutrals excluded. A crosstab analysis was run, which showed that for officers who said that their Sheriff’s department’s policy was to routinely use restraints for these transports, 96.3% of them disagreed that their Sheriff’s policy was to NOT use restraints unless clearly needed for safety.

A Pearson correlation was also run to determine if there was a correlation between an officer’s stated Sheriff’s department restraint policy and their agreement/disagreement with the statement, “I would transport without restraints if I could ensure the individual’s and my safety.” A significant negative correlation was found ($r = -.518$, $p = .000$, two tailed). This suggests that the more officers agree that their Sheriff’s departmental policy is to use restraints for these mental health transports, the less they agree that they would transport without restraints (even) if they could ensure the individual’s and their own safety.

A crosstab analysis was run to determine if there was a difference in who can exercise discretion, by their Sheriff’s policy regarding use of restraints. When the categories were left continuous and a correlation was run, the result approached significance ($r = .283$, $p = .054$, two-tailed). This suggests that those deputies whose sheriffs have a routine policy of using restraints have less discretion than those whose sheriffs have a policy of no restraints.

T-tests were run to determine if there was a difference in officers’ self-assessments that they were adequately trained to conduct these transports by having had either Sheriffs Training (“Building Rapport with People in Mental Health Crisis”) or Vermont Police Academy Training (“Interacting with People Experiencing a Mental Health Crisis”) and no significant differences were found. This result correlates with qualitative comments by several officers that these short trainings, while valuable, are not a substitute for years of on-the-job training and experience.

Finally, a t-test was run to determine if those officers who had DMH Sheriff's training ("Building Rapport with People in Mental Health Crisis") factored the potential physical and psychological trauma to the patient more in their decision-making about use of restraints than those who had not had the training. A significant difference was found ($t(39)=2.249$, $p=.030$). Those with Sheriff's training had a lower mean ($m=1.84$) than those without training ($m=2.31$), suggesting that they considered the physical and psychological wellbeing of patients more in their restraint decisions than officers who had not had benefit of the training.

CHAPTER V

DISCUSSION

This study examined how five variables (officer-centered factors, departmental factors, policy factors, training factors, and resource factors) influence the decision-making of Vermont Sheriffs/deputy sheriffs regarding use of restraints for transports of individuals on ‘involuntary status’ to psychiatric facilities for care. In doing so, it also captured patient factors, i.e., to what extent the presentation of the transported individual may impact use of restraint. As part of the survey, respondents were asked to rate how much each of 22 items in a table factored into their decisions regarding use of mechanical restraints: a lot, some, none, or don’t know. Table 7 on page 64 ranks these factors in terms of both frequency and importance, i.e., the percentage of officers who provided an “a lot” response. Table 8 on page 65 merges the “a lot” and “some” responses, and results in a different ordering after the sixth item.

This study’s results demonstrate that, in the words of one officer, “Safety of all involved is primary consideration in all transports.” Ninety-two percent (92%) of respondents indicated that safety of the individual and the officer factors “a lot” in their decision on use of restraints. Seventy-eight (78%) of respondents agreed that “history of prior transport of the individual,” a patient-centered factor, influences their restraint decision “a lot.” This provides officers with empirical evidence about an individual’s behavior that confirms or refutes perceptions of danger and unpredictability, which are subjective, officer-centered factors that are based on attitudes, beliefs, and assumptions about the mentally ill. Sixty-nine (69%) of respondents stated that

“my individual Sheriff’s departmental policy” factors “a lot” into the dispositional equation.

This departmental factor can be highly influential as it can mitigate or negate the influence of all other factors by disallowing deputies’ discretion based on the merits of individual cases.

Table 7

Factors that Influence Restraint Use Ranked by Frequency & Importance (“A lot” Response)

		A lot	Some	None	Don't Know
1	Safety of the Individual	92%	8%	0%	0%
2	Safety of the Officer	92%	6%	2%	0%
3	History of Prior Transport of the Individual	78%	20%	2%	0%
4	My Sheriff's Individual Departmental Policy	69%	28%	2%	2%
5	Presentation of Individual at Transport Time	67%	29%	4%	0%
6	Presentation of the Individual at Initial Encounter	59%	33%	8%	0%
7	Liability Concerns	33%	33%	33%	0%
8	Age of the Individual (child or elderly)	29%	33%	37%	0%
9	VT Basic Academy Training	26%	41%	27.5%	6%
10	Number of Officers Available for Transport	26%	26%	49%	0%
11	Reduced Physical & Psychological Trauma for the Individual	24%	54%	22%	0%
12	Empathy for the Individual in Mental Health Crisis	22%	35%	43%	0%
13	VT Sheriffs Training (“Building Rapport With People Experiencing Mental Health Crisis)	22%	28%	31%	20%
14	VT Statute §7511	20%	41%	31%	8%
15	VT Act 80 Training	16%	28%	33%	23.5%
16	Qualified Mental Health Professional (QMHP) Checklist Recommendation	18%	43%	28%	12%
17	VT DMH Policy Letter regarding Children	18%	36%	30%	16%
18	Individual's Stated Preference Regarding Restraint	10%	37%	53%	0%
19	Negative Press Coverage	6%	14%	78%	2%
20	VT DMH Financial Incentive for Reduced Use of Restraints	6%	8%	80%	6%
21	Gender of Transported Individual (female)	4%	20%	77%	0%
22	VT DMH Statistics	2%	19%	73%	6%

Table 8

Factors that Influence Restraint Use Ranked by Frequency & Importance (“A lot” or Some”)

		A lot or Some		None	Don't Know
1	Safety of Individual	100%		0%	0%
2	Safety of the Officer	98%		2%	0%
3	History of Prior Transport of the Individual	98%		2%	0%
4	My Sheriff's Individual Departmental Policy	96%		2%	2%
5	Presentation of Individual at Transport Time	96%		4%	0%
6	Presentation of the Individual at Initial Encounter	92%		8%	0%
7	Reduced Physical & Psychological Trauma for the Individual	78%		22%	0%
8	VT Basic Academy Training	67%		27%	6%
9	Liability Concerns	67%		33%	0%
10	Age of the Individual (child or elderly)	63%		37%	0%
11	Qualified Mental Health Professional (QMHP) Checklist Recommendation	61%		27%	12%
12	VT Statute §7511	61%		31%	8%
13	Empathy for the Individual in Mental Health Crisis	57%		43%	0%
14	VT DMH Policy Letter regarding Children	54%		30%	16%
15	Number of Officers Available for Transport	51%		49%	0%
16	VT Sheriffs Training (“Building Rapport With People Experiencing Mental Health Crisis)	49%		31%	20%
17	Individual's Stated Preference Regarding Restraint	47%		53%	0%
18	VT Act 80 Training	43%		33%	24%
19	Gender of Transported Individual (female)	23%		77%	0%
20	VT DMH Statistics	21%		73%	6%
21	Negative Press Coverage	20%		8%	2%
22	VT DMH Financial Incentive for Reduced Use of Restraints	14%		0%	6%

The next most frequently cited items that officers indicated they consider “a lot” in their decisions on use of restraints were patient-centered factors: “presentation of the individual at transport time” (67%) and “presentation of individual at initial encounter” (59%). This helps officers assess the individual’s mental state and potential dangerousness in the moment and over the duration of the transport. Some officers will proceed to take as much time as needed to try to establish rapport with, and obtain the cooperation of the patient such that restraints will not be necessary. Other officers will focus on picking up and transporting the patient in the most time-efficient manner possible.

A factor that was more influential than this researcher had anticipated was “liability concerns” (33%) which factored “a lot” into one third of respondents’ decisions regarding use of mechanical restraints. One commented rhetorically, “Who wants to take on the Liability when I have a Career Ending injury as a result. Or when the subject in crisis kicks out a window of a cruiser and jumps out?” Notably, the research literature also cites “liability of outcome” as a factor that impacts law enforcement practices.

About 25% of respondents said that training factors (Vermont Basic Academy training and Vermont Sheriffs mental health training) influenced their decisions on restraint use “a lot.” Seventy-two percent (72%) of respondents reported having received Vermont Policy Academy “Act 80” Training on “Interacting with People Experiencing a Mental Health Crisis” and 43% of officers said this influenced their use of restraints “some or a lot.” Forty-six percent (46%) of respondents reported receiving DMH Vermont Sheriffs Training “Building Rapport with People in Mental Health Crisis” and 49% said that this training influenced their use of restraints “some” or “a lot.” (Note: This sheriffs training appears to be the most influential of the mental health trainings in reducing use of restraints for involuntary transports. One officer who initially said

that they hadn't had this training apparently later recalled that they had, for a 100% efficacy rate.)

About one quarter of officers indicated that their decision on use of restraints was influenced "a lot" by concerns for the patient: "age of the individual (child or elderly)" (29%), "reduced physical or psychological trauma for the individual" (24%) and "empathy for the individual in crisis" (22%). These results represent an integration of officer-centered factors (compassion) and patient-centered factors (vulnerability and/or reduced danger). Notably, (96%) of respondents agreed that, "I have a responsibility to provide the best possible care when transporting individuals in mental health crisis."

Fewer than 20% of respondents stated that policy-centered factors of other government agencies such as Vermont Statute §7511 (20%), Qualified Mental Health Professional checklist recommendation (18%), and DMH Commissioner's memo regarding children (18%) factored "a lot" into their decision-making regarding use of restraints. This underscores the sway of local Sheriff's department policy (69%) as compared to the influence of other government agencies' policies or even state law.

