

POLICE RESPONSE TO THE MENTALLY ILL: HOW PREPARED
ARE WE TO TAKE ON THE TASK?

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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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POLICE RESPONSE TO THE MENTALLY ILL: HOW PREPARED ARE WE TO TAKE ON THE TASK?

Nothing defines the quality of life in a community more clearly than people who regard themselves, or whom the consensus chooses to regard, as mentally unwell."

Renata Adler

Those in law enforcement who have spent any length of time in patrol can relate to the all too familiar call involving the "5150" subject in the community. This subject may turn out to be a homeless person who talks to himself, the 75 year old woman who believes people are trying to kill her, or a young Iraq war veteran with Post Traumatic Stress Disorder who is ready to take his own life. These examples most often involve mentally ill individuals. They also represent the types of unpredictable situations that we commonly require our law enforcement officers to handle. Why should law enforcement leaders be concerned? After all, isn't the mentally ill population the mental health system's problem? The fact of the matter is that law enforcement officers are often the first to respond to calls involving mentally ill persons. When police encounters with the mentally ill result in violence, death or the perception of unjustified police action, then it does indeed become a law enforcement problem.

Perhaps we should take into consideration a 2007 study cited in the *Psychiatric Services Journal*. Police departments reported on average, ten percent of their contacts with the public involve persons with mental illness (Watson & Angell, 2007, p. 787). In 1999, the U.S. Department of Health and Human Services reported one in four adults - approximately 57.7 million Americans experience a mental health disorder in a given year. One in seventeen lives with a serious mental illness, such as schizophrenia or

bipolar disorder, and about one in ten children have a serious mental or emotional disorder (1999, p. 408). According to the National Institute of Mental Health, suicide is the third leading cause of death for those 10 to 24 years old; 90 percent of those who commit suicide have a diagnosable mental disorder (October 2007). These numbers are rather staggering and will probably continue to increase law enforcement's interaction with the mentally ill. Many police managers seem to be acutely aware of this problem and have implemented programs to attempt to deal with the issue. The question is: how well are we preparing our officers to take on the task?

INTRODUCTION

The job of police work has evolved into a profession whose officers are required to have many specialized skills. Concerns such as homeland security, drug trafficking and active shooter scenarios have raised the bar of required skills and knowledge for today's law enforcement officer. Historic events have created a situation in which law enforcement officers are routinely called upon to respond to scenarios involving the mentally ill.

The deinstitutionalization movement, which began in the 1960's, led to the release of many of the mentally ill from psychiatric hospitals and placed them in the community (Teplin, 2000, p. 9). The failure of communities to develop appropriate community based mental health treatment programs left many mentally ill citizens on the streets without proper mental health care and supervision (Watson, Corrigan & Ottati, 2004, p. 1128). Since that time, law enforcement officers have been left with progressively more responsibility for dealing with the mentally ill (Petrocelli, 2007).

This deinstitutionalization has also resulted in increasing numbers of homeless mentally ill persons.

According to the Los Angeles Homeless Coalition, 1 in every 5 homeless persons has a severe or persistent mental illness (2009). Additionally, there are also thousands of Iraqi and Afghanistan war veterans who are returning home with significant mental health issues; including Post Traumatic Stress Disorder, major depression and traumatic brain injuries. These factors contribute to an unstable existence for many of the mentally ill who ultimately self-medicate with illegal drugs or alcohol. Officers are often first to respond to a mentally ill person in crisis and must stabilize volatile and unpredictable scenarios. Responding officers must act in accordance with the law, but they must also act in the interest and mandated protection of the mentally ill.

WHY SHOULD WE CARE?

