

Interactions with the Mentally Ill in Crisis – The Need for Change

By

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The Command College Futures Study Project is a FUTURES study of a particular emerging issue of relevance to law enforcement. Its purpose is NOT to predict the future; rather, to project a variety of possible scenarios useful for strategic planning in anticipation of the emerging landscape facing policing organizations.

This journal article was created using the futures forecasting process of Command College and its outcomes. Defining the future differs from analyzing the past, because it has not yet happened. In this article, methodologies have been used to discern useful alternatives to enhance the success of planners and leaders in their response to a range of possible future environments.

Managing the future means influencing it - creating, constraining and adapting to emerging trends and events in a way that optimizes the opportunities and minimizes the threats of relevance to the profession.

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“Shots fired...shots fired.” Broadcast over a police radio, these words cause even the most tenured of officers to experience anxiety and stress. Time comes to a standstill and all available resources rush to the scene to assist the officer calling for help. Colleagues hope and pray their coworkers are not injured. In the surreal atmosphere that follows, training kicks in and responses are on autopilot.

While most officers go their entire career without being involved in a shooting, those less fortunate are left with a lifetime of scars; physical and mental. Police officers are trained to react to threats to protect their own life and that of the public. While armed encounters with bank robbers and terrorists are glamorized by television and movies, real life is not quite the same. The aftermath of any shooting can be devastating for the officer. Even when they are uninjured, the psychological traumas last a lifetime. Officers expect these encounters, but what happens if the person on the other side of the armed encounter is not a terrorist or criminal, but a person suffering from mental illness? The results can cause a lifetime of problems for the officer, their agency, the families of the mentally ill, and the community.

For years, first responders have handled encounters with the mentally ill similarly to those who were not. It is time for policing to rethink how these encounters are handled. Most importantly, is there a better way for law enforcement to handle them? Departments should consider a measured response that includes; increased training for all officers, creating a cadre of officers specially trained in the needs of the mentally ill, and the creation of volunteer programs that include licensed clinicians to assist in the preliminary stages of these contacts.

The History of Mental Illness

The challenges associated with mental illness and law enforcement encounters can be traced to the late 1960's, when the deinstitutionalization of those suffering from mental illness began. According to the Criminal Justice/Mental Health Consensus Project report, in 1955, state mental health hospitals housed over 500,000 people; in 1999, only 80,000 were being housed (Council of State Governments, 2002)¹. This trend was solidified by the landmark O'Connor vs. Donaldson US Supreme Court Decision; which ruled in 1975 that mentally ill persons could no longer be institutionalized solely due to mental illness (O'Conner vs. Donaldson, 1975). The net effect was that mental illness was decriminalized, and many held at institutions were released back to their communities. Unfortunately, these actions moved some of the burden of housing the mentally ill to our jails.

Many suffering from mental illness could not cope and were arrested for crimes ranging from minor to the most heinous. Today, the recidivism rate of those with mental illness approaches 70% in some communities (Council of State Governments, 2002). According to the National Alliance on Mental Illness (NAMI), five percent of Americans suffer from a serious mental illness. In contrast, sixteen percent of those incarcerated suffer from a serious mental illness (NAMI, 2002). The burden does not only impact the jails. Some of those released were not able to assimilate back with their communities and families and became homeless. NAMI estimates that 25% of the homeless population suffers from a serious mental illness, with some estimates as high as 50% (NAMI, 2002).

¹ The Council of State Governments coordinated this comprehensive look at criminal justice / mental health issues with the assistance of the Association of State Correctional Administrators, the Bazelon Center for Mental Health Law, the Center for Behavioral Health, Justice and Public Policy, the National Association of State Mental Health Directors, The Police Executive Research Forum, and the Pretrial Services Resource Center. The report contains an in-depth analysis of these issues, and provides several policy statements on "best practices" in response.

Because of deinstitutionalization, peace officers throughout the country encountered mentally disturbed individuals in crisis more frequently. A small percentage of these encounters turn deadly, sometimes for the officer, but more often for the mentally disturbed individual. After the encounter, the officer's life is changed forever. Their department is often vilified, the community questions why a non-criminal was injured or killed, and the mentally disturbed person's family is left questioning how and why their loved one is gone.

Kristie Potter², a Marriage and Family Therapist, believes these encounters are a result of the mentally ill person's lack of medical care, inability or refusal to take prescribed medicines or their family's lack of knowledge of how to help them. Potter believes one of the common challenges families face is getting the mentally ill person to take prescribed medicines as directed. Some opt to discontinue taking their medicines because of the side effects. Others cannot take their medications because they do not have the resources to get them. The results often culminate with the person in crisis being contacted by first responders called to help them (Potter, Interview, August 2, 2008).