A patient-related factor, "individual's stated preference regarding restraint" factored into only 10% of officers' decision-making "a lot," although 47% of respondents said it influenced them "some or a lot." Six percent (6%) or fewer of survey participants identified gender of the transported individual (e.g., female), DMH financial incentives, DMH transportation statistics, or negative press coverage as factoring "a lot" into their decisions regarding use of mechanical restraints.

Officer-centered factors

This researcher was impressed by the enormous variability in officers' attitudes towards individuals on 'involuntary status,' particularly regarding their dangerousness, which is directly related to officers' primary concern about safety. Fourteen percent (14%) of officers considered these individuals "frightening to transport whether or not they are in restraints," while 29% were neutral and 57% disagreed. A slight majority (56%) stated that they were "too unpredictable" to transport without restraints, while 19% were neutral and 25% disagreed. Only one third (36%) felt that individuals in mental health crisis were "too dangerous" to transport without restraints, while 39% were neutral, and 25% disagreed. The high percentage of "neutral" responses could signify that officers are undecided or reflect officers' qualitative comments that, "It depends" on the individual, the officer, crisis, etc. As one officer emphasized, "Every case is EXTREMELY different."

Officers, many of who did not view their own attitudes and presentation as variables in the individual officer-mentally ill citizen interaction tended to fit one of two profiles. The first had generalized, absolutist, all-or-nothing crime-fighter thinking, which focused on getting the transport done as efficiently as possible and ensuring physical safety through a blanket policy of restraint. This mindset was evinced through officer comments such as, "I would never choose to transport unsecure as mental health patients are unpredictable at best;" "Transporting without restraints is a disaster waiting to happen;" or "I go by Department policy." A Sheriff who values social order at the expense of due process of law (i.e., one who Broderick (1987) would suggest has an 'Enforcer' type of officer style) not surprisingly reported that he has a department policy of 100% restraints and hard restraints.

The second profile of officer that emerged from this study evinced more sophisticated, service-oriented thinking, and considered patients' physical and psychological safety, as well as the merits of individual cases. This type of officer noted that every case is different and varying amounts of time are needed to establish rapport and cooperation, reducing the need for restraints. They also described a multi-factorial decision-making process: "There are many factors that go into the decision on the use of restraints." Notably, this officer type was cognizant of how their own presentation could influence the patient to go willingly and unrestrained as evinced by the comment, "In my experience Mental Health clients are cooperative when treated with dignity and respect." A deputy who values order maintenance and due process of law equally (i.e., one who Broderick (1987) would suggest has an 'Idealist' type of officer style) commented:

The primary goal is to accomplish the task with respect and allow as much dignity as possible within the specific circumstances of the transport. Transport officers are faced with a wide range of circumstances and I have never seen an (officer in this sheriff's department) treat an individual with disrespect. In fact, a psychiatrist at Vermont State Hospital commented to me about the humanity of our staff.

This survey's data confirms research that shows that individual officers and patients are different and that the disposition (in this case use of restraints for transport) depends greatly on the officer's attitudes and interaction in the individual officer-mentally ill citizen encounter as modified by level of officer discretion (Patch & Arrigo, 1999). One Vermont deputy remarked on how his practices had changed, "Mental health patient watches and hands-on experience has made me convert to not using restraints on transports."

In a study in a medical setting, Fisher (1994) concluded that factors intrinsic to people and organizations in power can influence restraint use as much or more than patient factors:

Although the rates of...restraint can be influenced by clinical factors (such as patient age and symptoms), they can also be substantially influenced by non-clinical factors such as cultural biases, staff role perceptions, and the attitude of the hospital administration. (p. 1590)

Patch & Arrigo make the case that when an officer has high discretion, their personal attitudes, beliefs, perceptions and assumptions about the mentally ill have the greatest potential to influence outcome, (such as the decision to transport using restraints). In Vermont, the 14 county Sheriffs have high discretion to set their individual departmental policies on restraints because DMH reserves final decision-making to them to ensure safety. This means that the 14 Sheriffs' personal attitudes towards individuals in mental health crisis have the potential to be greatly magnified in their deputies' practices in the field, either because Sheriffs don't delegate discretion, or because deputies can exercise discretion but don't think to question departmental norms.

Departmental Factors

Ninety-six percent (96%) of respondents reported that their county Sheriff's individual departmental policy factored "some or a lot" into their decision regarding use of restraints. In contrast, only 61% said the same of Statute §7511, which mandates, "It is the policy of the State of Vermont that mechanical restraints are not routinely used on persons subject to this chapter unless such circumstances dictate that such methods are necessary" (my italics). It appears that when local Sheriff's policy conflicts with statute, officers' natural tendency is to comply with the guidance of their superior officer. One deputy commented, "There are times when I feel no restraints are needed, but that puts me in violation of policy."

Fifty-six percent (56%) of respondents agreed that, "My Sheriff's policy is to routinely use restraints for transports of individuals on involuntary status" (which violates Statute §7511). Seventeen percent (17%) gave a "neutral" response, and 27% disagreed. When asked a slightly different question in reverse, (nullifying the potentially mitigating factor of danger), 33% agreed that, "My Sheriff's policy is to NOT use restraints unless clearly needed for safety," 12% gave a

neutral response, and 55% (which includes 3 of 5 participating Sheriffs) disagreed. The import of this nearly identical response (i.e., 55% versus 56%) is that it suggests that the Sheriffs who have a 100% blanket policy of restraint use do not have it for the primary purpose of safety!

A Pearson correlation test supported this, showing a significant strong negative (i.e. inverse) correlation ($r=.842$, $p=.000$). To further tease out whether the restraint policies are for the purpose of safety, a crosstab analysis was run. This showed that for officers who said that their Sheriff's department's policy was to routinely use restraints for these transports, 96.3% of them disagreed that their Sheriff's policy was to NOT use restraints unless clearly needed for safety.

Fifty-eight percent (58%) of officers surveyed agreed that, "I would transport without restraints if I could ensure the individual's and my safety." In an effort to determine why 42% of officers would use restraints anyway, a Pearson correlation was run to determine if there was a correlation between an officer's stated Sheriff's department restraint policy and their agreement or disagreement with the above statement. A significant negative correlation was found ($r=-.518$, $p=.000$, two tailed). This suggests that the more officers agree that their Sheriff's departmental policy is to use restraints for these mental health transports, the less they agree that they would conduct transports without restraints (even) if they could ensure the individual's and their own safety.

Resource Factors

Thirty-eight percent (38%) of respondents stated that their county Sheriff's department was not adequately staffed to handle these transports (21%), or gave a neutral response (17%). Thirty-eight percent (38%) said they were not adequately resourced (i.e., staff restraints and/or vehicles) to handle these transports or gave a neutral response. The staffing issue is related to

another resource – officer time. Ninety-four percent (94%) of respondents stated that they do transports of individuals on ‘involuntary status’ as an “as needed” duty. A majority (58%) said that they spend less than 5% of their time doing this type of transports, and 51% that they spend 0-30 minutes building rapport with the patient. Only 11% (n=5) spent over 30 minutes building rapport, and 38% said “It varies/depends.”

Even so, nearly a third of respondents (29%) agreed that, “Individuals in mental health crisis take up more than their share of sheriff transport time.” (Forty percent gave a “neutral” response, and 31% disagreed.) Given this response, and that state-funded Transport Deputies’ primary function is to transport prisoners, it is reasonable to speculate that some Sheriffs and deputies may be inclined to use restraints for transports of individuals on ‘involuntary status’ to conserve officer time.

Training Factors

While there have been studies on law enforcement attitudes toward the mentally ill and the benefit of mental health training to change officers’ behaviors, it has not been known if this extends to reduced use of mechanical restraints for the transports of individuals on ‘involuntary status.’ This study’s results show that Vermont “Act 80” Training and Vermont DMH Sheriffs Training do reduce the use of restraints. Respondents also cited the impact of years of on-the-job training and experience serving with other agencies as providing them with the knowledge and skills to transport individuals on ‘involuntary status’ without restraints. An older deputy with a great many years of experience and trainings stated, “To say that a couple of recent trainings have greatly influenced me would be inaccurate. However, trainings give you new info and perspectives.”

One deputy described how his county sheriff's department had taken initiative to create advanced mental health instruction for its officers using actual cases and lessons learned. "We've generated training in-house based off of prior incidents and methodologies to provide superior care to in-crisis patients."

More often than not, our agency provides a more holistic level of care than the medical personnel provide. In the words of an ER doctor, 'the closure of the State Hospital has forced hospitals to revert to 19th century treatment of the mentally ill.' However my department acts as a pioneer in the Law Enforcement community as it pertains to mental health. It is not a difficult concept to look at patients in crisis and recognize the difference."

Policy Factors

Only 17% of respondents said they were "very" familiar with Vermont Statute §7511, which was passed by the Vermont legislature 10 years ago regulating involuntary transports, and 21% stated that they were "not aware of statute." Only 14% of officers said that the statute "strongly" influenced their use of restraints, while 37% said that state law had "no influence." Similarly, only 14% of officers said that the DMH Commissioner's 2007 policy memorandum influenced their decision to NOT use restraints when transporting children, and 22% stated they were not aware of the policy. Also, only 18% of respondents said that the QMHP Transportation Information Checklist for Persons on Involuntary Status (Appendix F) influenced their decision on restraint use "a lot." Clearly, internal sheriffs' department policies have much more clout with deputies than policies of external agencies.

Culture Change

Each Vermont sheriff's department can be thought of as a unique law enforcement sub-culture that has differentially evolved since Statute §7511 was passed 10 years ago stipulating that, "It is the policy of the state of Vermont that mechanical restraints are not routinely used on persons subject to this chapter unless circumstances dictate that such methods are necessary."

