Recommendations for Law Enforcement Response to Individuals with Mental Illness

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Recommendations for Law Enforcement Response to Individuals with Mental Illness

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Abstract

Purpose

The police are the first step in and the most visible part of the criminal justice system. The decisions that are made in the street on calls for service can have a long and lasting impact on the people they contact. This is especially true when they are dealing with mentally ill subjects. In the 1950s and 1960s the changing laws pushed the mentally ill out of state-run hospitals and back into communities, but there was inadequate treatment available. This has led to an increase in the number of contacts the mentally ill have with law enforcement. When inadequately trained officers are placed in these situations, there can be negative outcomes. The behavior of people experiencing a mental health crisis is often unpredictable and can lead to the unnecessary use of force and incarceration. However, there have been promising advances in training and police programs that can limit these negative interactions. The purpose of this paper is the provide recommendations for how law enforcement can best respond to calls involving individuals experiencing a mental health event.

Methods

The method of approach for this paper was the collection and review of secondary research and statistics. There was a review of scholarly articles, textbooks, police agency policies, and other formal reports from government and police research institutions. A review of law enforcement standards for mental health training in police academies, along with a review of the effectiveness of such training was also conducted. There was also an examination of the Memphis, Tennessee CIT program which was the first of its kind to coordinate the response to mental health issues with the police department, city government, local universities, and the mental health communities (James & Gilliland, 2013). This research was analyzed to support the

assertion that additional training and program implementation will ultimately provide for better police services for the mentally ill.

Key Findings

As calls for service with the mentally ill continue to increase, implementing appropriate mental health programs and training is an important action item for any police administrator. Officers who are trained in programs such as Crisis Intervention Teams (CIT) have shown the ability to divert the mentally ill to treatment facilities in lieu of incarceration. Well-trained officers have also shown improved de-escalation skills and a decreased use of force when compared to untrained officers. Police utilization of training and technology in their mental health response has also shown an ability to decrease labor costs. Research shows that successful implementation of these programs depends on several items, the most important of which is the ability to build partnerships with the various mental health stakeholders in the community. Utilizing officers who have an interest in and volunteer for the mental health training has also been shown to benefit these programs. Additionally, ensuring the training of police communications employees is important because they are the first point of contact for most people in need of police services, and they can set the tone of the officer's encounter with a mentally ill subject.

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SECTION 1: INTRODUCTION

STATEMENT OF THE PROBLEM

According to the National Institute of Mental Health (NIMH), a mental illness is defined as a mental, behavioral, or emotional disorder that occurred within the last year and lasting long enough to meet the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) but does not include developmental or substance abuse issues (National Institute of Mental Health, 2019). NIMH further states that, as of 2017, 20% of American adults (46.6 million) had a mental illness while 11.2 million had what was defined as a serious mental illness meaning there was serious functional impairment (National Institute of Mental Health website, 2019). This has led to a steady increase in contacts with people having mental illnesses over the past few decades (Major County Sheriffs of America [MCSA], 2019; Steadman, Cocozza, & Veysey, 1999). Research has generally shown that 7% to 10% of all police contacts involve a person with a mental illness (Lord & Bjerregaard, 2014). Estimates indicate that up to 20% of police time is spent responding to incidents involving people with mental illnesses (McTackett & Thomas, 2017).

One cause of this is the deinstitutionalization of psychiatric hospitals which has led to more people with mental illness present in public (Roberg, Novak, Cordner, & Smith, 2015). In 1955 there were 559,000 patients in state mental health hospitals in the United States, but by 2016, that number had fallen to 37,679 while the national population nearly doubled (Lamb & Weinberger, 2017). Patients who had previously been institutionalized are now living in communities where they can seek their treatment on an outpatient basis (Engel & Silver, 2001). Unfortunately, not everyone seeks treatment and if they do, the treatment may be inadequate

which means many of these people with mental health issues end up re-institutionalized in prisons and jails (Perez, Leifman, & Estrada, 2003).

When a person experiences a mental health crisis, the police are frequently the first to respond. This is because many of these situations involve inherent dangers to the person in crisis or the public in general. Additionally, although they are not mental health professionals, the police are available 24 hours per day and are expected to address these crises and determine whether mental health treatment or arrest is the best course of action. The officer essentially becomes a "street corner psychologist" who is responsible for determining whether the criminal justice system or the mental health system is more appropriate for the individual (Lamb, Weinberger, & DeCuir, 2002, p. 1266). Although it was never the intent, a combination of inadequate mental health services and improperly funded community programs has led to an increased burden on the police who often have little or no training to deal with the mentally ill (Cummings & Edmondson, 2016).

When the police arrive on scene, their training and experience will have a significant impact on the outcome of the incident. Officers are generally well trained to get emergency situations under control with an arrest because it is usually the most efficient way to deal with the problem (Lurigio, Smith, & Harris, 2008). Further, these contacts can result in the use of force up to and including deadly force. This is likely because the behavior of mentally ill subjects is often unusual or even aggressive which can be interpreted by officers as hostile or resistive leading to the use of force (Morabito et al., 2012). Studies also suggest that people with mental illnesses are disproportionately involved in police shootings and represent 25% or more of the fatalities (Bennett, 2017). While these use of force incidents may have been legally

justified, that does not change the fact that some likely could have been handled in a less-than-lethal manner.

PURPOSE OF THE RESEARCH

The purpose of this research is to provide recommendations for how law enforcement can best respond to calls involving individuals experiencing a mental health event. Being able to more efficiently and effectively address these issues could lessen the use of force, including deadly force, which is the goal of every law enforcement agency, officer, and administrator.

As police contacts with people experiencing mental health crises are sure to continue, it is important that officers are provided with additional training to help address the issue. Research suggests that implementation of Crisis Intervention Team (CIT) training is one way to improve the response to calls for service involving mental health patients by improving the attitudes, knowledge, and overall confidence of officers in these situations (Arey, Wilder, Normore, Iannazzo, & Javidi, 2016). This type of training has also shown success in de-escalating situations involving people with mental illnesses (Compton et al., 2011; MCSA, 2019), reducing the use of deadly force (Vickers, 2000), and reducing the number of people with mental illnesses in jail (Hanafi, Bahora, Demir, & Compton, 2008). CIT trained officers have also been shown to be more skilled at selecting non-punitive options when dealing with mental health patients which will hopefully reverse the trend of sending these subjects to jails and prisons (Wood & Watson, 2017). These are all significant accomplishments given the unpredictability of this type of police interaction.

In addition to the implementation of CIT programs, there are other innovative methods that police departments are utilizing to deal with calls involving mental health issues. Some agencies are teaming up with social workers during field work or as hired consultants to assist

officers (Dean, Lamb, & Proctor, 2000). Other agencies are using technology to help. Harris County, Texas is using computers and tablets to coordinate video chat telepsychiatry from the scene of incidents (Police Executive Research Forum [PERF], 2018) while officers in Minnesota are utilizing the Vitals™ phone application to help improve relations during contacts with people who have mental health, behavioral, and developmental disorders (Autism Society of Minnesota, 2016).

Several states have also recognized the need for additional police training in the area of crisis intervention. For instance, the state of Washington passed the Douglas M. Ostling Act in 2015 which requires a minimum of eight hours of crisis intervention training in their state police academy and two hours of inservice training for every officer each year ("Crisis Intervention Training Bill," 2015). A similar law passed in Minnesota in 2018 requires 16 hours of continuing education credit in mental health training for every officer during their licensing period (Minnesota Board of Peace Officer Standards and Training [Minnesota POST], n.d.). These states have recognized the need to have officers who are confident and competent when dealing with people experiencing a mental health crisis.