In response to the decriminalization of mental illness, laws were created allowing mentally ill persons in crisis to be placed on temporary holds so they could be evaluated by professionals. In 1969, California created a law allowing for the temporary (no more than 72 hours) detention of mentally ill persons for evaluation and treatment in three circumstances: they are a danger to themselves, they are a danger to others, or they are gravely disabled (California Welfare and Institutions Code, Section 5150). When warranted, they are treated; most are released. Because of the deinstitutionalization, as well as the new laws, police departments across the nation were forced to deal with a problem they were ill equipped to handle at the time.

² Kristie Potter is a licensed Marriage and Family Counselor and works for the City of Union City as an Intervention Counselor, having done so for the last six years. Potter has experience working with at risk youth, families of youth suffering from mental illness, and victims of violent crimes.

According to Attorney Kim Colwell³, a majority of the officer involved shooting cases she has defended have involved a response to a mentally ill person in some sort of crisis, primarily paranoid schizophrenics who have stopped taking their medications, or people who are in some sort of drug induced delirium (Colwell, Interview, July 14, 2008).

Often, civil lawsuits pave the way for police practices. Law is reviewed and applied to a given case, clarifying societal expectations of law enforcement when they respond to mentally ill persons in crisis. When cases are lost, the message is clear - change the way you are doing business. A recent court case affecting Northern California law enforcement further clarifies what those expectations might be in the future.

Union City Case Study

In March of 1998, the Union City Police Department was called to the home of Lucilla Amaya. Family members called the police to help them control Amaya because she was hallucinating and acting extremely irrational while in possession of two knives. They also told police she was possibly under the influence of methamphetamine and had been detained for a mental health commitment in the past. Their primary concern was an attempt by Amaya to harm herself or her father and daughter.

Officers arrived to find an obviously agitated Amaya behind a metal screen security door, holding a knife and making threats. She was hallucinating and reported conversations with a deceased family member. She exhibited signs of paranoia, believing men were out to harm her, and was afraid of the police. During the encounter, Amaya's mood fluctuated between extremely excited and speaking incoherently, to moments of calmness with some semblance of coherence.

³ Kim Colwell is an attorney with Meyers-Nave, a major law firm specializing in public entity law. They represent numerous public entities in California, including thirty cities and counties in Northern California. Colwell has been the head of their civil litigation division since 2002. She has eighteen years of experience in the public litigation field, specializing in defending cases involving police conduct.

Less than fifteen minutes later, Amaya continued her threats, moved towards family members and was fatally shot by an officer who believed he was protecting the lives of the family.

Amaya's family sued the City of Union City for wrongful death and won a verdict of approximately two million dollars. Of significance were the responses given by jurors when they were later questioned regarding their verdict. While they believed Amaya was responsible for her own actions due to mental illness and/or methamphetamine use, they felt the City had a duty to provide a better response to the crisis (Munoz, 2004 and 2007). They expressed several concerns, two are pertinent here. They believed mental health professionals should have been part of the immediate response and police officers should have specialized training in mental health issues. The City of Union City appealed the verdict, but eventually lost the appeal (Munoz, 2004 and 2007).

Attorney Kim Colwell said that if she could generalize, juries are critical in these cases because there is not a psychological expert available on-scene, on-call or on-staff. According to Colwell, "they would like to have some sort of an intervention before it gets to a point that a shooting occurs". She said with the exception of one agency, police budgets typically don't allow for that, adding, none of the agencies she represents have a staff or on-call mental health professional. Another recurring theme she noted was juries believe police acted too quickly and didn't allow the event to unfold at a slower rate; believing extra time gives the person in crisis much more opportunity to surrender (Colwell, Interview, July 14, 2008). This can result in large jury awards.

According to Union City Police Chief Greg Stewart⁴, the effects of the above shooting were substantial. Aside from the jury award and costs to defend the case, the community's perception of the department was dramatically impacted. "There were those who wanted to sympathize with and support the family. There were those who wanted to support the Department, understanding the police went there to help and that Amaya was armed and threatening others" said Stewart (Stewart, Interview, May 28, 2008).

The Department discussed above was in turmoil as the case wound its way through the courts (it takes years). Ultimately, perhaps more importantly, officers involved in these types of incidents suffer a lifetime of psychological aftereffects from the actions they were forced to take on the dates in question. Colwell said that in every case she defended, the officer was impacted dramatically by the shooting. In those cases, each officer related that they didn't want to shoot, but felt they had no other choice; "If they could roll back the clock, every single one of them would" (Colwell, Interview, 2008).