Some counties still have a policy of 100% restraints for transports of individuals on ‘involuntary status’ regardless of mitigating factors such as the patient’s prior transport history, presentation at time of transport, age (child or elderly), and cooperation. Other counties have reputations for more progressive, humane, service-oriented, and effective policies, which enable a majority of patients to be safely transported without restraints.

Paoline (2003), who has synthesized years of research on police culture, refers to this variation as “*ideological differentiation*, whereby subcultures reflect competing stances toward issues such as ‘the nature of the work, the choice of the appropriate techniques, the correct stance toward outsiders, or the best way to treat particular clients’” (p. 207). Paoline’s analysis builds on Brown’s (1988) examination of differences in officers’ attitudes toward ‘aggressiveness’ and ‘selectivity’ in forming four typologies of officers. These are: (1) the “*old style crime fighter* (i.e., highly aggressive and selective)”; (2) the “*clean beat crime-fighter* (high aggressiveness and non-selective); (3) the “*service-style officer* (low aggressiveness and selective);” and (4) the *professional officer*. Paoline describes the professional officer as being “effective in balancing the needs and concerns of citizens and supervisor, might be less likely to be suspicious, maintain the edge over citizens, lay low from supervisors, and adhere to a strict crime-fighting approach compared to the old-style crime-fighter, who embodies many of the traditional occupational culture values” (p. 207).

Statewide Policy

This survey asked participants to what extent they would favor a statewide Vermont sheriffs’ policy regarding use of restraints for transports of individuals on ‘involuntary status.’ It purposely did not specify a “restraints” or “no restraints” policy or mention discretion, to encourage the widest breadth of responses. My personal bias is that a statewide sheriffs’ policy

of “no restraints” could be very effective as a “common point of departure” *if* it also provided officers discretion to deviate from it on a case-by-case basis as needed to ensure the safety of all involved.

It’s a subtle nuance, but debating a statewide policy would require Sheriffs and deputies to reflect and ask themselves, “Is my basic world view that this population is dangerous and/or should be treated like prisoners, or that they are vulnerable, can in many situations be reasoned with, and are patients in need of medical care?” This fundamental question of worldview is not unlike the question “Is man basically good or basically evil?” It is important because is the lens through which officers perceive and interpret all of their individual interactions with people in mental health crisis.

This leads to the next question, “How do my attitudes, perceptions, and biases towards people in mental health crisis influence my policy and treatment of them?” This begets another question, “To what degree does the individual’s presentation at time of transport (i.e., perceived non-cooperation or dangerousness which influence use of restraints) depend on my basic world view and how I have interacted with, and succeeded or failed to communicate, deescalate, build rapport, and reason with them?”

A great many officers who elaborated on their survey responses described the patient’s behavior as if it occurred in isolation without considering how their own presentation affected the individual officer-mentally ill citizen interaction. A few officers commented that officers’ behaviors (particularly “common sense and patience”) influenced the patient’s presentation. Fewer officers wrote comments demonstrating that they view the encounter as transactional, subjective, and relational. For example, one officer stated, “In my experience mental health patients are cooperative when treated with dignity and respect.”

Certainly, individual county Sheriffs' personal attitudes about mental health patients and their departmental policies regarding restraints influence new deputy sheriffs who are developing a belief system of what is "normal" policy and procedure based on their "on-the-job training." This tends to perpetuate and reinforce certain attitudes and practices within a department. Patch & Arrigo (1999) state:

It is reasonable to speculate, for example, that certain police precincts attract a certain kind of applicant, which in turn results in a police department populated by a particular type of police officer. This police force would likely evince definite trends, which would differ from other precincts with either more diverse or highly concentrated personnel compositions. (p. 33)

Notably, a progressive Vermont Sheriff's department that generates in-house mental health training and has a humane transport policy of "no restraints" unless a deputy can articulate a valid reason why such are needed, also proved to be diverse in the composition of its officers, employing four of the six female deputies who took part in this survey. Responses to questions suggested that the department employed officers with a wide range of beliefs, and that they felt comfortable expressing them.

Statistically, respondents were evenly split on the idea of a statewide sheriffs policy regarding use of restraints for the transportation of individuals on 'involuntary status.' Thirty three percent of officers (33.4%) favored it, 33.3% were "neutral," and 33.3% "were against. A higher percentage of officers (21%) reported that they "strongly favored" a statewide sheriffs policy than were "strongly against" (17%). One officer commented, "Consistency is always good in my opinion as to how individuals are handled, just in case two deputies are working together for the first time and may have conflicting policies within their department."

The high percentage of "neutral" responses suggests that many deputies may not have considered this issue before, that a statewide sheriffs' conversation on its merits has not been

initiated, or that deputies may unthinkingly follow their Sheriff's stated policy even if it allows for discretion. That is to say that some officers, because they are junior in rank or more rigid in their thinking, may not take the very first step of decision-making, which is realizing there is a decision to be made (Yates, 2003). Two of five Sheriffs who answered this question "strongly favored" a statewide policy, two indicated they were "slightly against," and one was "strongly against." One deputy commented, "Sorry, this made me laugh a little. Actually a lot! You can't get all sheriffs to agree to what day it is, let alone a blanket policy."

Seventeen officers commented on the issue of a statewide policy at the end of the policy section of the survey. Six emphasized that, "Each case is different" and "should be assessed on its own merits" or "evaluated individually." Some expressed related concerns that, "A statewide blanket policy would be a nightmare" or "complicate the issue more than it is," or "create more of a problem than help resolve an issue." One officer stated that, "The use of restraints cannot be set out by statute or policy due to the ever-changing behavior and unpredictability of the patients and has to be left up to the transport teams." Another commented, "14 different Sheriffs. 14 different opinions. Most actual Sheriffs have not transported a violent mental health patient in years. Statewide policies are very prone to fail."

In contrast, other officers saw potential benefit in a statewide policy as long as it provided for the key element of discretion.

I think a policy is a great idea as long as all parties understand that sometimes restraints are absolutely necessary. Making sure that the policy does not scare those transporting someone in crisis from making a safe decision is crucial. The policy should make it clear to officers that they can still use their own discernment when transporting those in mental health crisis."

Another officer mirrored this sentiment: "You can't have a universal (statewide) policy unless you provide officer discretion."

Discretion

This study shows that only 55% of surveyed deputies say that their Sheriff's county policy allows them to exercise discretion regarding use of restraints for involuntary transports, 19% were neutral, and 26% disagreed. Thirteen percent (13%) of deputies said they CANNOT exercise discretion due to their rank/junior status, 19% were neutral, and 68% disagreed. Six percent (6%) of deputies said that, "At times I am required to transport individuals in restraints when I would prefer not to," 11% were neutral, and 83% disagreed.

It is unclear whether officers who have discretion (especially in counties where stated policy is to use restraints) actually use it... Some officers seemed to not engage in an internal decision process about the use of restraints or feel a need to exercise discretion because of their Sheriff's policy of using restraints and/or their own pervasive belief that all people in mental health crisis are dangerous. One officer commented that, "I would never choose to transport unsecured as mental health patients are unpredictable at best." Another stated categorically, "All transports should be done in restraints" (my italics). As Arrigo & Patch (1999) concluded in their research study of *Police Officer Attitudes and Use of Discretion in Situations Involving the Mentally Ill*, "Clearly, officer attitudes and their use of discretion toward disordered citizens are embedded within the decision making process." (p. 33)

Based on this survey's ranking of 52 officers' responses about the extent to which 22 items factor into their decision on use of mechanical restraints, it is clearly evident that county Sheriffs' individual departmental policies can have a disproportionate influence on deputies' use of restraints, amplifying the impact of Sheriffs' own personal attitudes. "My Sheriff's individual departmental policy" (ranked 4th) outweighed Vermont Statute (ranked 14th), Qualified Mental Health Professional checklist recommendation (ranked 16th) and DMH Commissioner's policy

regarding children (ranked 17th) in influence. In response to these policy questions, (including the one about a statewide sheriff's policy), one respondent simply stated, "I go by Department policy." Another officer viewed the decision to use restraints as a more complex matter, but also felt constrained by his individual Sheriff's departmental policy:

Each DMH transport is different and has to be handled on a case-by-case basis. Sometimes hard restraints are needed and sometimes, soft restraints are the best method. There are times when I feel no restraints are needed but that puts me in violation of policy.

Other officers also thought more independently and were prepared to deviate from their Sheriff's individual departmental policy and defend their actions if needed to prevent harm to the mental health patient on 'involuntary status:'

There have been some circumstances where a partner and myself will not use a restraint due to an injury or some other unusual situation. A policy may not allow discretion but the circumstances call for some discretion. I am prepared to face whatever ramifications that may result when my decision is not consistent with a policy or procedure.

Several officers commented that their discretion was limited to type of restraint, rather than being allowed to decide whether or not to use restraints: "My only discretion is whether to use soft or hard restraints." Another stated, "We have discretion to switch from soft to hard restraints mid-transport if needed."

Intriguingly, some officers did not realize that there was a decision to be made about restraints because they thought it had already been made: "I make the assumption that Mental Health has made a decision that a secure transport is necessary and need to be aware that what I see as an officer may not be reflective of the individual's condition." This confusion may stem from Qualified Mental Health Professionals sometimes making checklist recommendations for "secure transport" because there is no alternative transport available, not because the individual

is dangerous or in need of restraint. (Note: This may explain why only 18% of officers said that the QMHP Checklist factored “a lot” into their decision regarding use of mechanical restraints.)