A number of well-publicized deadly force incidents involving mentally ill individuals have substantially increased awareness among community members and advocacy groups over the lack of mental illness intervention skills for officers. Despite the tremendous responsibility placed upon law enforcement to resolve calls involving the mentally ill, many officers and deputies are poorly equipped to do so (Schwarzfeld, Reuland & Plotkin, 2008). Although these contacts may make up a relatively small percentage of an agency's total calls for service, they can prove to be among the most challenging types of calls for responding officers. Spurred by numerous headline-grabbing cases that have resonated with the public, there is an ongoing concern over the

lack of mental health training for officers. Some of the more prominent incidents have been:

- In February 2000, San Diego police officers shot and killed a stick-wielding homeless man who rushed at them. In May 2000, a 55 year old, 5-foot-1 inch, 102-pound mentally ill homeless woman was shot to death by a Los Angeles police officer who said she lunged at him with a screwdriver (Jamieson & Wilson, 2000)
- In August 2002, Owasso (state) police officers killed a mentally ill man who was threatening suicide. Officers shot 32-year old Todd Hastings after he refused orders to drop a sword. Though the officers' actions were found to be within department policy, the mentally ill man's family filed a law suit against the officers and the City

Although a number of factors contribute to incidents such as this, they are tragic for families, communities and law enforcement agencies alike. Ronald Ruecker, Director of Public Safety for Sherwood City Oregon, believes that a number of issues, including a lack of understanding about mental illness on the part of officers as well as limited, local mental health resources may prevent agencies from establishing effective programs for dealing with the mentally ill (Ruecker, 2008, p.12). A study cited by the Psychiatric Services Journal found that the perceived stereotype of dangerousness associated with the mentally ill may lead officers to inadvertently escalate situations through body language and speech (Watson, Corrigan & Ottati, 2004).

WHY HAS IT COME TO THIS?

Driven by changes in treatment philosophy which began in the 1960's, many of the mentally ill were removed from psychiatric hospitals and were placed into the community. This movement was driven by the belief that persons with mental illness should receive community based services and treatment, allowing them to function as full members of the community (Geller & Morrissey, 2004, p.1128). Due to the mismanagement of the deinstitutionalization movement, namely a lack of planning of community based services for the chronically mentally ill, many mentally ill citizens were left on the streets without proper mental health care and supervision (Watson, Corrigan & Ottati, 2004, p. 1128).

Other trends affecting the availability of public mental health services include ongoing reduction of mental health funding and the skyrocketing costs of Medi-cal. With California's \$42 billion dollar budget gap in 2009, and the prospect of massive cuts, proposed cuts to an already struggling Medi-cal system will further limit access to services for the seriously mentally ill (www.nami.org/GradingtheStates2009). Simply put, ongoing funding reductions will continue to burden a mental health system that cannot handle the present demand. These trends have left law enforcement officers with increasingly more responsibility for dealing with the mentally ill in crisis or otherwise (Petrocelli, 2007).

SO HOW ARE WE DOING?

Dr. Michael Bolton has completed extensive research related to police interactions with the mentally ill. He suggests that both situational and officer characteristics play a part in how police officers respond to persons with mental illness.

Officers are more likely to arrest a mentally ill person if they are involved in a crime, if they have a criminal history or if it is likely the person will continue to be a problem. His research also implies that officers generally do not maintain negative attitudes about mental illness; however, officer and organizational dynamics do influence perceptions about the mentally ill.

Younger, less experienced officers tend to have a heightened perception of danger when faced with a mentally ill person who displays bizarre or unstable behavior. Officers from an organization that operates from a community oriented policing philosophy and those with more frequent contact with the mentally ill have more positive perceptions (Bolton, 2005). A number of studies cited by the Psychiatric Services Journal have also concluded that most officers do not feel adequately trained or qualified to respond to individuals with mental illness (Watson & Angell, 2007, p. 789).