Unfortunately, turning back the clock may not have altered the outcome of this incident. While the ultimate outcome may not have changed using different techniques, agencies constantly search for potential solutions. Agencies that have experienced similar negative outcomes have searched for solutions to the question of how to better handle these types of cases. Two models have emerged; Crisis Intervention Teams (CIT) and Psychiatric Emergency Response Teams (PERT).

CIT

In 1988, in response to increased volatile encounters, the Memphis Police Department created a strategy to better respond to crisis calls involving the mentally ill; a Crisis Intervention

⁴ Chief Stewart has over thirty years of law enforcement experience. He worked closely with attorneys defending the City of Union City in the Amaya lawsuit, and has significant insights into law enforcement shooting cases as a result.

Team (CIT). The team is comprised of specially trained officers who receive 40 hours of training from mental health professionals. This training encompasses the identification of individuals in crisis and identifying their probable psychiatric condition (paranoid schizophrenia, bi-polar disorder, traumatic brain injury, and drug and alcohol issues for example). After the probable condition is identified, officers receive training in de-escalation techniques specific to each condition along with assisting in finding resources that may help the person in crisis.

These specially trained officers respond immediately to crisis calls involving the mentally ill. Because of their advanced training, CIT Officers are better prepared to de-escalate these potentially volatile encounters. As a result, Memphis has seen a decline in the use of force needed to resolve the encounters, officer injuries have declined, community perception has been positively affected, and the Department and City of Memphis have seen an overall decrease in the costs associated with mentally ill persons (Cochran, 2008). According to Memphis CIT Coordinator Major Sam Cochran, 225 members of the Department's 1,000 member patrol force are CIT trained. Team members respond to around 12,000 crisis calls every year. Cochran said the program has been very successful. As a result, at least 50 other law enforcement agencies have created similar programs across the country (Cochran, Interview, August 4, 2008).

Union City Police Corporal Brandon Hayward recently attended a CIT training program. Prior to attending the training, Hayward felt equipped to deal with mentally ill persons. He is a qualified team leader of the Hostage Negotiation Team with nine years of police experience. He has been involved in many crisis situations. Hayward returned from the training and realized there had been more to learn. The CIT training provided an in-depth look at mentally ill persons, their medicines, challenges and how they process information. Once a mentally ill person in crisis is identified, the training provided methods on how to break their moments of psychosis,

making the need to use force less likely. Hayward said he has used these techniques several times with great success, receiving complements from peers as well as the families of those he has dealt with. Hayward believes the CIT training was extremely beneficial, but cautioned it should be reserved for senior officers who have experience dealing with mentally ill people. He felt the advanced components of the training might be lost on less experienced officers. (Hayward, Interview, August 1, 2008).

As a result of the success in Memphis, other departments have created similar programs. The San Jose California Police Department has a program almost identical to Memphis, created in the 1990's. Beginning in 2007, the Chicago Police Department will start implementation of a CIT program as well. In July of 2007, the National Institute of Mental Health (NIMH) provided a grant to conduct a two year study to establish the effectiveness of the Chicago CIT program as it is implemented (NIMH, 2007). CIT could become the "standard of care" for law enforcement. Even with its success, though, the CIT approach is not the only one emerging to deal with the mentally ill.

PERT

In 1997, the San Diego County Sheriff's Department and the San Diego Police Department created a Psychiatric Emergency Response Team (PERT). They pair specially trained officers (similar to CIT) with licensed mental health professionals and respond to crisis calls involving the mentally ill (PERT, 2008). According to James Fix, Psy.D.⁵, PERT was originally funded through a federal grant. Due to its success and community support, the program was expanded in 1998 and funding was continued through the County. Today, PERT employs 23 full time clinicians and its annual operating budget of approximately \$2,000,000 is

⁵ James Fix, Psy.D., is the Executive Director of PERT, Incorporated. PERT Incorporated is a non-profit agency that partners with law enforcement throughout San Diego County to provide crisis response services from licensed clinicians.

funded entirely by San Diego County. Currently, PERT teams respond to over 8,000 calls a year, of which 4,000 are truly crisis type interventions. Because of the partnership with law enforcement, PERT clinicians are often the first on the scene. Fix said one of the benefits of PERT is its ability to take the emergency room out to the street. Officers and clinicians are able to complete evaluations on-scene, and make referrals as appropriate. Only those few who really need emergency room visits go. The remainder are provided the appropriate level of service. Some are provided rides to their own providers, assisted with obtaining and taking their medicines, and referred to counseling as appropriate. Fix summed up the PERT program as one intended to most effectively transfer the consumer from the field to the most appropriate resource. Because of this philosophy, consumers are not spending endless hours waiting in overburdened emergency rooms and patrol officers are not tied up handling calls involving mentally ill people.