Proper Use of Sheriffs’ Resources and Function

The research literature has demonstrated that “officers do not believe that involuntary hospitalization is a proper use of their resources and function (Bittner, 1967; Broderick, 1970)” (Patch & Arrigo, 1999, p. 30). For this reason my survey asked if officers thought that transports of individuals on ‘involuntary status’ to inpatient facilities was a proper use of sheriffs’ resources and function. Sheriffs’ and deputies’ beliefs that involuntary transports was *not* a proper use of their resources and function (21%) was highly correlated with their assessment that there was inadequate staffing (21%) to perform this duty. A Pearson correlation was run and there was a significant positive correlation between adequate staffing ($r=.468$, $p=.000$, two-tailed) and the belief that this was a proper function. This suggests that the more officers agree that staffing is adequate to do this, the more they believe it is a proper sheriffs’ function, and the reverse is also true. A Pearson correlation regarding *time* approached significance ($r=.269$, $p=.056$, two-tailed.) This negative correlation suggests that the more officers agree that this type of transport takes too much time the less that they agree that it is a proper use of sheriffs’ resources and function.

Qualitative analysis of officers’ written comments generated an important finding that some and possibly a lot of officers feel strongly that these transports are inherently not a proper use of sheriffs’ resources or function if the transported individual is not dangerous. While 42% of respondents agreed that it was a proper use, almost as many (37%) were undecided, and 21% felt that it was not. One officer stated, “Against a statewide policy because I am against sheriffs doing DMH transports.” Several made comments such as, “If the individual is ‘safe’ enough to

transport without restraints, then there is not a need for law enforcement to be involved in the transport.” Other officers reiterated this view:

If the sheriffs are being utilized for a mental health transport, it is assumed that there is some level of risk or destructive/combatative behavior and restraints WILL be used. If restraints are NOT used, what’s the sense of going through the expense of paying Sheriffs to transport? Might as well call a taxi. Seem like an awful waste of resources, but then again, it’s coming from a “broken” system.

Many officers equated a request for armed sheriffs’ transport with danger and an attendant need for restraints. Ironically, mental health training may be shifting the perspectives of some officers to believe that many individuals on ‘involuntary status’ are not inherently dangerous, thus these transports are not a proper use of sheriffs’ resources and function:

What is the need for armed law enforcement to do a transport if they are not to be secured? If they are unpredictable, pose a risk of flight they should be secure so the ability for escape and fight is limited. Risk of injuries to deputies and people in crisis is reduced by the use of restraints. Risk of escape is reduced by the use of restraints. People in crisis often do not respond to pain or control techniques well. If it comes to having to use restraint techniques the amount of force needed could likely cause serious injury to either party.

One Sheriff told a news reporter in April 2012, “If you call us, it means you’re asking for the most secure kind of transport.’ He said he would prefer that the Department of Mental Health have its own personnel do the transports. ‘When it comes right down to it, we should not be in the mental health business” (Gram, 2012, p. 2). Several deputies who were surveyed voiced frustration about a broken system. One stated, “I feel our mental health system has failed our residents of Vermont in crisis and have left it to Law Enforcement to pick up the pieces,” and another that, “I feel more resources should be focused on the mental health system than Law Enforcement that is basically picking up the pieces of people in crisis.”

This argument that it is not a proper use of sheriffs’ function to involuntarily transport mental health patients who are not dangerous to inpatient facilities would seem to have merit if

an alternative method of transport is available. Ironically, a study by Durham, Carr, and Pierce (1984) using hospital admission records showed that police involvement strongly influenced the success of a referral for involuntary commitment. The researchers' findings were that only 19% of individuals referred without police involvement were successfully committed by gatekeeper hospital staff as compared with 39% of individuals where police were involved in making the referral for civil commitment.

Based on these findings, it is clear that individual officers have incredible power to determine the system to which a mentally ill individual will be routed, as well as authority to influence the extent to which the execution of that decision will be successful. This outcome obtains regardless of police perceptions concerning the appropriateness of their involvement. (Patch & Arrigo, p. 31)

A Catch-22 could exist where, if a parent drives a child in need of psychiatric care to a hospital instead of a sheriff, it might be less likely that the child would be successfully admitted to the facility. The issue of "danger to self or others" cuts both ways if this qualification for getting admitted to a psychiatric hospital is translated by transport officers into an absolute need to use restraints, and suggests that the patient's presentation at transport time should be an important factor in the decision. An alternative means of transport such as one Vermont county's mental health van pilot project could fulfill both requirements as it's staffed by retired deputy sheriffs who transport almost 100% unrestrained. As an experienced officer remarked, "Transporting Mental Health clients is a very challenging duty since they often need secure transports but they are ill and not "deserving" of being shackled and in the custody of armed police."

This study suggests that Vermont is in a transitional stage in the evolution of transport of individuals on 'involuntary status.' Sheriffs' attitudes toward these individuals are changing and alternative transport methods are being piloted with the goal of greatly reducing restraints and trauma for patients transported to psychiatric facilities for care. In its January 15, 2014 report to

the Vermont legislature, DMH directly attributed a marked drop in restraint use since April 2012 to one county's mental health van pilot project as "it responds to the entire northern tier of the state, an area where metal restraints continue to be used by (four county Sheriffs) as a matter of policy" (Vermont DMH, 2014, p. 31). Based on this initial success, DMH is supporting a pilot program in a second Sheriff's county, "using a least-restrictive approach by deputies in plain clothes with an unmarked van. Progression to some type of restraint is utilized only when a no-restraint approach fails" (DMH, 2014, p.28).

While the efficacy and affordability of mental health vans is being tested sheriffs will need to continue to transport individuals on 'involuntary status' to psychiatric facilities for care. Practice evidence has demonstrated that restraints are not necessary in most cases. This study suggests that an effective interim measure might be for Vermont Sheriffs to voluntarily adopt a statewide policy of no restraints (in conformance with existing statute) as their starting point, with the crucial provision that deputies have discretion to utilize restraints if needed for safety. This would provide consistency (i.e. policy) and flexibility (i.e. discretion), acknowledging that mental health patients are not inherently dangerous but every case needs to be handled based on its individual merits.

Any practical discussion of restraint policy and procedures needs to return to the heart of the question of why this issue matters. Officers may not be cognizant that the use of restraints on individuals experiencing mental health crisis can cause lasting psychological harm (especially to patients with trauma histories) and impact their willingness to engage in follow-on outpatient treatment. A blanket policy of using restraints (instead of officer judgment) for these transports to ensure the patient's "physical safety," can have the unintended outcome of harming their already fragile psychological safety. Allen, et al. (2003), found in their research that 54% of

patients said that the experience of being in restraints at any time during a psychiatric crisis had made them unwilling to see subsequent care. Currier, et al. (2011) similarly found that patients who were brought to the emergency department and physically restrained during the course of clinical care had a decreased likelihood of attending follow-up outpatient appointments. Thus it can reasonably be posited that sheriffs' use of restraints for transports of patients on 'involuntary status' can impact how patients are treated at the hospital and contribute to their unwillingness to seek follow-on care. An unintended outcome is that patients might "bounce back" and be more likely to need to be transported again.

Appendices G and H are DMH statistical graphs that show trending in Vermont sheriffs' use of restraints for transports from July 2012 – Jun 2013 and July 2013 – January 2014. An impressive reduction (from 80% restrained to 80% unrestrained) has been achieved since April 2012. Monthly rates of restrained transports have been as low as 3% (in October 2013) and as high as 37% (in December 2013), while still trending down. Rates have varied because of the restraint policies of counties that transported patients, and also the small *n* number whereby a person who legitimately needs restraints skewed the results. Why is it necessary to further reduce the use of restraints? Because if even one individual is unnecessarily put in restraints or metal shackles, it matters. Swanson, Swarz, Elbogen, Van Dorn, Wagner, Moser, Wilder & Gilbert (2008) state,

The common use of law enforcement officers and vehicles to transport psychiatric patients in handcuffs (Dupont & Cochran, 2000; Kaufman 2007), the trappings of criminal arrest and the process of involuntary hospital admission may contribute to patients' traumatic experiences of coercion (Hiday, et al., 1997; Iversen, et al., 2002; Lidz et al., 1998; Monahan et al., 1996)" (p. 256).

They conclude, "Understandably, mental health service providers as well as consumers would seek to avoid these practices whenever possible (p. 256). As one Vermont doctor stated, by

transporting people without restraints “it really sets up the next level of care to start off on a much better footing” (Berard, 2012).

Summary

In summary, the factor that is most responsible for a marked reduction in use of restraints for transports of individuals on ‘involuntary status’ since April 2012 is one Vermont county’s Mental Health Van Pilot Project that transports 99% unrestrained. This mental health van team also conducts transports for several counties that have historically conducted these transports 100% restrained. Mental health trainings, in particular DMH sheriffs trainings on “Building Rapport with People in Mental Health Crisis” and “Safe Transport Strategies” have helped to change attitudes and practices. A multi-agency interdisciplinary “Involuntary Transportation Working Group” as well as intensive DMH review of practices and rationale for restraint use have also reduced use of mechanical restraints. None of these gains could have been achieved without a strong collaborate partnership between mental health and law enforcement that has been developing over several decades.

Study Limitations

A limitation to this study was that six out of 14 Vermont sheriffs (a 43% response rate) participated, one of who completed less than half of the survey. Three other Sheriffs opted out after reading the Informed Consent, and one more was disqualified because he hadn’t conducted an involuntary transport within the last five years. Four Sheriffs did not access the survey at all, possibly due to an erroneous belief that the independent researcher was conducting it on behalf of DMH. The Sheriffs who didn’t participate to have their views considered among their peers’ were from counties with stricter restraint policies. Thus, if everyone had participated, the results

might have been more conservative. Deputy sheriffs were better represented, with respondents from nine out of 14 counties (i.e., 64% of Vermont counties).