SIGNIFICANCE OF THE STUDY

Police generally do a good job of dealing with various forms of crises because they are common occurrences in their daily operations. Additionally, officers generally have substantial training in how to respond to these types of situations. However, police training in the area of crisis intervention involving people with mental illnesses has been lacking even though this is an area responsible for a significant portion of police calls for service. While there have been advances in this area in recent years, there is still room for improvement. The significance of this research is to provide law enforcement administrators with recommendations for improved

tactics, programs, policies, and additional training that can enhance their response to citizens who have mental health crises. Doing so has the potential to improve public relations with a currently marginalized group, reduce unnecessary uses of force, and to redirect mental health patients away from the criminal justice system when appropriate.

METHODS

The method of approach for this paper is the collection and review of secondary research and statistics. There will be a review of scholarly articles, textbooks, police agency policies, and other formal reports from government and police research institutions. A review of law enforcement standards for mental health training in police academies, along with a review of the effectiveness of such training will also be conducted. There will also be an examination of the Memphis, Tennessee CIT program which was the first of its kind to coordinate the response to mental health issues with the police department, city government, local universities, and the mental health communities (James & Gilliland, 2013). This research will be analyzed to support the assertion that additional training and program implementation will ultimately provide for better police services for the mentally ill.

LIMITATIONS

Dealing with the mentally ill is frequently unpredictable. As with any law enforcement call for service, the success of the outcome is largely dependent upon the circumstances of that call along with the training and experience of the officer(s) assigned. Because these circumstances vary so greatly during police calls for service, comparing successes and failures is difficult for researchers. Additionally, the studies reviewed generally have limited samples from a limited geographic region. This can make generalizing any findings problematic. Readers should understand that there is no simple solution that will be effective in every police encounter

with a mentally ill subject. The suggestions offered in this paper are based upon the research reviewed and are recommendations to improve the current situation of law enforcement response dealing with individuals experiencing a mental health event.

SECTION II: LITERATURE REVIEW

The following review is broken down into five sections. The first section will cover the history of mental health hospitals. The next section will discuss the process of deinstitutionalization of the mentally ill. This will be followed by a discussion of the significant court cases that deal with the rights of the mentally ill and a review of the civil commitment process. The final portion will cover some of the significant consequences of deinstitutionalization policies such as homelessness, increased police contacts, increased police use of force against the mentally ill, and reinstitutionalization of the mentally ill in jails and prisons.

HISTORY OF MENTAL HEALTH HOSPITALS

Since our nation was founded, we have been trying to find the most appropriate place to house individuals who are suffering from mental illness. Jails and prisons were the solution for many years prior to the creation of psychiatric hospitals (Boatwright, 2019). It is estimated that 20% of the jail and prison population in the late 1700s and early 1800s had a severe mental illness (Boatwright, 2019). This problem was at least temporarily solved with the implementation of psychiatric hospitals.

The first publicly funded psychiatric hospital opened in Massachusetts in 1833 after Reverend Louis Dwight was delivering bibles in jails and observed how poorly the mentally ill were treated (Boatwright, 2019). He was able to recognize that these institutions were not the

best location for the mentally ill and he lobbied for better treatment. As support grew, more psychiatric hospitals were built.

These state-run psychiatric hospitals provided several benefits over jails and prisons for people with mental illness. They provided medications, treatments, and therapy, along with work and vocational training (Yohanna, 2013). State hospitals often provided work for the residents and they often produced goods that could be used at the facility. This provided a sense of normalcy for many of the residents. Unfortunately, this service was eventually taken advantage of by businesses that saw a chance to make a profit by selling goods to the hospitals which ultimately meant there was less work for the residents and more idle time (Yohanna, 2013).

By the mid-1900s there were almost 350 state psychiatric hospitals with nearly 560,000 patients (Boatwright, 2019). At the peak in 1955 there were 339 psychiatric beds per 100,000 people in the U.S. (Lamb & Weinberger, 2005). Unfortunately, as they continued to take in more patients, the quality of care decreased and the cost to run them rose to a point where they were no longer efficient (Boatwright, 2019). After World War II Albert Deutsch authored an exposé showing the public the overcrowded and often horrible conditions of these hospitals (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2008). This was part of the impetus for what became the deinstitutionalization of the mentally ill.

DEINSTITUTIONALIZATION OF THE MENTALLY ILL

Deinstitutionalization is the name given to the movement where the severely mentally ill were transitioned from state hospitals back into the community for outpatient treatment (Boatwright, 2019). Yohanna (2013) says that there were three reasons for deinstitutionalization: a belief that mental hospitals were cruel and inhumane, the hope and belief that new

antipsychotic medications would provide a cure for many, and the desire to save money. Unfortunately, community-based care has not shown the ability to provide the desired improvements for any of these three issues.

One factor contributing to the deinstitutionalization movement was the wide implementation of the drug chlorpromazine, commonly known as Thorazine, which was the first effective antipsychotic drug used to treat serious mental illnesses (Torrey et al., 2008). The success of this drug in treating disorders such as schizophrenia meant that doctors were able to treat patients in their own communities on an outpatient basis even though they had previously required hospitalization. Advocates for the mentally ill encouraged and supported this plan. Unfortunately, some states simply saw closing the psychiatric hospitals as a way to save money. Instead of spending the savings on improving community-based outpatient treatment, many states left an already marginalized group without adequate services (Perez et al., 2003). Community-based treatment was supposed to be the alternative to hospitalization so that people with serious mental illnesses could live in public, but financing for this goal was scarce and mental health treatment was not a high priority in many areas (Lamb & Weinberger, 2017).

The deinstitutionalization movement was accepted by the federal government, and in 1963, President Kennedy signed the Community Mental Health Centers Act. This Act authorized $3 billion to support the movement and to create community-based mental health treatment to replace the very expensive and failing state hospitals (Boatwright, 2019). Unfortunately, President Kennedy was assassinated before this money could be appropriated, and Vietnam War distracted the country from the issue (Boatwright, 2019). What had been a potential breakthrough for community-based mental health treatment unfortunately ended up being abandoned.

Oddly enough, the deinstitutionalization movement gained bipartisan support. Although the reasons for their support could not have been more different, fiscal conservatives and liberal civil rights supporters both wanted the hospitals shut down (Torrey et al., 2008). The conservatives saw an opportunity to save money while the civil rights supporters were lobbying for people who they felt were being unnecessarily confined in these institutions. Regrettably, the money saved was never effectively utilized to provide the necessary community mental health treatment for those that needed it.

SIGNIFICANT COURT CASES

Several court cases also contributed to the deinstitutionalization movement. One such case was the 1966 federal court decision of *Lake v. Cameron*. This was the first federal case that limited the ability of states to civilly commit mental health patients. Prior to this time, mental health hospitals had very little judicial oversight, and the patients who had been involuntarily committed had very little recourse as attorneys and advocates were not often involved in decisions to release or retain patients (Perlin, Gould, & Dorfman, 1995). However, the Civil Rights Era began to change that. In this case, the court determined that states had to use the least restrictive means necessary to treat the mentally ill (Wilk, 1988). This meant that mental health patients had to be released from the hospital if there was a possibility to do so (Yohanna, 2013).

The 1972 case of *Lessard v. Schmidt* was a federal district case out of Wisconsin which further constricted the ability of the states to utilize an involuntary civil commitment. This was a class action suit on behalf of all adults being involuntarily committed under Wisconsin law. The case challenged the statute allowing civil commitments because the plaintiffs argued it failed to adequately describe the standard for commitment (Perlin et al., 1995). The court concluded that the right to freedom is fundamental and therefore, people suffering from mental illness but have

not committed a crime cannot be deprived of their freedom if there is a less drastic way to do so

(Perlin, 2003). The *Lessard* court further put the burden of showing that involuntary

hospitalization was necessary on the entity that was recommending it. In doing so, they were

required to show what other alternatives were available, which alternatives they had investigated,

and why those alternatives were not viable (Perlin, 2003). This clearly made involuntary

commitments more difficult to obtain.