When asked about the impact of having a mental health professional available at every mental crisis call, Colwell expressed some concern about the ability to get them to the call in time to make a difference. She felt incidents may unfold before on-call type clinicians could arrive, but in cases where they could, she saw a benefit. Colwell believed a program of first responder clinicians should provide a better opportunity to reap potential benefits. First, she hypothesizes that maybe some of the volatile incidents might be resolved, preventing a violent confrontation and eliminating the resulting litigation. Second, if the professional was a volunteer, their testimony might be viewed favorably by a jury. They would likely be viewed as impartial, unbiased observers. Third, the professional may be able to obtain helpful information from the individual's medical records to resolve the crisis peacefully. This information may be difficult, if not impossible, for a police officer to get because of patient confidentiality laws. On the

downside, if the event did not resolve peacefully and litigation ensued, costs would be increased due to the expert testimony required to support the professional's actions; adding a malpractice component to the lawsuit. Overall, Colwell felt the addition would be beneficial (Colwell, Interview, 2008).

Hayward also saw a benefit to having licensed professionals available to assist officers at these calls. While he felt the CIT training he received left him better equipped to handle crisis calls, he still believes there may be complex occasions where the mental health professional would be able to use their expertise to help resolve it (Hayward, Interview, 2008).

While it is difficult to quantify how many lives have been saved as a result of their programs, both Memphis and San Diego anecdotally report a reduction in the number of cases ending in tragedy. In addition, they believe there is a reduction in the cases where force was used to detain a mentally ill person and have received positive community support of their programs. Where the PERT and CIT examples have been effective in larger departments and suburban areas, a viable solution for smaller or rural departments needs to be found.

Issues for Smaller Agencies

Chief Stewart is familiar with the CIT programs of the Memphis and San Jose Police Departments. He is very supportive of the programs, but felt implementation in smaller agencies could be a challenge: "Assigning specially trained officers to different shifts and different sectors to handle calls involving those with psychological difficulties would be a great thing. It's a matter of how many people it would require to run the program to have those trained officers available twenty-four hours a day, and whether or not you can accommodate that in an agency your size" (Stewart, Interview, 2008). Although peace officers in California receive less than a day of training regarding the mentally ill in the police academy, the Criminal Justice/Mental

Health Consensus Report suggests officers receive 8-15 hours of training in the academy and 20 hours of annual in-service training for all officers (Council of State Governments, 2002). In contrast, mental health professionals receive in excess of 3000 hours of internship/training prior to receiving a license (California Board of Behavioral Sciences, 2008; California Board of Psychology, 2008). Certainly, it would be prudent to consider enhancing the number of training hours for the police, and to specifically acquaint them with strategies and tactics to deal with the mentally ill.

So where does the law enforcement profession go from here? According to NAMI, the World Health Organization (WHO) predicts that by 2020, childhood mental disorders will rise by 50%. While this takes into account all of the world population, it portends an increase in America as well (NAMI, 2002). It is apparent the mental health problem isn't going to go away or solve itself. According to the Surgeon General in a report on mental health, over seven percent of the adult population suffers from some sort of a mood disorder. Over one percent of the population suffers from schizophrenia (Surgeon General, 2008). These disorders are the ones officers most often come into conflict with.

Advancements in medicine may hold the potential for better care for the mentally ill. If mentally ill persons start to receive better care (and they take advantage of it) – will that possibly result in less encounters with the police? Will better care, if they access it, result in them taking their medications and having less outbursts and incidents? Probably not - so many in the mental health field have publicly discussed that many mentally ill folks just don't consistently take their medicines as they should – that fact may leave a better coordinated response as the only viable option.

Potential Solutions

While the potential solutions are many, some rise to the top. All agencies, no matter what their size, should incorporate additional training in these areas for all of their officers. They should provide select officers with advanced training in CIT and create systems to ensure they are the first responder to crisis calls. They should create partnerships with clinicians to assist with training and crisis responses, and clinicians should volunteer with their local departments to create response teams similar to those of PERT.

Increased Training

The basic training requirement should be increased to meet those recommended in the Criminal Justice/Mental Health Consensus Report, which suggests officers receive 8-15 hours of training in the academy, and 20 hours of annual in-service training. Mental health professionals should provide training in mental health crisis issues to their local departments. Whether the training is provided by county mental health departments, or volunteers, it would go far as a strong base for the beginnings of a formal CIT or PERT program. They should set up trainings that deal with the mental health issues prevalent and problematic in their community, while at the same time providing guidance and support in ways to resolve them peacefully. Live training scenarios could be used.