As Vermont is a small, liberal, rural state with a mostly white population, this study's results may not be generalizable to other parts of the country with urban areas, more ethnically diverse populations, alternatives to sheriffs' transport, a State Hospital, and shorter transit to psychiatric facilities for care. However, a variety of law enforcement attitudes and practices have been represented in this study that reflect a range of variable responses toward persons experiencing mentally health crisis. Law enforcement personnel in other states have begun inquiring about Vermont's emerging model of humane, unrestrained mental health transport to determine if the model can be replicated in their cities.

Future Areas of Research

The specific focus and scope of this paper precluded study of the related issue of the impact of sheriffs' use of mechanical restraints on individuals who are involuntarily transported, both in terms of physical and psychological trauma, and subsequent willingness to engage in outpatient treatment. It is suggested that this is important follow-up research to fill a gap in the literature that has significant implications for practice.

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APPENDIX A

Letter to Executive Director



December 30, 2013

Bram Kranichfeld, Esq.
Executive Director
Vermont Department of State's Attorneys and Sheriffs' Association
12 Baldwin Street
Montpelier, VT 05633-6401

Dear Mr. Kranichfeld,

My name is Catherine Reed. I'm writing to request your approval to conduct a voluntary and anonymous online survey of Vermont Sheriffs and their Deputies to study factors that have contributed to a marked decrease in restraint use for the transport of individuals on involuntary status to psychiatric facilities since April 2012. This research is to fulfill my Master's degree thesis requirement at Smith College School for Social Work.

This research would allow sheriffs to share law enforcement perspectives about barriers and facilitators to transporting individuals who are on involuntary status without restraints, and to have their views considered among those of their peers. I would provide you with an Executive Summary of my findings at the conclusion of this study.

I have enclosed a paper copy of my survey and Informed Consent for your review. If these meet with your approval, I will e-mail you the survey link and ask that you distribute it through your Sheriffs and Deputy Sheriffs membership e-mail list, to include those individuals who conduct transports for the Lamoille County mental health van pilot project.

I will need to advise Smith College by January 21, 2014 if you have approved my study, in order to proceed with the research. Thank you very much for your time and consideration.

Sincerely,

Catherine Reed

APPENDIX B

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 24, 2014

Catherine Reed

Dear Catherine,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form. □

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D. □ Co-Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor

APPENDIX C

Informed Consent



Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

Title of Study: Contributing Factors to Sheriffs' Decreased Use of Restraints for the Transport of Mentally Ill Individuals on Involuntary Status to Psychiatric Facilities in Vermont

Investigator: Catherine Reed, Smith College School for Social Work, Master's Degree Student, phone number

Dear Potential Research Recipient:

My name is Catherine Reed and I am a master's candidate at Smith College School for Social Work (SSW). I am conducting a study to explore factors that have contributed to a marked decrease in restraint use for the transport of individuals on involuntary status to psychiatric facilities since April 2012. This study is in partial fulfillment of requirements for a Master's degree in Social Work.

You were selected to participate in this study because you are a current, former, or retired Vermont Sheriff or Deputy Sheriff who has conducted transit transports of individuals on involuntary status within the last five years. If you choose to participate, I will ask you to fill out an anonymous online survey. This will include general questions about you and questions about factors that may influence your decision to use restraints. Each section ends with a free-write space to expand on your answers or bring up considerations that I may have overlooked. This survey will take an estimated 30 minutes to complete.

There are no foreseeable risks of being in this study. Your participation will allow you to share valuable knowledge and experience from a law enforcement perspective about barriers and facilitators to conducting involuntary mental health transports without the use of restraints. You will also have the opportunity to have your beliefs, concerns, and recommendations about these transports considered among those of your peer sheriffs. I will provide an Executive Summary of my findings to the Vermont Department of State's Attorneys and Sheriffs so that you may view the aggregated results.

Your confidentiality will be protected consistent with Federal regulations. This online survey is designed to be anonymous and will use Survey Monkey software. As such, no I.P. or e-mail addresses will be captured. I will be the sole person who will have access to the

raw data. All research materials including the survey data, analyses and consent documents will be stored in a secure location for three years, and then destroyed. I will disguise all information given the small number of participants, and no county will be mentioned by name in any publication or presentation. In the event that materials are needed beyond the three-year period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

I have completed the Collaborative Institutional Training Initiative (CITI) online training course prior to Smith College School for Social Work Review Board approval for this study. The certificate of completion is on file at the SSW.

As a voluntary participant, you have the right to withdraw from the study before or during the survey without penalty. Once you have completed the survey online, I will not be able to remove it from the study since I will not be able to identify your survey among the other surveys in my study.

If you have questions about your rights or any aspects of this study, do not hesitate to call me at phone number or the Chair of the Smith College School for Social Work Human Rights Subjects Review Committee at (413) 585-7974.

BY CHECKING THE BOX BELOW AND WRITING THE DATE, YOU INDICATE THAT YOU HAVE VOLUNTEERED TO BE A RESEARCH PARTICIPANT IN THIS STUDY AND THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE.

I agree to participate _____

Date

APPENDIX D

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

WELCOME

THANK YOU FOR YOUR INTEREST IN PARTICIPATING IN MY SURVEY ON VERMONT SHERIFFS' USE OF MECHANICAL RESTRAINTS WHEN CONDUCTING INVOLUNTARY TRANSPORT OF INDIVIDUALS WHO ARE IN MENTAL HEALTH CRISIS AND IN THE CARE AND CUSTODY OF THE VT COMMISSIONER OF MENTAL HEALTH.

Please answer the following screening questions:

*** 1. (1) Are you a Vermont Sheriff or Deputy Sheriff?**

- Sheriff
- Deputy Sheriff
- Neither

SCREENING QUESTION

*** 2. In the last five years have you conducted involuntary transports of individuals who were in mental health crisis and in the care and custody of the VT Commissioner of Mental Health?**

- Yes
- No

INFORMED CONSENT

Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

Title of Study: Contributing Factors to Sheriffs' Decreased Use of Restraints for the Transport of Mentally Ill Individuals on Involuntary Status to Psychiatric Facilities in Vermont

Investigator: Catherine Reed, Smith College School for Social Work, Master's Degree Student, (603) 448-5610

Dear Potential Research Recipient:

My name is Catherine Reed and I am a master's candidate at Smith College School for Social Work (SSW). I am conducting a study to explore factors that have contributed to a marked decrease in restraint use for the transport of individuals on involuntary status to psychiatric facilities since April 2012. This study is in partial fulfillment of requirements for a Master's degree in Social Work.

You were selected to participate in this study because you are a Vermont Sheriff or Deputy Sheriff who has conducted transit transports of individuals on involuntary status within the last five years. If you choose to participate, I will ask you to fill out an anonymous online survey. This will include general questions about you and questions about factors that

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

WELCOME

THANK YOU FOR YOUR INTEREST IN PARTICIPATING IN MY SURVEY ON VERMONT SHERIFFS' USE OF MECHANICAL RESTRAINTS WHEN CONDUCTING INVOLUNTARY TRANSPORT OF INDIVIDUALS WHO ARE IN MENTAL HEALTH CRISIS AND IN THE CARE AND CUSTODY OF THE VT COMMISSIONER OF MENTAL HEALTH.

Please answer the following screening questions:

***1. (1) Are you a Vermont Sheriff or Deputy Sheriff?**

- Sheriff
 Deputy Sheriff
 Neither

SCREENING QUESTION

***2. In the last five years have you conducted involuntary transports of individuals who were in mental health crisis and in the care and custody of the VT Commissioner of Mental Health?**

- Yes
 No

INFORMED CONSENT

Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

Title of Study: Contributing Factors to Sheriffs' Decreased Use of Restraints for the Transport of Mentally Ill Individuals on Involuntary Status to Psychiatric Facilities in Vermont

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Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

may influence your decision to use restraints. Each section ends with a comment space to expand on your answers or bring up considerations that I may have overlooked. This survey will take an estimated 30-45 minutes to complete.

There are no foreseeable risks of being in this study. Your participation will allow you to share valuable knowledge and experience from a law enforcement perspective about barriers and facilitators to conducting involuntary mental health transports without the use of restraints. You will also have the opportunity to have your beliefs, concerns, and recommendations about these transports considered among those of your peer sheriffs. I will provide an executive summary of my findings to the Vermont Sheriffs Association so that you will have the benefit of viewing the group results.

Your confidentiality will be protected consistent with Federal regulations. This online survey is designed to be anonymous and will use Survey Monkey software. As such, no I.P. or e-mail addresses will be captured. I will be the sole person who will have access to the raw data. All research materials including the survey data, analyses and consent documents will be stored in a secure location for three years, and then destroyed. I will disguise all information given the small number of participants, and no county will be mentioned by name in any publication or presentation. In the event that materials are needed beyond the three-year period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

I have completed the Collaborative Institutional Training Initiative (CITI) online training course prior to Smith College School for Social Work Review Board approval for this study. The certificate of completion is on file at the SSW.

As a voluntary participant, you have the right to withdraw from the study before or during the survey without penalty. Once you have completed the survey online, I will not be able to remove it from the study since I will not be able to identify your survey among the other surveys in my study.

If you have questions about your rights or any aspects of this study, do not hesitate to call me at (603) 448-5610 or the Chair of the Smith College School for Social Work Human Rights Subjects Review Committee at (413) 585-7974.

BY CHECKING THE BOX BELOW, YOU INDICATE THAT YOU HAVE VOLUNTEERED TO BE A RESEARCH PARTICIPANT IN THIS STUDY AND THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE.