In the 1972 Alabama Federal District court case of *Wyatt v. Stickney*, the court

determined that most people did not need long-term institutionalization because treatment, which

was identified as a constitutional right, would be successful (Perez et al., 2003). Judge Frank

Johnson wrote that the due process clause of the Constitution was being violated because citizens

were being deprived of their rights by being confined for therapeutic reasons, but they were still

being denied adequate treatment ("Right to treatment," 2017). The court recognized that the

cause of the inadequate treatment was a lack of adequate operating funds, but they determined

this was still not acceptable (Boatwright, 2019). This case also concluded that the state held a

responsibility to provide community-based treatment to those individuals who were identified as

being able to be treated in such a manner (Perez et al., 2003). The goal of this decision was to

reintegrate these subjects into the community they were from so they could continue to live their

lives as normally as possible.

This case developed what became known as the Wyatt Standards. The three standards

spelled out the requirements for treatment programs in public mental health hospitals. They said

that there had to be a humane environment, an adequate number of staff who were qualified to

provide treatment, and individualized treatment plans (Boatwright, 2019). Because many state

run hospitals were unable to fulfill these obligations, many patients were simply released (Boatwright, 2019).

The 1975 U.S. Supreme Court decision in *O'Connor v. Donaldson* further defined exactly what is needed for an involuntary commitment. The court said that finding someone has a mental illness is not an adequate reason to confine them against their will absent some other information (Boatwright, 2019). The court also concluded that involuntary commitment is not permitted if the person is not a danger and is capable of living on his own or with the help of family or friends (Perlin et al., 1995). As the years progressed, the courts continued to provide more rights to the mentally ill and make it more difficult to hold mentally ill patients against their will.

In 1999 the U.S. Supreme Court decision in the case of *Olmstead v. L.C.* further broadened the rights of the mentally ill. The opinion in this case determined that mental illness was a disability which was covered under the Americans with Disabilities Act (Yohanna, 2013). This had significant implications because it meant that all government agencies, not just the state-run hospitals, had to make reasonable accommodations to move the mentally ill out of the institutions and into community-based treatment (Yohanna, 2013).

THE CIVIL COMMITMENT PROCESS

As can be seen above, the courts gave mental health patients significantly more rights over the years. This made the process much more difficult for officers to force people into treatment when they thought it was necessary. The same disorders that create issues with a mentally ill person's thoughts and functioning can also impair their ability to rationally think which can lead to a refusal to accept mental health treatment (Testa & West, 2010). This is an

unfortunate circumstance because hospitalization is frequently a critical first step in a patient receiving necessary psychiatric care (Testa & West, 2010).

The current standard for a court to grant a civil commitment is quite difficult to reach. A person cannot be committed against his or her will unless they are diagnosed as having a mental illness, there must be a strong likelihood of physical harm to that person or someone else, and there must not be any other less restrictive means to provide treatment to that person (National Alliance on Mental Illness Minnesota [NAMI Minnesota], 2016). Testa and West (2010) argue that this standard was well intentioned, but problematic. They argue that access to psychiatric care is limited for patients who would significantly benefit from it but are not considered dangerous and therefore cannot be forced into treatment. This can also lead to situations where family members can do nothing but watch their loved ones suffer through mental illnesses until they become a danger. These patients who refuse treatment are frequently the ones who will eventually have contacts with the police.

CONSEQUENCES OF DEINSTITUTIONALIZATION

The closure of state-run hospitals resulted in far fewer psychiatric beds available for the mentally ill. As the psychiatric hospitals closed, this led to an increase in the number of people with mental illness in communities. Despite the best intentions for releasing these patients, the community-based treatment was inadequate, and problems ensued. Homelessness and police contacts increased because there were more mentally ill people in public creating disturbances. Additionally, these increased contacts with the police, combined with the frequently unpredictable behaviors of people who are often a danger to themselves or others when not properly medicated, had led to increased police use of force. Severely mentally ill patients who have been deinstitutionalized frequently have difficulty adjusting to living in the community and

end up requiring acute hospitalization (Lamb & Weinberger, 2005). Because there are fewer beds available, this leads to a situation where patients either need to be quickly discharged before they are fully stabilized, or they are turned away altogether (Lamb & Weinberger, 2005). Both situations are far less than ideal because of the long-term implications this lack of treatment may have on the individual. The final option left for law enforcement is to incarcerate the mentally ill for a law violation despite sometimes knowing that this is not the best option for the patient. These are often minor offenses where the mentally ill are incarcerated for a period of time that is insufficient to administer any worthy treatment for what is often a chronic issue (PERF, 2018). This can initiate a cycle of incarceration.

HOMELESSNESS

One of the unanticipated impacts of deinstitutionalization was an increase in homelessness. Limited community treatment options meant many of the mentally ill subjects without family support were unable to secure housing upon release. Studies have shown that approximately one third of homeless people meet the diagnostic criteria for a major mental illness, and this will frequently place them in a position where they will be exposed to more police contact (Markowitz, 2006).

A study conducted in San Francisco, California showed that approximately 35% of their homeless population suffers from some sort of mental illness (Sparks, 2018). When symptomatic, the behavior of these mentally ill subjects is often very visible and potentially disruptive which will frequently lead to increased attention from the police who often receive calls for service to address quality of life issues (Sparks, 2018). This increased enforcement can lead to more mentally ill subjects going to jails and prisons.

Although they are more likely to be participants in crime, it is important to note these homeless mentally ill subjects are also more likely to become victims of crime because they tend to be easier targets (Markowitz, 2006). A review of six studies on this topic revealed that the victimization of the homeless, especially women, is substantially higher than for housed individuals (Roy, Crocker, Nicholls, Latimer, & Ayllon, 2014). This is another unfortunate side effect of deinstitutionalization without providing adequate community services.

INCREASED POLICE CONTACTS

As more mentally ill subjects have been released back into their communities, they have had more contacts with the police (MCSA, 2019; Steadman et al., 1999). According to Cordner (2006), a three-city study found that 92% of officers had at least one contact with a mentally ill person in the previous month and that officers averaged 6 such contacts per month. McTackett and Thomas (2017) cite a study that says police contacts with the mentally ill increased nearly 228% following deinstitutionalization. Included in this problem is an increased number of mentally ill subjects who are no longer receiving any treatment at all which increases their likelihood of having police contact if their illness is not under control. This is a serious problem deserving of attention.

Increasing the number of police contacts is problematic on several levels. First, these are generally time-consuming calls for service which tend to divert resources away from criminal matters and other more traditional law enforcement services (Livingston, 2016). One study showed that police contacts with the mentally ill averaged more than double the amount of time on the call and required more officers to deal with the situation (Charette, Crocker, & Billette, 2014). Officers are often frustrated with the health care and social service systems which seem to constrain their ability to rapidly, effectively, and efficiently resolve situations involving the

mentally ill (Livingston, 2016). These time-consuming cases frequently end with officers spending hours in the hospitals only to have the patient discharged after a short period of time (Morabito et al., 2012). Administrators may also become understandably frustrated with this situation as they are forced to take one or more officers off the street to deal with what most would consider non-law enforcement related calls. Resulting uses of force are also concerning for administrators who may end up with unnecessarily injured or killed officers or citizens. This begs the question as to whether the best resources are being used for the job.

Additionally, police officers are not mental health professionals. The police are trained to handle many different types of crises, but once a situation is stabilized, they are limited in what type of services they can provide. Much like officers are not trained to provide a high level of medical treatment on the street, they are also not trained to provide mental health services. This is clearly something that is best left to mental health professionals, but despite the significant demand around the clock, they are often in very limited supply, especially overnight. Even those officers who are trained in crisis intervention need to understand that the actions they take during a call for service are only a temporary solution to what is often a chronic mental health issue that cannot be addressed during one contact with the police (Bonkiewicz, Moyer, Magdanz, & Walsh, 2018). The long-term solution is to get the proper mental health treatment from a professional.