The National Mental Health Information Center reports that most police departments around the country receive only five to eight hours of mental health training in the basic academy (Dupont, 2004). California POST requires four hours of mental health training in the basic academy (California POST, 2008). Such training deals with the very basic components of mental illness (2008). Cumulatively, officers want to know how to recognize mental illness, how to deal with suicidal or psychotic behavior, and how to handle violence or potential violence among mentally ill individuals (Bean, 1999). As suggested in a recent report by the Technical Assistance and Policy Analysis Center for Jail Diversion, a lack of training may contribute to a belief held by some officers that it is best to deal with mental health crisis situations quickly. The ramifications of this notion can be crucial because it is within the first few seconds of an interaction between

an officer and a mentally ill person that determines whether it will be a productive or problematic situation (Reuland, 2004).

Research also suggests the majority of individuals who assault officers are under the influence of drugs or alcohol, or are mentally ill (Watson & Angell, 2007, p. 789). When an individual's source of impairment is unclear or is a combination of both factors, i.e., dual diagnosis cases, an officer's ability to resolve a crisis situation is further complicated. Additionally, when confronting a mentally ill person who displays disconcerting behaviors such as belligerence, verbal abuse or disrespect, an officer may be more likely to respond in a punitive manner (Teplin, 2000, p. 12).

SO WHAT'S WORKING?

Beyond the four hour POST required training, a number of progressive agencies have answered the call for improved police response to mentally ill persons. Two of them are of special note.

San Diego County's Psychological Emergency Response Team (PERT) program, which was implemented after several officer-involved shootings involving mentally ill individuals, is one example. The San Diego PERT program partners trained officers with mental health professionals to respond to situations involving mentally ill persons. Select officers, deputies and mental health professionals complete a 40-hour training course which includes several topics related to mental illness such as crisis response, homelessness and substance abuse. In addition to the initial 40-hour training, officers receive on-going mental health training (Community Research Foundation, 2004). As compared to pre-PERT days, the San Diego PERT program has been successful resolving

more situations peacefully and diverting more mentally ill persons to services versus custody.

The Memphis Crisis Intervention Team (CIT) program is a model for training that has been adopted by hundreds of communities in more than 35 states. The success of the Memphis model of CIT is grounded in the partnership between law enforcement and the community to serve the needs of the mentally ill. Selected officers receive 40 hours of training designed to equip them with specialized skills to respond to mental disturbance calls. Officers learn to recognize the signs of psychiatric distress and how to deescalate a crisis. Officers also learn how to link people with appropriate treatment. The well documented success of the CIT program includes a reduction in officer injuries and the diversion of mentally ill persons from custody to treatment services (NAMI, 2008).

**WHAT IMPACT WILL THE MENTALLY ILL POPULATION HAVE ON
FUTURE LAW ENFORCEMENT TRAINING STANDARDS?**

Although no level of training can prepare an officer to peacefully resolve every scenario, law enforcement leaders are always looking at ways to improve response methods. Law enforcement agencies throughout the country have implemented a variety of mental health training programs for their officers. These range from very basic supplemental training to full forty-hour crisis intervention training programs. Such training is intended to better equip officers to handle calls involving the mentally ill. The obvious need for mental health training for law enforcement should in no way overshadow the need for officer safety or protection of life.

As Boise, Idaho Police Lieutenant Ron Winegar notes, “Police tactics won’t change if officers or the public are threatened. If someone is in a meth paranoia or

mentally ill, we don't change our tactics. People are still a danger to police officers". (Kreller, 2008). This, however, does not exempt police managers from the responsibility and need to address the mentally ill population. The best outcome is to diffuse a situation eloquently and peacefully, and refer a mentally ill subject to temporary treatment when possible.