*3. I agree to participate

- Yes
 No

GENERAL INFORMATION ABOUT YOU:

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

4. What is your age?

- 20-29
- 30-39
- 40-49
- 50-59
- 60 or above

5. What is your gender?

- Female
- Male

6. What is the highest level of education you have completed?

- High School
- Some College
- Bachelor's Degree
- Master's Degree or higher

7. Which race/ethnicity best describes you? (Please choose only one.)

- American Indian or Alaskan Native
- Asian / Pacific Islander
- Black or African American
- Hispanic American
- White / Caucasian
- Other (please specify)

8. How many total years have you been employed in law enforcement?

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 26-30
- 31 or more

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

9. Have you received Vermont Sheriffs' Training by DMH ("Building Rapport with People in Mental Health Crisis" which is primarily taught by Mourning Fox and Kristin Chandler)?

- Yes
 No

10. Have you received Vermont Police Academy Training on "Interacting with People Experiencing a Mental Health Crisis?"

- Yes
 No

11. What Vermont County are you currently employed by?

- | | | |
|----------------------------------|----------------------------------|----------------------------------|
| <input type="radio"/> Addison | <input type="radio"/> Franklin | <input type="radio"/> Rutland |
| <input type="radio"/> Bennington | <input type="radio"/> Grand Isle | <input type="radio"/> Washington |
| <input type="radio"/> Caledonia | <input type="radio"/> Lamoille | <input type="radio"/> Windham |
| <input type="radio"/> Chittenden | <input type="radio"/> Orange | <input type="radio"/> Windsor |
| <input type="radio"/> Essex | <input type="radio"/> Orleans | |

12. How many times in the last 5 years have you performed a transport of an individual who was on "involuntary status" (i.e., in the care and custody of the VT Commissioner of Mental Health)?

- | | | |
|-----------------------------|-----------------------------|-------------------------------|
| <input type="radio"/> None | <input type="radio"/> 21-30 | <input type="radio"/> Over 50 |
| <input type="radio"/> 1-10 | <input type="radio"/> 31-40 | |
| <input type="radio"/> 11-20 | <input type="radio"/> 41-50 | |

13. Have you ever conducted a transport and not known if the individual was on involuntary status?

- Yes
 No

14. Is conducting involuntary transports your primary duty or "as-needed" duty?

- Primary Duty
 As-Needed Duty

15. What percentage of your time do you spend conducting involuntary transports?

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

16. From a departmental perspective, how much time is necessary to build rapport with the individual who is experiencing mental health crisis before conducting a transport?

SECTION A: RESOURCE FACTORS

This survey will focus on five factors that can impact an officer's decision to use mechanical restraints for the involuntary transport of individuals who are experiencing mental health crisis and are in the care and custody of the VT Commissioner of Mental Health. These are: resource-driven factors, officer-centered factors, departmental factors, policy factors, and training factors. Please indicate the extent to which you PERSONALLY agree or disagree with each statement:

17. Involuntary transport of individuals who are in the care and custody of the Vermont Commissioner of Mental Health is a proper use of sheriffs' resources and function.

Strongly Disagree Disagree Neutral Agree Strongly Agree

18. My county sheriff's department is adequately staffed to handle these transports.

Strongly Disagree Disagree Neutral Agree Strongly Agree

19. My county sheriff's department is adequately resourced (i.e., has enough soft restraints and/or vehicles) to handle these transports.

Strongly Disagree Disagree Neutral Agree Strongly Agree

20. As a Transport Deputy, the reason I DON'T use SOFT restraints for these transports is: (Mark all that apply.)

- N/A (I do use soft restraints)
- N/A (I'm not a transport deputy)
- They take too long to put on
- I haven't had training
- My department doesn't have enough soft restraints
- My department has a policy of hard restraints

21. If two officers are available for a transport it is less likely that restraints will be used.

Strongly disagree Disagree Neutral Agree Strongly Agree

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

22. VT DMH financial incentive have reduced the use of restraints by my sheriff's department.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

23. Please add any comments here:



SECTION B: OFFICER-CENTERED FACTORS

24. I would describe my personal officer style as:

- Value social order at the expense of due process of law
 Value order maintenance and due process of law equally
 Value neither due process nor social order, but "go along to get along"
 Value due process of law at the expense of social order

25. Individuals in mental health crisis take up more than their share of sheriff transport time.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

26. I have a responsibility to provide the best possible care when transporting individuals in mental health crisis.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

27. I feel that I am adequately trained to handle transports involving individuals in mental health crisis.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

28. It is frightening to conduct involuntary transports of individuals in mental health crisis, whether or not they are in restraints.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

29. Individuals in mental health crisis are too unpredictable to transport without restraints.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

30. Individuals in mental health crisis are too dangerous to transport without restraints.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

31. I would transport without restraints if I could ensure the individual's and my safety.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

32. Please add any comments here:

SECTION C: DEPARTMENTAL FACTORS

33. My sheriff's department's policy is to routinely use restraints for involuntary transports.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

34. My sheriff's department's policy is to NOT use restraints unless clearly needed for safety.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

35. I CANNOT exercise discretion regarding use of restraints due to my rank/junior status.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

36. I CAN exercise personal discretion regarding use of restraints for involuntary transports.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

37. At times I am required to transport individuals in restraints when I would prefer not to.

- Strongly Disagree Disagree Neutral Agree Strongly Agree

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

38. Please add any comments here:



SECTION D: POLICY FACTORS

39. How familiar are you with Vermont Statute 18 V.S.A. §7511, Chapter 179?

- Very Moderately Slightly Not aware of statute

40. How much does Vermont Statute 18 V.S.A. §7511, Chapter 179 influence your use of restraints?

- Strongly Moderately Slightly No influence Not aware of statute

41. To what extent does the Vermont DMH Commissioner's 2007 policy memo (revised 2011 and 2013), influence your decision to NOT use restraints when transporting children?

- Strongly Moderately Slightly No influence Not aware of policy

42. To what extent would you favor a statewide sheriff's policy regarding use of restraints?

- Strongly favor Slightly favor Neutral Slightly against Strongly against

43. Please add any comments here:



SECTION E: TRAINING FACTORS



Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

44. To what extent has mental health training made you better able to communicate with and deescalate individuals in mental health crisis who you involuntarily transport?

- Greatly Moderately Slightly No influence Have not had training

45. To what extent has mental health training made you prefer soft over hard restraints?

- Greatly Moderately Slightly No influence Have not had training

46. To what extent has mental health training increased your confidence and skill to do involuntary transports of individuals in mental health crisis without any restraints?

- Greatly Moderately Slightly No influence Have not had training

47. To what extent has mental health training changed your view of involuntary transports from "prisoner transport" to "patient transport?"

- Greatly Moderately Slightly No influence Have not had training

48. Please add any comments here:



SECTION F:



Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

49. How much does each item factor into your decision regarding use of mechanical restraints?

	A lot	Some	None	Don't Know
A. Vermont Basic Academy Training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. VT Act 80 Basic Awareness Training ("Interacting With People Experiencing Mental Health Crisis")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. VT Sheriffs Training ("Building Rapport With People in Mental Health Crisis")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Vermont Statute §7511 18 V.S.A. regarding "Least Restrictive Means"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Vermont DMH Commissioner Policy Letter regarding Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. My County Sheriffs Individual Departmental Policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Qualified Mental Health Professional (QMHP) Checklist Recommendation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Safety of the Officer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Safety of the Transported Individual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
J. History of Prior Transport of the Individual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
K. Presentation of the Individual at Initial Encounter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
L. Presentation of the Individual at Transport Time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
M. Individual's Stated Preference regarding Restraint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
N. Reduced Physical/Psychological Trauma for Individual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
O. Age of the Transported Individual (child or elderly)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P. Gender of the Transported Individual (female)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vermont Sheriffs Use of Restraints to Transport Individuals on Involuntary

Q. Number of Officers Available for Transport	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
R. Vermont DMH Financial Incentive for Reduced Use of Restraints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
S. Empathy for the Individual in Mental Health Crisis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
T. Liability Concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
U. Negative Press Coverage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
V. Vermont DMH Statistics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

APPENDIX E



State of Vermont
Department of Mental Health
Office of the Commissioner
Redstone Building
26 Terrace St
Montpelier, VT 05609-1101
www.mentalhealth.vermont.gov

Agency of Human Service

phone 802-828-3824
fax 802-828-3823
tty 800-253-0191

MEMORANDUM

TO: Department of Mental Health (Adult and Children's Units), Designated Agencies (All Divisions), GMPCC Admissions Office

FROM: Paul Dupre, Commissioner

DATE: October 18, 2013

SUBJECT: Involuntary Transport of Children Under the Age of 10

.....

As originally described Commissioners' memos regarding Title 18, §7511, Humane Transport (Hartmann, 12/6/2007 & Oliver, 3/17/2011) the Department of Mental Health (DMH) continues to assess and cultivate a culture trauma-informed, involuntary transport. This memo is intended to address involuntary transport of children under the age of ten (10) and clarify questions from the field since Tropical Storm Irene and the Involuntary Transport Work Group of 2012.

This memo continues the expectation established by Commissioner Hartman (12/6/07) that all designated agency, involuntary transports of children aged ten (10) and younger to be done, *whenever possible* by parents, guardians, ambulance, mental health transport staff in safe vehicles or specially designated sheriff alternative vans in plain clothes.

It remains true that when a child under the age of ten (10), in the care and custody of the Commissioner of Mental Health (Involuntary Status) is transported by sheriffs and it is *proposed* that this child will be transported in metal handcuffs, The Commissioner of Mental Health or designee is to be reached via GMPCC admissions, 24 hours a day at 802-888-6770. The usual and customary paperwork (transport checklist) is to be completed and faxed to DMH Quality Management at 802-828-3823, where any further review will occur.