INCREASED USE OF FORCE AGAINST THE MENTALLY ILL

In addition to the above issues, an unfortunate effect of the increased police contacts with the mentally ill is that the police will periodically be required to use force up to and including deadly force. Due to the unpredictability of encounters with the mentally ill, their actions can frequently be interpreted as hostile by officers. Although these actions may not be intended to

create fear in the officers, some situations can become tense when the officers do not get the compliance that is expected, and this can escalate to a violent encounter (Morabito et al., 2012).

Not knowing about the mental illness of a subject when dispatched to a call for service is also problematic and can magnify this issue. Officers are trained to deal with tense situations but interpreting the intent of an unknown subject's actions is difficult with very limited information. Actions that may be interpreted as an attack from one person may actually just be odd behaviors exhibited by a mentally ill subject with no ill intent. Being able to correctly read these actions in a split second is where the issues arise. Officers are often placed in situations where the preservation of self, coworkers, and the public is their priority. This can unfortunately lead to deadly encounters.

Research suggests that officers develop specific frames of reference for dealing with these types of incidents (Watson, Swartz, Bohrman, Kriegel, & Draine, 2014). These frames of reference are called "schemas," and are developed based on how an officer is socialized into the organization along with their training and experience. These schemas are used as a framework for interpreting data (Watson et al., 2014). In law enforcement that means an officer will use prior training and experience to determine the proper reaction to a situation. This can be problematic because the erratic behavior of the mentally ill could present as dangerous behavior that an officer has witnessed in the past and may generate an unnecessary physical reaction. This further demonstrates the importance of having officers who are well-trained in dealing with the mentally ill.

Police are generally trained to use the lowest level of force required to obtain control. Best practices also say that they should be trained to use de-escalation skills whenever possible to decrease the likelihood of the need for force (Watson et al., 2014). However, that does not

explain why police shootings of the mentally ill are on the rise or why the mentally ill are disproportionately impacted representing 25% in fatal police shootings (Bennett, 2017). People with a mental illness are 16 times more likely to be killed during a police encounter than other civilians (Fuller, Lamb, Biasotti, & Snook, 2015). These numbers are staggering and clearly need to be addressed as soon as possible.

REINSTITUTIONALIZATION

Deinstitutionalization led to situation where many mentally ill people were back in the community, but the services were lacking so many did not have adequate treatment and housing which led to a worsening of their condition (Lamb & Weinberger, 2017). This caused an increase in the number of calls for service involving people with mental illness, and the police tried to handle many of these calls informally without involving the criminal justice system (Cordner, 2006). Unfortunately, the options became limited as repeat calls with the same individuals continued and something had to be done. The civil commitment process had become much more difficult, so officers now had to prove that the subject was a danger to him or herself or another. When faced with a situation where it was not safe to release the subject on his or her own, but a civil commitment was not possible, these subjects were often transported to jail.

Watson et al. (2014) say that the police are the gatekeepers of access to the mental health or criminal justice system. Given that the police are most commonly the first responders to crises involving the mentally ill, this makes sense. Despite a clear lack of training in dealing with the mentally ill, the police are often tasked with making the decision of whether the mental health or criminal justice system is the appropriate option for an individual. Further, these decisions are usually made with a limited amount of background information after only a short period of time with the person. This is a great deal of power for an officer on the street to have,

and it is a great responsibility. Officers are given significant power and authority to make these decisions which can have a huge impact the lives of the mentally ill people they contact.

Even though officers may determine that the situation they are handling is clearly related to a mental health problem, issues with the mental health system may lead them to believe that the criminal justice system could be the best option. Long waiting times in hospitals and often unpredictable decisions made by the mental health professionals as to whether the patient will be admitted make the process difficult to plan for. However, officers are very comfortable with the criminal justice system and know the intricacies of how it works. Additionally, when the mentally ill are not admitted to psychiatric hospitals, officers know that the criminal justice system cannot say no to them (Lamb, Weinberger, & Gross, 2004). Markowitz (2006, p. 49) refers to these as "mercy bookings" where the police refer a criminal charge because they know they have limited medical options and they know the arrested person will be forced into treatment through the judicial system. Ultimately, the criminal justice system is quick and predictable. These are two items of value for any patrol officer.

Police may also miss the signs of mental illness when they are in contact with a subject because they lack the necessary training. Some of the symptoms of mental illness may present as those of someone who is intoxicated or under the influence of an illicit drug. Dealing with intoxicated subjects is a common occurrence for most patrol officers, so this may lead them to misdiagnose the situation. Furthermore, these indicators of drug or alcohol abuse may mask the underlying cause of the problem (Lamb et al., 2004). This can lead officers down the wrong path where they simply miss the signs of mental illness. This is a likely situation given the fact that many mentally ill people also have substance abuse disorders (Lurigio, 2013).

The goal of deinstitutionalization was to get the mentally ill patients out of the mental health institutions and into community treatment. The country has closed state hospitals because of the poor conditions patients were kept in, but unfortunately, we have ended up reinstitutionalizing many of these same people in jails and prisons which frequently have even worse conditions (Perez et al., 2003). Without proper mental health care and proper police training, many people are now simply being institutionalized elsewhere. Because of the lack of adequate community mental health treatment, big city jails are now housing more and more mentally ill inmates. The Los Angeles County Jail, the Cook County Department of Corrections (Illinois), and Rikers Island (New York) now each house more mentally ill subjects than any single psychiatric hospital in the United States (Treatment Advocacy Center, 2016). Studies have shown that the percentage of subjects in prisons and jails with a diagnosable mental health disorder is approximately 20% which is greater than the general population (Markowitz, 2006).

Housing the mentally ill in jails and prisons is problematic because most inmates are not provided adequate treatment for their issues and they are also more likely to have disciplinary problems and higher rates of recidivism (MCSA, 2019). The goal of deinstitutionalization was to get these patients out of confined care which has not been adequately realized. Additionally, the cost savings anticipated by many states is not happening. Rather, they are simply redistributing the costs from the mental health system to the criminal justice system. This is an ineffective and inefficient way to handle these cases.

More important than the associated costs is that jails and prisons frequently lack the ability to adequately treat the inmates with mental illnesses because this is clearly not their primary goal. Jails and prisons do not have the necessary staff that can recognize and treat those with mental illnesses (Markowitz, 2006). Less than 50% of mentally ill subjects in county jails

are even receiving mental health treatment at all (Perez et al., 2003). Also problematic for clinicians who work in these facilities is that they are often unable to find adequate community treatment, resources, and housing for these offenders who are being released (Lamb & Weinberger, 2013). This can create a vicious circle of arrest and imprisonment when the mentally ill are unable to obtain the basic necessities needed to live on their own.

In addition to the lack of treatment while incarcerated and upon release, prisoners with mental health and substance abuse issues are also more likely to be unable to make bail, end up in segregation, and be victimized while incarcerated (Abreu, Parker, Noether, Steadman, & Case, 2017). These are serious concerns that further show the issues of housing mentally ill subjects in jails and prisons. The criminal justice system has an obligation to improve this situation and must do better to limit the incarceration of the mentally ill whenever possible.

The police are one of the most visible forms of government and they carry with them a substantial amount of power. As the gatekeepers who control the entry to the criminal justice system, they also share an awesome amount of authority and power that can significantly influence the long-term health and wellbeing of a person with mental illness. Given the deficiencies of the criminal justice system in handling the mentally ill, it is of the utmost importance that these gatekeepers are adequately trained to deal with these situations. This can limit the number of mentally ill subjects who are impacted by the criminal justice system.