RECOMMENDATIONS

It is prudent for law enforcement leaders to ensure officers have a solid foundation of mental health training. It is an endeavor that requires the support and commitment of the Executive Staff as the first key step to developing and implementing a quality, ongoing training program. Any training strategy must be based on agency dynamics and identified factors unique to each organization. The following recommendations can provide a solid foundation for the implementation of a comprehensive mental health training strategy such as CIT, PERT or similar models:

- Create a partnership with the County Mental Health agency for training ideas and formulation. You may find they will directly teach the training as a sub-contractor. Their participation will aid in either the increase or decrease in patient referrals
- Establish an executive steering committee comprised of all stakeholders to collaboratively work to formulate ideas and implement an effective training program
- Partner with the National Alliance of the Mentally Ill (NAMI) for ongoing educational resources and training opportunities

- The creation of a data collection mechanism is critical in order to monitor the overall achievement of program objectives. This will provide for an ongoing assessment of the training strategy and will facilitate any needed adjustments

STRATEGY DEVELOPMENT

In deciding how to embark on improved mental health training, law enforcement leaders should keep in mind that there is no one model that is a “one size fits all.” The Memphis CIT model is a well validated program which has been well received by many police organizations. Other agencies have implemented law enforcement-mental health co-response models such as the San Diego PERT program. Ultimately, the chosen course of action will be determined by several factors including budgetary constraints, available mental health resources and agency commitment.

The common denominator to the success of existing programs has been the strong collaboration amongst all stakeholders; including law enforcement agencies, mental health partners and the community (Schwarzfeld, Reuland & Plotkin, 2008). The envisioned outcome of any strategy should be to provide officers with the needed skills to safely and effectively handle calls involving mentally ill persons and to minimize the risk of injury to officers and those encountered. Taken further, the strategy should facilitate the safe and secure assessment and transportation of an individual in crisis, who meets the criteria established in Welfare and Instructions Code (WIC) Section 5150, to an appropriate mental health facility. Operating with these goals in mind, law enforcement is both fulfilling the legal mandate to protect the welfare of the mentally ill and also preventing the potential liability exposure associated with excessive force.

California POST offers both a 32 and 40 hour CIT course. Based on the Memphis model, a number of California agencies have embraced this training model and have anchored their training programs to its concepts. The Ventura County CIT program is one that has become a national model for proactive interface and collaboration between police agencies and mental health partners for the care and treatment of mentally ill persons (www.venturacountycit.org). Some possible benefits of the CIT program are:

- The tuition for the existing 40 hour P.O.S.T. approved CIT course is free to participating agencies. This would equate to a substantial savings in training costs for the department
- CIT trained deputies could provide on the job mental health training for other patrol deputies. They could also provide roll call briefing and/or provide department wide training bulletins related to various mental health topics
- The CIT curriculum could be included as part of the P.O.S.T. mandated Advanced Officer training, which is in-house training required for all in-service officers.
- NAMI has been a strong advocate of CIT training for law enforcement and has shown past support through the provision of mental health training resources as well as funding sources

CONCLUSION

As we reflect on the question of whether or not today's law enforcement officers are prepared to take on the challenges associated with the mentally ill population, many would conclude that the answer is "no." This article has presented the argument for the increased need for additional mental health training for law enforcement officers. Not only are there greater numbers of mentally ill persons functioning within our

communities today but also law enforcement officers are having increased interaction with this segment of the population.

Law enforcement officers are regularly responding to calls involving the mentally ill and are doing so with varying levels of success. This variation can be attributed to inadequate and in some cases a clear lack of mental health training for responding officers. When such calls end with an unjustified death or injury of a mentally ill subject, an officer's actions are subject to question and often attributed to a lack of mental health training. In those cases in which an officer's actions are deemed to be outside the realm of reasonableness, responsible police managers must ask the questions, "What happened?" and "How can we prevent it from happening again?" Not only can we improve upon our mental health training standards but we also have an obligation to our officers and to our communities to do so.

The alternative of implementing mental health training standards for law enforcement is a viable and necessary response to the ongoing impact of the mentally ill population on the police profession. Innovative programs such as the PERT and CIT programs serve as two good examples for consideration. If we are to be progressive in our attempts to fulfill our commitment to the community then our resources and preparation must mirror the needs of the community. To do otherwise would be irresponsible and contradictory to the community oriented policing philosophy.

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