In summary:

- Children on involuntary status CAN be transported by any *safe* alternative (see above).
- If metal handcuffs are proposed to be used on a child <10 years of age call, commissioner or designee via 888-6770 24/7

Thank you for your continued support in this effort. It is unique to Vermont and something of which we can be proud.

APPENDIX F

TRANSPORT INFORMATION CHECKLIST
FOR PERSONS ON INVOLUNTARY STATUS

Name of individual transported _____ DOB _____
Designated Agency _____ Name of QMHP: _____
Address Transported from: _____ Address Transported to: _____
Time and Date of LAST Assessment: _____ Time and Date of Transport _____

Pursuant to 18 V.S.A. §7511, secure transport and escort shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. Secure transport shall only be used when an individual poses a risk of harm to self or others and a less restrictive alternative is clinically contraindicated.

Observation period prior to transportation decision may be used but should NEVER delay transport. Individual and/or family preference will be considered and accommodated, if possible, for mode of transport.

Considerations in Determining Mode of Transportation:

(Additional space below for elaboration, if needed.)

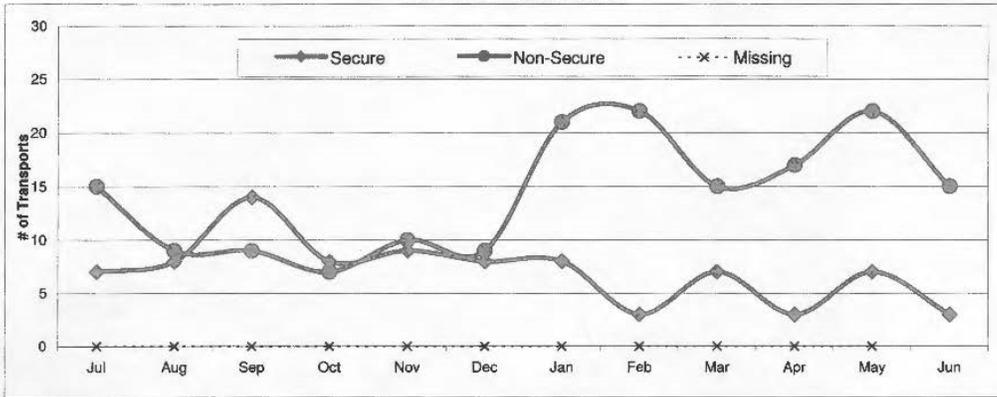
1. What is the client's history of transport behavior? cooperative unwilling triggering unknown?
2. Have the client's friends/family been consulted regarding transportation options? No Yes
3. Has the client been consulted regarding transportation options? No Yes
4. Is the client able to regulate his or her behavior? No Yes client approachable to discuss options? No Yes
5. Any adverse events in last 24 hours of which transporters ought to be aware? No Yes
6. Does client's mood seem stable and sustainable for the length of transport ordered? No Yes
7. If client was given PRN medication in the ED, have you discussed whether medical monitoring via ambulance would be necessary? No Yes

Other supporting reasons for mode of transport provided, OR please reference from above

Signatures REQUIRED on back: OVER▶

APPENDIX G

**Involuntary Transports: Adults and Youth
Jul 2012 - Jun 2013**



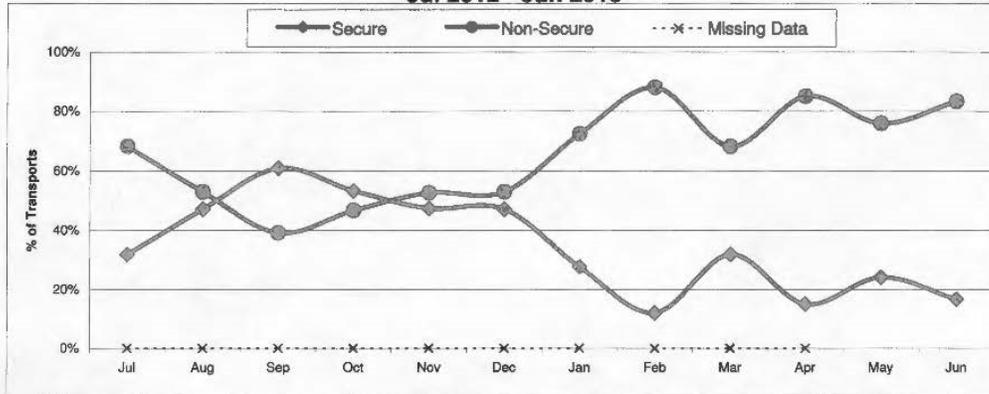
Type of Transport	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Secure	7	8	14	8	9	8	8	3	7	3	7	3
Non-Secure	15	9	9	7	10	9	21	22	15	17	22	15
Missing	0	0	0	0	0	0	0	0	0	0	0	0
Total	22	17	23	15	19	17	29	25	22	20	29	18

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Secure transports involve the use of soft or metal restraints and non-secure transports are unrestrained.

For more information, contact Cindy Chornyak at 802-828-1709 or cindy.chornyak@state.vt.us.

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Involuntary Transports: Adults and Youth Jul 2012 - Jun 2013



Type of Transport	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Secure	32%	47%	61%	53%	47%	47%	28%	12%	32%	15%	24%	17%
Non-Secure	68%	53%	39%	47%	53%	53%	72%	88%	68%	85%	76%	83%
Missing	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total Transports	22	17	23	15	19	17	29	25	22	20	29	18

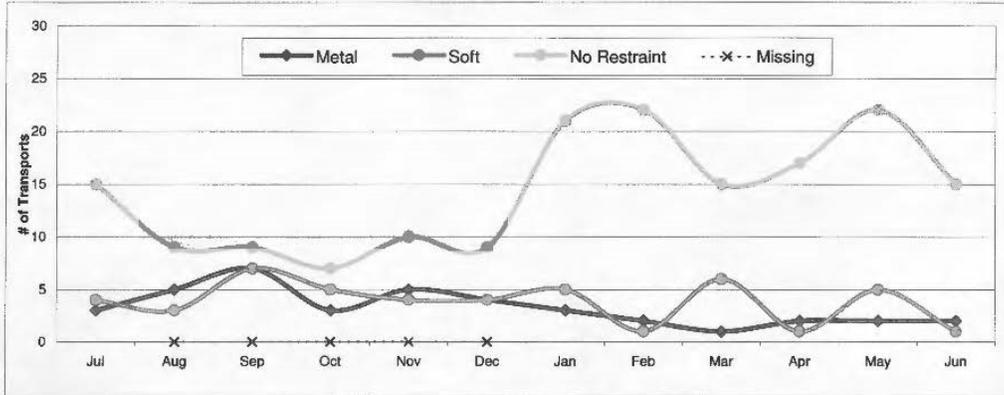
Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.

Based on the Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Secure transports involve the use of soft or metal restraints and non-secure transports are unrestrained.

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**Involuntary Transports by Restraint Type: Adults and Youth
Jul 2012 - Jun 2013**



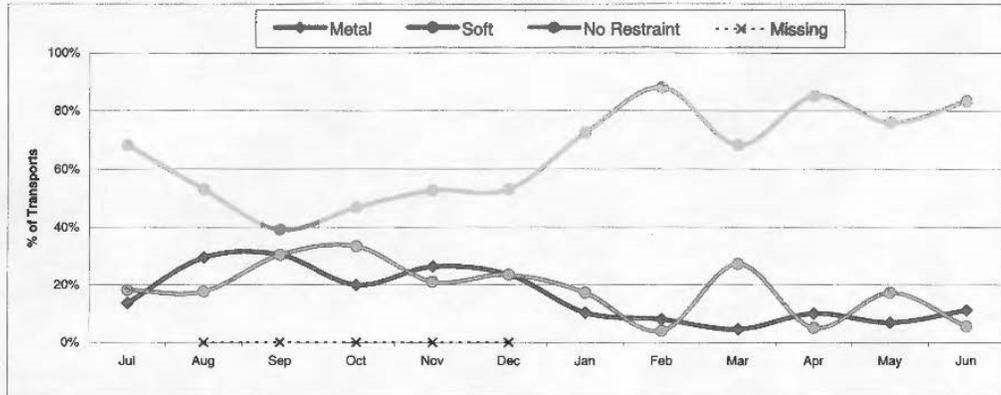
Type of Restraint	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Metal	3	5	7	3	5	4	3	2	1	2	2	2
Soft	4	3	7	5	4	4	5	1	6	1	5	1
No Restraint	15	9	9	7	10	9	21	22	15	17	22	15
Missing	0	0	0	0	0	0	0	0	0	0	0	0
Total	22	17	23	15	19	17	29	25	22	20	29	18

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Secure transports involve the use of soft or metal restraints and non-secure transports are unrestrained.