SECTION III: CURRENT LAW ENFORCEMENT MENTAL HEALTH INTERVENTIONS AND PROGRAMS

Over the years, police administrators have recognized that there is significant room for improvement in their responses to people with mental illnesses. In the past, police would simply deal with the mentally ill as calls for service came into the department. More recently, however,

they are also proactively addressing the identified problems as they arise. Although providing services to the mentally ill is not what most people would consider a traditional service of the police, administrators have recognized that the increased calls for service with this group have placed them in the position where a proactive, problem-oriented response is the best option. Properly addressing the immediate concerns and dealing with the issues before they get more significant is the proper response of a forward-thinking police agency. This can be completed by implementing programs such as Crisis Intervention Teams, integration of the police with social workers and psychologists, the use of new technology, and more thorough police academy and post-academy training.

CRISIS INTERVENTION TEAMS (CIT)

Crisis Intervention Teams (CIT) are likely the most common form of mental health response in American policing with 2,645 local and 351 regional programs in the United States (University of Memphis CIT Center website, n.d.). The CIT program model originated in Memphis, Tennessee after the shooting of a young African American man who had a history of mental illness was armed with a knife and cutting himself while threatening suicide (Vickers, 2000). As the police arrived, they did exactly what they were trained to do. The man refused to drop the knife and became more agitated, eventually charging at the officers. The officers responded with deadly force and killed the man. The shooting was determined to be legally justified, but the use of deadly force is always undesirable for everyone involved.

This was also a racially charged incident and turned out to be the spark that led the mayor to develop a task force with the objective of developing a program that would address the safety needs of not only the mental health consumers, but everyone in the public as well as the officers (Vickers, 2000). The mayor brought in a wide range of stakeholders to address the issue. He

included the police, representatives from the psychology department at the University of Memphis, managers of the mental health facilities in the area, representatives of the National Alliance for the Mentally Ill (NAMI), and local citizens. The future successes of this program were almost certainly due to the forethought of the mayor to get this many concerned parties together. Politically speaking, the mayor also developed trust as he decided not to immediately cast the blame on either the police or those with mental illnesses. The program developed by this group has become the standard by which many people compare other mental health intervention programs.

The strength of the CIT concept is that it involves a network of so many entities working toward a common goal. Major Sam Cochran with the Memphis Police Department described it as

> …not just a program to train police officers to deal with the mentally ill. It is a concept that brings all kinds of interest groups together in a network, and if that concept is not nourished, the program will fail (2013, as cited in James & Gilliland, p. 102).

This statement reflects the understanding of the Memphis Police Department that they are not alone in the challenge they are facing, and that they would be unable to have success without their partners working with them.

The entities involved in the current Memphis CIT program are even more numerous than those involved in the original task force. The network involves the Memphis city government, the Memphis Police Department, NAMI, five of six local mental health facilities, the emergency rooms of the public hospitals, educators from relevant departments of the University of Memphis and University of Tennessee, several private practice psychologists, and groups dealing with battered women and sexual assault victims (James & Gilliland, 2013). It is important to

understand that these programs could not be successful without the active participation of all these involved parties working together. The relationships that have been built and developed over the years allow for better communication between the police, the mental health practitioners, and the mental health consumers.

To ensure a thorough understanding of the realities the police and mental health providers face each day, they also did job shadowing. CIT trained officers, and all supervisory personnel, were taken into mental health facilities for an orientation while the mental health workers were brought to the police academy and rode with officers on patrol (James & Gilliland, 2013). This gave each of them a better understanding of the role the other plays in this process, and helped them better understand the policies, procedures, and limitations of the process from another point of view. This type of integration can develop a level of trust between the police and the mental health system that has traditionally been absent. This trust can mean that, even if there is a disagreement in a treatment decision, there is an understanding and respect for why that decision was made.

CIT TRAINING

The goal of CIT is to divert those in a mental health crisis away from the criminal justice system (University of Memphis CIT Center, 2019). The classroom training for CIT is 40 hours. While this may not seem like a lot of time, from the standpoint of a police administrator, it is significant and shows the dedication to the cause. Considering most of these officers are shift workers and count toward minimum patrol staffing, administrators are investing not only the cost of the class and the salary for the officers to attend, they may also need to pay overtime to backfill a vacancy. Although the financial cost can be significant, failing to provide officers with the proper tools to do their job can be even more costly.

During the training, the students are provided instruction in a number of topics such as cultural awareness of the mentally ill, mental health diagnoses, psychotropic medications and side effects, drug abuse and dependency, suicide intervention, use of community resources, mental health law, and verbal defusing and de-escalating techniques among others (James & Gilliland, 2013; University of Memphis CIT Center, 2019). Most of this training is classroom lecture based, but two sections are not. The first is the training on de-escalation. According to James and Gilliland (2013), this portion is taught by four different instructors and covers 12 of the 40 hours of training. This gives the trainees the opportunity to see four different perspectives from people who have experience with the program. On the last two days part of the training involves a practical application of the techniques learned during role-playing exercises where veteran CIT officers play the role of mental health clients. These scenarios get more complex as the class progresses, and these are performed in front of the other trainees with the understanding that they can learn from their successes and failures.

One of the most valuable parts of the training, according to prior graduates, are the "fishbowl" discussions (James & Gilliland, 2013). These discussions occur at a mental health facility. While there, they observe a mental health professional, who is also a CIT instructor, and interact with mental health patients who speak about their prior interactions with the police. The trainees are then offered the opportunity to speak with the patients and ask any questions they may have.

With thousands of officers around the country now trained in CIT, the impacts are becoming more visible. One of the benefits of having CIT trained officers is that they have shown the ability to reduce the number of people with mental illness in the jails by directing these patients toward treatment (Hanafi et al., 2008). The treatment options in jails and prisons

are largely inadequate, so when officers know that the underlying problem with a person they are contacting is related to mental health, the best option is treatment outside of the criminal justice system. CIT trained officers can better identify the mental health related problems and are more likely to prevent these people being incarcerated.

CIT trained officers are also provided with multiple intervention options when dealing with the mentally ill, and they are more likely to utilize less punitive options (Wood & Watson, 2017). With continued CIT training of law enforcement, there is a hope that reinstitutionalization of the mentally ill will slow significantly as officers use less invasive, more treatment-oriented intervention options. Officers who have received this training are better able to identify situations where the root cause of the call for service they are assigned may be a mental health problem. In these circumstances, they can better determine when incarceration is or is not appropriate.

In an evaluation of the Memphis CIT program, results showed along with a decrease in incarceration, there was an increase in transports to mental health facilities. In the first 16 months of the Memphis program which covered 1987-1988, there were 5,831 mental health related calls for service and 3,424 transports (James & Gilliland, 2013). The number of mental health calls for service has increased significantly since the program has started, but so have these transports (James & Gilliland, 2013). This is a positive trend suggesting that the training, as well as the partnership with local hospitals, is having a significant positive impact.

CIT training has also been shown to have an impact on use of force incidents involving mentally ill subjects. CIT trained officers have shown an increased ability to utilize de-escalation strategies and a decreased use of weapons or physical force during calls involving mental health patients (Mulay, Vayshenker, West, & Kelly, 2016). A study conducted with the

Chicago Police Department by Morabito et al. (2012) also showed the potential of reducing use of force with CIT trained officers. Analysis of the Memphis Police Department's own records showed that their CIT program led to a decrease in the use of restraints and deadly force as well as a decrease in the overall injuries to both citizens and officers (Vickers, 2000). Since use of force incidents are an area of high liability for a police agency, reducing it in any way possible is clearly desirable. The ability to determine a subject's intent to cause harm to an officer is an important part of deciding to use force because officers do not want to use it unnecessarily. Although force will always be necessary in some circumstances, there is evidence to support the idea that CIT training is a way to better educate officers to know when it is appropriate. Utilizing training to limit liability is a wise choice for any administrator or city official.

INTEGRATION OF MENTAL HEALTH WORKERS WITH THE POLICE

Although the CIT program is the most common mental health intervention program for the police in the United States, there are other innovative programs that are working to assist law enforcement in this venture as well. These programs aim to integrate mental health workers with the police so they can respond to issues as they are happening. Police departments see this as a type of problem-oriented policing because they understand that "…prevention, intervention, and stabilization require more than police action and goes beyond the capability of any single agency" (Lamin & Teboh, 2016, p. 1). They identified a problem and recognize that it goes beyond their own abilities, so they understand that to effectively intervene and prevent future problems, they need to work with other agencies (Dean et al., 2000).