Advanced Training / Specially Trained Officer Response Teams

Chief Stewart understands that not all officers would be able to complete advanced mental health training. Further, he thinks some may relate to mentally ill persons better than others, with or without training (Stewart, Interview, 2008). Using the CIT model, only 25-30% of first responders would need to attend the advanced training. Factoring in all of the related expenses, it costs approximately \$1,000 to send an officer to a one week training session, a small

price to pay in light of the potential benefits. Because of civil suits, it is possible law enforcement will have no choice but to have some variation of this training occur – thinking of negligent training and the fact that encounters with the mentally ill is part of their most critical response calls. Departments would be able to select the best suited members to receive the advanced training and assign them to crisis intervention teams to respond to crisis calls,

Licensed Clinicians

One solution is for departments to hire licensed clinicians to respond to crisis calls. For smaller or rural departments, the costs associated could be prohibitive. The number of clinicians required to operate a program 24 hours a day, 365 days a year, could be more than the current operating budgets of smaller, rural departments. As mentioned above, the annual operating budget for the San Diego PERT program is \$2,000,000; most of that is clinician salary expense. While smaller departments could operate with fewer clinicians, the costs would still be substantial.

A more viable solution would be for smaller or rural departments to form partnerships with mental health experts in their communities. Currently, there are Special Weapons and Tactics (SWAT) teams across the country that have volunteer medical doctors as team members (to provide emergency medicine should the need arise). Mental health practitioners could also volunteer and assist first responders with mental crisis calls. Many states have reserve police officer programs perfect for this.

Potter believes a volunteer program could be a viable solution. She believes it is an ethical obligation for her profession to give back to the communities they serve. One way to accomplish this would be to volunteer to assist law enforcement with these crisis calls by providing their expert opinions and suggestions. She has spent many years working with a police

department as a resource to families in crisis. The partnership has afforded her the opportunity to see how police operations work and to understand why practices and procedures are in place. As she has assimilated into the police culture, she has been able to return the favor, providing insights to officers of the psychology profession. She believes other practitioners would also benefit and enjoy the opportunity to work with law enforcement, understanding that not every therapist is willing and able to work under the extreme conditions that could be required. Potter cautioned that malpractice insurance could be an issue and thought the small cost associated for a city to provide it would be offset by the services they received in return. In instances where cities could not afford to provide it, the reserve officer designation could afford some protection as the professional would be considered a city employee and covered under that umbrella (Potter, Interview, 2008).

Society has always had the task of caring for those who were unable to care for themselves. Typically this has meant women and children, with anyone suffering from mental illness shunned. It is only in recent centuries that those suffering from mental illness have received care. Those from well off families received the best of care, while those at the lower end of the scale did not fair so favorably. According to Robert Christensen, M.D., M.A., in a letter to the editor of the *Psychiatric Services Journal*, psychiatrists and psychologists have an ethical duty to care for those who cannot care for themselves due to mental illness, and who may be at the lower end of the socio-economic scale (Christensen, 2000). One way to fulfill this obligation would be for clinicians to volunteer and help respond to those in crisis.

Once a sufficient number of trained professionals were available, call out lists and rotations could be established to help share the responsibility and put these professionals where they are needed.

Conclusion

This three pronged approach would go far to help mitigate the challenges faced when officers with minimal training in mental health issues are called to a crisis scene. We owe it to our communities to do the best job we can. When asked about responses to those in crisis, Chief Stewart said, “We’re always looking for a better way to do things; how can we do it efficiently, effectively and best utilize the dollars we have? It might be that we are forced, based on the number of incidents we are handling in the future, or maybe by statute, to increase training to officers in these areas, have specialized response units, or even on-call mental health counselors available to respond. We can’t be complacent with our responses and continue to do business as we have in the past because that’s the way we have always done it. If we can improve services to our community, then that should be our ultimate goal.” (Stewart, Interview, 2008)

A multifaceted response involving increased training, mental health volunteers, and community involvement can help decrease the number and severity of these encounters. We owe it to ourselves, our professions and our communities to work together to provide this level of support to those in crisis. In doing so, we decrease the burden on local budgets and allow those funds to be spent proactively responding to other challenges instead of paying jury awards, court costs and providing psychological treatment to police officers placed in these situations. However, the greatest benefit of such a partnership is not monetary. If just one life can be saved, then the proposed partnership and solution is worth pursuing.

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