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Involuntary Transports: Adults and Youth Jul 2012 - Jun 2013



Type of Restraint	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Metal	14%	29%	30%	20%	26%	24%	10%	8%	5%	10%	7%	11%
Soft	18%	18%	30%	33%	21%	24%	17%	4%	27%	5%	17%	6%
No Restraint	68%	53%	39%	47%	53%	53%	72%	88%	68%	85%	76%	83%
Missing	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total Transports	22	17	23	15	19	17	29	25	22	20	29	18

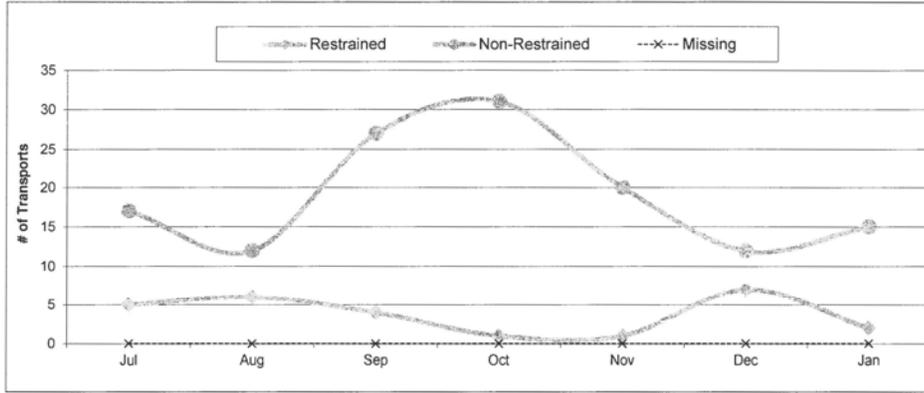
Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
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APPENDIX H

**Involuntary Transports: Adults and Youth
Jul 13 - Jan 14**

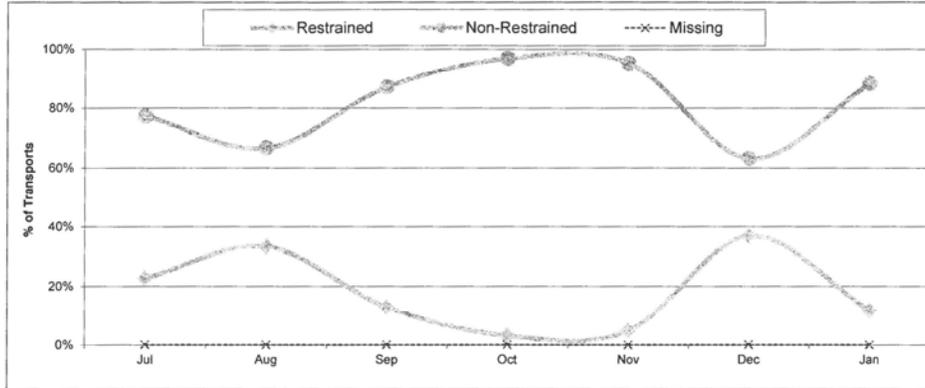


Type of Transport	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Restrained	5	6	4	1	1	7	2	26
Non-Restrained	17	12	27	31	20	12	15	134
Missing	0	0	0	0	0	0	0	0
Total Transports	22	18	31	32	21	19	17	160

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Restrained transports involve the use of soft or metal restraints and non-restrained transports an unrestrained.

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Involuntary Transports: Adults and Youth Jul 13 - Jan 14

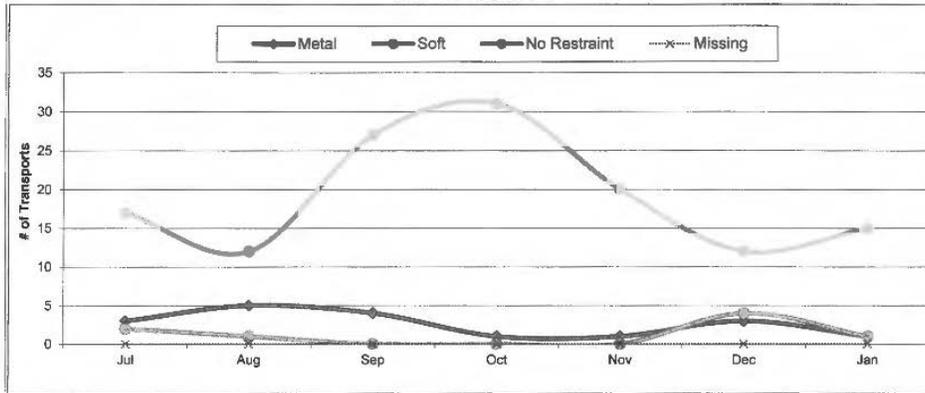


Type of Transport	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Restrained	23%	33%	13%	3%	5%	37%	12%	16%
Non-Restrained	77%	67%	87%	97%	95%	63%	88%	84%
Missing	0%	0%	0%	0%	0%	0%	0%	0%
Total Transports	22	18	31	32	21	19	17	160

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Restrained transports involve the use of soft or metal restraints and non-restrained transports are unrestrained.

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**Involuntary Transports by Restraint Type: Adults and Youth
Jul 13 - Jan 14**

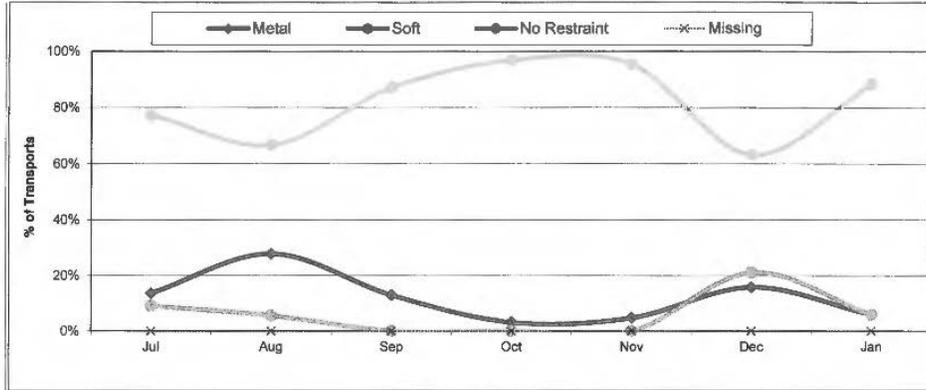


Type of Restraint	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Metal	3	5	4	1	1	3	1	18
Soft	2	1	0	0	0	4	1	8
No Restraint	17	12	27	31	20	12	15	134
Missing	0	0	0	0	0	0	0	0
Total Transports	22	18	31	32	21	19	17	160

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Restrained transports involve the use of soft or metal restraints and non-restrained transports are unrestrained.

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Involuntary Transports by Restraint Type: Adults and Youth Jul 13 - Jan 14

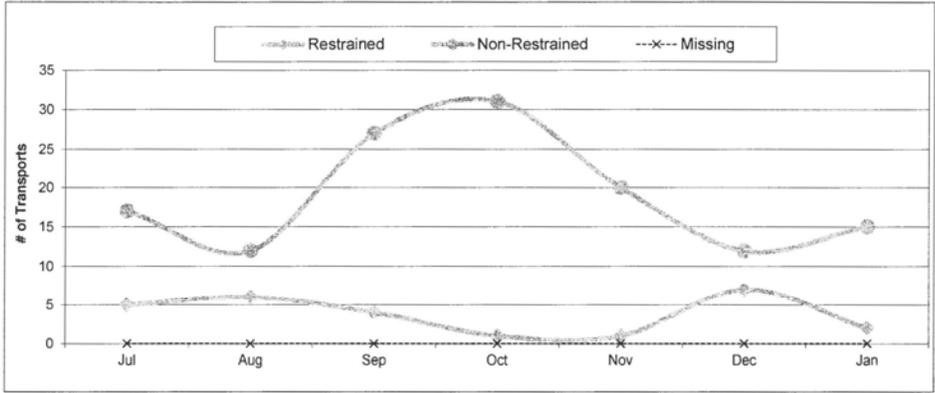


Type of Restraint	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Metal	14%	28%	13%	3%	5%	16%	6%	11%
Soft	9%	6%	0%	0%	0%	21%	6%	5%
No Restraint	77%	67%	87%	97%	95%	63%	88%	84%
Missing	0%	0%	0%	0%	0%	0%	0%	0%
Total Transports	22	18	31	32	21	19	17	160

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
 Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Restrained transports involve the use of soft or metal restraints and non-restrained transports are unrestrained.

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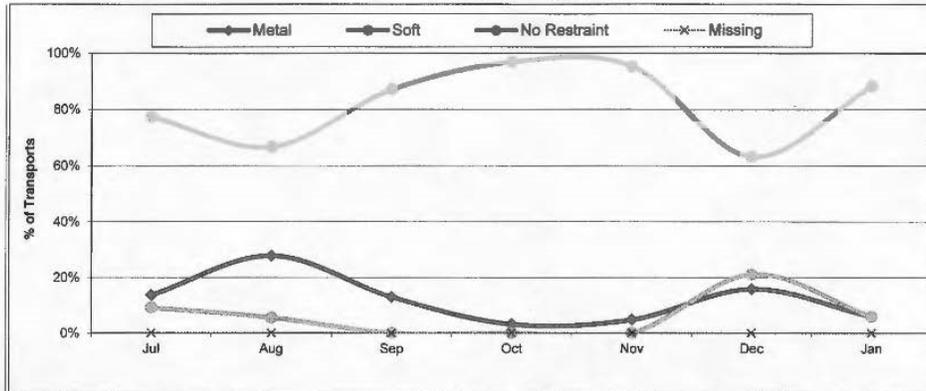
Involuntary Transports: Adults and Youth Jul 13 - Jan 14



Type of Transport	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Restrained	5	6	4	1	1	7	2	26
Non-Restrained	17	12	27	31	20	12	15	134
Missing	0	0	0	0	0	0	0	0
Total Transports	22	18	31	32	21	19	17	160

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner. Restrained transports involve the use of soft or metal restraints and non-restrained transports are unrestrained.

Involuntary Transports by Restraint Type: Adults and Youth Jul 13 - Jan 14



Type of Restraint	Month of Transport							Total
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Metal	14%	28%	13%	3%	5%	16%	6%	11%
Soft	9%	6%	0%	0%	0%	21%	6%	5%
No Restraint	77%	67%	87%	97%	95%	63%	88%	84%
Missing	0%	0%	0%	0%	0%	0%	0%	0%
Total Transports	22	18	31	32	21	19	17	160

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