SOCIAL WORK AND POLICE PARTNERSHIP

The integration of social workers and the police has proven to be beneficial when dealing with people in the mental health community. One of these innovative programs was developed

in Lumberton, North Carolina and is called the Social Work and Police Partnership (SWAPP). The Lumberton Police Department at that time consisted of 60 officers and they had two full-time social workers assigned with them. The original purpose of this program was to provide substance abuse treatment for victims and suspects. Analysis by Dean et al. (2000) concluded that there was initial resistance by the officers, but they came to support the program after it began to help an underserviced group and virtually eliminated repeat calls for service. These repeat calls for service were essentially eliminated through the intervention of the social workers who were able to provide resources to the citizens. This created free time for the officers and allowed the social workers to handle other types of cases which primarily included mental health patients. According to the authors, one of the advantages of having the police and social workers team up is that the police involvement provides a "slight element of coercion" (Dean et al., 2000, p. 27). This means that patients who are uncommitted to treatment may be more likely to do so if there is an understanding of possible problems if they do not.

CRISIS INTERVENTION UNIT – CHAPEL HILL, NC

Another similar program utilized in Chapel Hill, North Carolina is called the Crisis Intervention Unit. Established in 1973, it was one of the first in the country to have social workers and police officers working together (Town of Chapel Hill, NC Police Department, 2019). The program has grown over the years and consists of four full-time and seven part-time social workers who respond to not only emergency mental health crises such as in-progress suicidal and barricaded individuals, but also non-emergency situations such as ongoing psychiatric problems that are frequently referred to them by patrol officers the following day (Dean et al., 2000).

This unit also provides follow up services for clients including referrals to other agencies and conducts training for law enforcement and other human services organizations in areas such as critical incident response and defusing conflicts (Town of Chapel Hill, NC Police Department, 2019). Their training also extends into the community where they have established programs in the schools, but they also educate community groups and citizens about activities that are more likely to get them involved in crisis situations (Dean et al., 2000).

Although agencies throughout the country frequently work with social workers, these above examples show the benefit of having them integrated within the police department. Being able to respond while a crisis is taking place is invaluable for not only the subjects involved, but also the police department. Furthermore, having experts who can follow up with the ongoing issues is beneficial for not only showing the citizens that you are concerned about them, but also to prevent future problems. This is a great example of problem-oriented policing.

POLICE PARTNERSHIPS WITH PSYCHOLOGISTS

Although less common, some agencies utilize the services of psychologists for dealing with the mentally ill. These services are most often utilized in more extreme circumstances such as tactical situations where they are needed with a crisis negotiation team. Other than with larger departments where they may provide internal services to employees, these psychologists are most commonly hired as consultants to assist in these high-stress and low-frequency events because they often involve dealing with mentally ill patients during incidents involving hostages or barricaded suspects. Research shows that approximately 52 percent of hostage situations are initiated by people who are mentally ill or mentally disturbed (James & Gilliland, 2013).

What is problematic is that the police culture often has difficulty bringing outsiders into their departments as members or consultants. Having a successful relationship depends upon a

mutual acceptance of the roles between the police and the psychologist, professional credibility from both sides, and the ability of the psychologist to sometimes operate during rough field conditions (Hatcher, Mohandie, Turner, & Gelles, 1998). Mutual acceptance means that both sides need to understand their roles within the relationship. As mentioned above, this can be especially difficult for law enforcement which sometimes looks at an outsider as a person who does not fully understand the profession. The skepticism is also related to the need for professional credibility. Psychologists who are looking to get involved with the police may have already obtained credibility within their own profession, but that does not automatically translate to credibility with their law enforcement partners. Their ability to perform on police calls is incredibly important. Working outside of a sterile office environment is also necessary. Working hostage and barricade scenarios is often under less than ideal circumstances and during less than ideal times. These are situations that police officers are usually accustomed to but may be difficult to adjust to for those who are not used to it.

Acting as a consultant is the most common way for psychologists to be involved with the police. They are generally involved as subject matter experts with the negotiation process and can offer a unique point of view as a behavioral science expert, but they should have expertise in negotiations (Augustin & Fagan, 2011). These psychologists can also use their professional expertise to assess suspects on scenes, provide training to officers on negotiating and other mental health topics, and they can also provide psychological support and post-incident counseling for the officers involved in critical incidents (Augustin & Fagan, 2011).

The willingness of some law enforcement agencies to incorporate psychologists into their work shows a great deal of professional growth over the years. Police agencies are generally difficult to penetrate because they often feel that they do not need outsiders to tell them how to

operate. However, most agencies understand that tactical options such as the utilization of a

SWAT team are not always the best for concluding hostage and barricade incidents. The belief

that bringing in outsiders can serve a benefit shows an understanding that there is a possibility

that police operations, especially with the mentally ill, can be improved.

THE USE OF TECHNOLOGY

Technology has infiltrated every part of our lives and this is no different for police

organizations working with people who have mental health issues. Using computers, tablets, and

applications on phones has proven to be helpful for agencies throughout the country.

TELEPSYCHIATRY

The Harris County, Texas Sheriff's Department recognized a problem with limited access

to mental health professionals, especially in the rural areas of their jurisdiction. This is

especially problematic because detaining someone who is mentally ill to take them far from their

homes can be an additional stressor that can create more issues for the patient. Their solution

was the implementation of a telepsychiatry program. This program provides deputies in the field

with tablets so they can access contracted psychiatrists and counselors at the Harris Center for

Mental Health and Intellectual and Developmental Disabilities via video chat as necessary

(PERF, 2018). This provides the deputies on mental health related calls for service the

opportunity to consult with a mental health professional as needed. These mental health

professionals can also speak directly with the patient to better assess the situation. The ability to

speak with the patient directly is helpful because it can prevent the loss of information that

occurs when information is being passed on from one person to the next. Experience on calls for

service also shows that sometimes the patients are not willing to speak with officers or are not

willing to speak as honestly and openly about their mental health issues as they are with a mental health professional (Lee, 2018).

They have also found this program to be cost effective. Harris County is over 1,700 square miles which means there is a potential for a lot of travel time while transporting mental health clients for services. Being able to have a mental health professional complete an assessment on scene can save a significant amount of time, and therefore, the cost of an employee's labor. By avoiding jail stays and hospital transportation, phase one of this program in Harris County saved over $26,000 (Lee, 2018).

Similar savings are being seen at the Los Angeles County Jail. Although not implemented by field officers yet, the jail is utilizing similar technology to cut costs. In some circumstances, inmates are housed a distance away from where they can receive mental health treatment. In these situations, deputies were required to transport the inmate 45 miles to another facility where services could be provided which meant significant transportation costs (PERF, 2018). The use of telepsychiatry means inmates can contact the on-call psychiatrist via video chat to determine what the next step in treatment should be.

All parties involved understand that this program is not a perfect substitute for face to face appointments, but there certainly is a value for everyone. The most significant benefit is that it provides immediate services to people who are in need. A secondary benefit is that it saves time and money for police who would otherwise be forced to transport these patients to a location where face-to-face services could be provided.

VITALS™ PHONE APPLICATION

Another innovative way to provide first responders with necessary information about someone with a serious mental health or developmental issue is with the Vitals™ phone

application. This is a downloadable program that connects a person with visible or invisible disabilities and disorders with first responders and educators (Vitals Aware Services website, 2019). The reliability of the program depends upon the patients themselves, family members, or caregivers who create and update a Vitals profile that identifies any conditions, medical information, contact information, triggers, de-escalations techniques and other data that may be helpful for first responders and other helpers (Autism Society of Minnesota, 2016). The patient is then provided a Vitals beacon which is carried and alerts first responders on their phone via Bluetooth technology when they within are 30-80 feet. The officer gets access to that person's profile which will include their name, picture, and diagnosis among other things. The profile may also include information about what type of stimuli could escalate the situation further or may even have audio clips of a family member's voice which would help settle the person down (Adler, 2017).

The idea for this application came after an altercation between the police and an autistic child became physical (Adler, 2017). When the police do not know about diagnoses such as autism or other mental health disorders, there can be significant problems including use of force. However, if the officers know that the person has a mental health diagnosis and are provided with information that could assist during the interaction, there is a much higher probability that the event will end more positively. This type of technology has the potential to make a substantial impact in the interactions between law enforcement and the mental health community, especially when dealing with crisis situations.

INCREASED ACADEMY AND POST-ACADEMY TRAINING

Despite the value of technology, education and training is likely the best way to improve relations between the police and the mental health community. Providing a solid basis of

knowledge for how to deal with the mentally ill while new officers are in the police academy is a necessity that has become even more evident in recent years. This training provides the skills necessary for officers to properly engage mentally ill subjects and to minimize the likelihood of injury to the officer or subject.

ACADEMY TRAINING

The police academy is where official training starts. Each state develops training standards for their officers, so they are as ready as possible to be successful in their patrol function. These academies tend to focus on the tactical skills such as firearms and defensive tactics instead of the personal skills needed to effectively communicate with people. This is likely because tactical skills are an important aspect of officer safety skills that help keep them from being injured.

A survey of 280 departments from throughout the United States conducted by the Police Executive Research Forum (2015) asked how many hours the respective police academies spent on various topics including mental health training. The survey provided interesting results indicating tactical training remains a priority throughout the country. They found that, on average, police academies spent 58 hours on firearms, 49 hours on defensive tactics, 40 hours on Constitutional law, 24 hours on use of force scenarios, and only 10 hours on communications skills, 8 hours on de-escalation techniques, and 8 hours on crisis intervention. These are concerning numbers when you consider how many mentally ill subjects an average patrol officer will encounter in his or her first year, must less an entire career. Furthermore, these situations have potential to spiral out of control quickly which can result in poor outcomes for everyone involved.

POST-ACADEMY TRAINING

Departments and governments across the country have more recently identified a shortcoming in their academy curriculum that needs to be addressed through additional training. Unfortunately, this mandated training frequently results from citizen contacts that end poorly due to inadequate training. For instance, the Douglas M. Ostling Act in Washington was passed in 2015 requiring a minimum of eight hours of crisis intervention training in the state police academy and two hours of inservice training on this topic for every officer every year ("Crisis Intervention Training Bill," 2015). While any additional training is beneficial for officers, the fact is that the mandate resulted from a death on a call for service with a mentally ill subject. On October 26, 2010 the Bainbridge Island, Washington Police Department was dispatched to the Douglas Ostling residence after they received a bizarre 911 call. When they arrived, officers encountered Ostling inside his house armed with a double-bladed ax. Officers gave him commands to drop the ax, and he refused to do so. One of the two officers on scene then fired through the door striking and killing Ostling. His parents sued the city claiming excessive force by the officers and a failure by the department to adequately train officers to deal with the mentally ill. A federal jury cleared the officers of the excessive force complaint but determined that the Bainbridge police administration failed to adequately train the officers on this topic (Martin & Armstrong, 2012).

Although not initiated by any single case, the Minnesota Board of Peace Officer Standards and Training (POST) recognized the need for ongoing training in this area for officers who are already certified. In 2017 the state passed a law requiring that, as of July 1, 2018, all certified officers must complete at least 16 hours of training in crisis response and conflict management during their three-year licensing cycle (Training in Crisis Response, Conflict Management, and Cultural Diversity, 2018). Specific to crisis response, the state requires

training in understanding the challenges of mental illness, the concerns of special populations with mental illness (such as veterans, trauma victims, and those with substance abuse issues), and a discussion on strategies for managing situations involving people in a mental health crisis (Minnesota Department of Public Safety [Minnesota DPS], 2018). While any skills learned are beneficial to the officers, the information about managing situations involving mental health crises is arguably the most important because failures in this area are so incredibly visible. The failures in these situations are the ones that make the news and create significant liability for a department and government.

THE R-MODEL

One innovative post academy training program in use at the Minnetonka, Minnesota Police Department is referred to as the R-Model which was developed by psychologist Jillian Peterson and sociologist James Densley of The Violence Project. The unique part of Peterson and Densley's plan is that they look to combine traditional CIT and mental health training while identifying the specific needs of the department and community they are working with and then tailoring the training to those needs (Wittenborg, 2018).

The "R" in R-Model stands for research, respond, and refer. Peterson and Densley started by doing research with the Minnetonka Police Department to determine exactly what their needs were. This meant they did ride alongs, conducted interviews with officers, and had undergraduate students analyze data and identify trends from prior crisis calls (Wittenborg, 2018). This research identified the fact that these officers did a great job at de-escalating situations almost every day. This meant that de-escalation training, a large part of CIT training, was not a significant priority for this department. Instead of providing training on de-escalation, the researchers were instead able to focus on other topics such as how to avoid triggering people

in crisis. Part two of the program is responding which means a discussion about how the way the officers respond might impact the crisis. The final part of the program is referrals. This means the officers provided information on how to more appropriately use local resources to help benefit the people experiencing the crisis.

As mentioned earlier, outsiders developing trust with the tight knit police profession can be difficult. This can be especially true with academics such as Peterson and Densley when officers do not fully understand their motives. However, Minnetonka Police found that the professors in this pilot program had already established their credibility with the officers because of the work they did at the beginning such as their interviews and ride alongs (Wittenborg, 2018). Establishing this rapport is an important part of developing a training program that will be accepted.

While these are great starts toward improving the current situation, there is clearly a need to continue growing and improving as a profession. The need for improved police academy and in-service training must be recognized as a priority throughout the country as we address the mental health concerns that continue to present themselves. While use of force by the police will always be a necessity in some circumstances, appropriate training can minimize it.

SECTION IV: RECOMMENDATIONS FOR IMPLEMENTATION OF SUCCESSFUL MENTAL HEALTH PROGRAMS IN LAW ENFORCEMENT

Research has shown that mental health programs for law enforcement can have a positive impact on the relationships built with the mentally ill and others. However, implementing these types of programs is not something that can be completed overnight. The following section reviews some important considerations to take for developing the most successful program possible.

BUILDING PARTNERSHIPS

The Memphis Model of CIT is more than just a training program. It is built around the strong relationships of the stakeholders in the mental health community who want to provide treatment instead of incarceration (Compton et al., 2010). For the system to work as it was intended in Memphis, that means the city government, the police department, mental health facilities, hospitals, psychology professors from local universities, and other organizations such as the National Alliance on Mental Illness (NAMI) got together to try to solve the problem. Their meetings helped develop the CIT program that has become the standard that others are trying to replicate throughout the country. Interagency cooperation is the key to the success of these programs because no single entity would have been able to successfully implement the program, as intended, on their own.

Compton et al. (2010) says another essential part of a successful CIT such as the one implemented in Memphis is a "no refusal" policy at an emergency psychiatric facility. The authors say this type of policy ensures a minimal turnaround time for officers to get back on the street so they can focus on other calls. This limits the amount of time officers are forced to spend in a hospital simply waiting on the process of ensuring the patient is assessed by the right people and provided the appropriate treatment. Limiting the amount of time officers spend in hospitals has been shown to increase their satisfaction and willingness to utilize the mental health system instead of incarceration (Steadman, Deane, Borum, & Morrissey, 2000). While the officers want the patient to get the needed treatment, this wasted time sitting and waiting in a hospital is a source of significant frustration as they know their time could be better spent elsewhere. There is still value in a CIT program for police departments but developing a

partnership with the mental health facilities is a basic need that will make the program much more effective.

It is also important to get the community involved in the development of any mental health program. The police department is ultimately accountable to the citizens and government of their jurisdiction. Furthermore, the funding for the training and program implementation comes from the taxpayers. It is important for the chief executive of the police department to be able to articulate the reasons why a program like this is important and how it can better serve the needs of the community.

The same need for networking and collaboration is applicable to the remaining programs reviewed in this research. Integrating mental health workers into police operations requires a significant amount of cooperation and policy development for successful implementation. Ensuring everybody understands the roles of all of those involved is important to avoid duplicating efforts and to run an efficient program. With the utilization of technology, those relationships are similarly important. Implementing a telepsychiatry program or a phone application such as Vitals™ requires significant collaboration with agencies and businesses outside of the law enforcement field. The Vitals™ application is a great example of how these non-traditional relationships between public and private entities can produce innovative solutions to complex problems.

SELECTING THE CORRECT OFFICERS

For any police-related mental health program, selecting the correct officers to participate is important. As with any program in any profession, having uninterested people involved can be detrimental. Officers who have been forced into these positions can be even more

problematic as they may not be willing to provide the needed attention to the objectives of the program.

Studies have shown that officers involved in the CIT program frequently volunteer because they are more likely to have been exposed to mental illness and the mental health system personally or through somebody in their family (Compton, Bakeman, Broussard, D'Orio, & Watson, 2017; Kubiak et al., 2017). This relationship undoubtedly gives these officers a unique perspective into mental illness and perhaps a willingness to go above and beyond what other officers may do to get these people the help they need and deserve. The intrinsic drive to help this specific population all but guarantees that the officer will provide a more thorough and thoughtful service to the client. An officer who is forced into the training may not be willing to invest any extra time into a program that they do not support or believe in.

A study by Compton et al. (2017) showed that officers who volunteered for the training had better post-training jail diversion outcomes during contacts with the mentally ill when compared to those officers who were assigned. Furthermore, the study showed the volunteers had greater helping attitudes, were better at making referral decisions, were better at de-escalation, had better attitudes about people with mental illness, and were more likely to refer a patient for services instead of making an arrest. These are all positive outcomes that support the use of volunteer officers.

Compton et al. (2017) says that assigning officers to the CIT training may lead to a situation where the program is not as effective as desired. However, the authors do not suggest that there is no benefit to assigning officers to this training. They suggest that sending the entire department to basic mental health response training would be beneficial, but that the best option is to select volunteers for the specialized CIT positions within the program.

TRAINING COMMUNICATIONS STAFF

Another important aspect of implementing a successful mental health program in a police department is training communications staff. While the officers should be trained because they are the people who will have personal contact with the mentally ill patients, something else to consider is that the workers in the communications centers will frequently be the first to have contact with a mentally ill individual. The call takers and dispatchers who work in these communications centers are a crucial link in the CIT program because they are the first line of communication in emergency calls for service, and they are the ones who set the tone of how the call will go (Compton et al., 2010). If the communications staff is not adequately trained to recognize potential mental health issues of the caller or suspect of an incident, the response of trained officers may be delayed. Additionally, without proper training, the communications staff could possibly aggravate the caller which could result in a more difficult situation for the responding officers to deal with. Responding to mental health patients who are agitated is problematic for officers because it can lead to negative outcomes.

Compton et al. (2017) suggests that dispatchers and call takers should receive CIT training, but that it should be separate from the training the officers get. Public safety communications and policing are two very different roles with very different jobs that share a common mission, and they are deserving of training developed for their specific role. Unfortunately, much like with officers, this type of training is difficult for departments to get their staff to. Communications centers are usually operated with far fewer employees than police departments, so pulling staff for training is problematic and can create staffing shortages. However, this is a worthy investment for any agency that is trying to fully implement a CIT program to best serve the needs of the public.

OTHER CHALLENGES TO SUCCESSFUL IMPLEMENTATION

One other problem that can create significant issues for departments trying to implement mental health programs is their geographic location. Urban locations generally have access to a much greater number of resources than their rural counterparts. Those officers in rural areas with a low population density become an integral part of the response to mental health crises (Compton et al., 2010). This is because there are rarely any governmental mental health services that are available every hour of the day like the police. Furthermore, once the crisis has been dealt with, there is frequently a long distance to travel if there is a need for mental health services from a professional provider because available facilities may be limited. Compton et al. (2010) suggests that this may be a reason to have a higher percentage of officers in a rural setting trained in mental health intervention. The authors suggest that, due to the higher number of officers working any given shift in an urban setting, there is less of a need to have many officers trained. However, in rural settings where there many only be a handful of officers working at one time or only one officer available to respond, there is a need to have them appropriately trained to deal with these mental health crises. To ensure there is always a trained officer available, it may require a majority of a department attend the training.

SECTION V: SUMMARY AND CONCLUSIONS

The police have seen an increased number of contacts with people who have mental illnesses over the last several decades. This has been largely attributed to the deinstitutionalization policies of the government started in the 1960s. The goal of these policies was to get patients out of mental health institutions to get them into treatment back in their communities because the belief was that most of them did not need forced inpatient treatment.

However, this plan did not solve all the problems it had hoped to solve because the community-based treatment was underdeveloped and underfunded.

With the closure of state-run psychiatric hospitals, there were fewer beds available for the mentally ill meaning there were more people with mental illnesses in public than there had ever been before. These patients often had difficulty adjusting to their new freedom and many were unable to get the treatment that they needed and had previously gotten at the in-patient institutions. The lack of treatment and structure in their day led to negative consequences such as homelessness and increased contacts with the police.

Unfortunately, the police are often ill-equipped to deal with mental health crises that are best served by mental health professionals. Despite the lack of mental health training for many officers, they are usually the first responders to crises involving mentally ill subjects because they operate 24 hours a day. Improper training for the officers can lead to negative outcomes such as reinstitutionalization in jails and prisons, and potentially unnecessary uses of force that sometimes result in death. These are outcomes that departments should be doing everything in their power to prevent.

Thankfully there are ways for administrators to limit the negative outcomes that sometimes occur during interactions with the mentally ill. CIT is one of the most promising programs to do this. This program has been replicated throughout the U.S. and beyond, but some of them are incomplete. For CIT to operate as intended, there must be a significant network of stakeholders involved and working together. When it is implemented as it was intended, CIT trained officers have shown an ability to reduce the use of all types of force including deadly force, are better at de-escalating situations, and they can reduce the number of mentally ill subjects taken to jail.

Another way to improve relations with the mentally ill is through the integration of mental health professionals with the police. Whether this means they are actually riding in the cars with the officers or stationed and available at the department, social workers and psychologists have proven their worth. They can respond immediately to scenes and deliver professional services that would otherwise have to be provided in psychiatric facilities.

Technology has also been utilized to improve police relations with the mentally ill. Whether it is with telepsychiatry or phone applications such as Vitals™, technology has allowed officers to provide better and more immediate services to patients in the field. This is important because it is saving time and money while also providing immediate attention to patients who have contact with the police. In many circumstances, this means that situational assessments can be made right on scene. This saves the need for a police transport and helps prevent the potential for incarceration in many circumstances.

Training is another area where police administrators would be wise to invest. While they may provide input on what is taught in the police academy, their impact in this area is likely limited. However, they have significant control over what is instructed by their own department during in-service training or external training they send their officers to. Research shows substantial benefits in providing mental health training to officers. Failing to adequately train officers can create some serious liability for the department. This is a significant investment up front, but it will likely pay off in the long run.

Police administrators should recognize the need to implement these programs if they have not already done so. They have shown a great ability to improve relations with the mentally ill, reduce the use of force, and direct patients into treatment instead of jails. These are admirable goals that should interest every police administrator. Taking proactive steps to improve police

services should be a constant goal of every department. Utilizing these recommendations is an

excellent way to start that improvement.

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