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**Police Response to Persons with Mental Illness**

435**Wesley G. Jennings & Edward J. Hudak**

Prior to the 1960s the mentally ill were virtually “warehoused” in large state psychiatric hospitals in abject living conditions and with little emphasis placed on their treatment (Perez, Leifman, & Estrada, 2003). The nineteenth century marked the beginning in British and American construction of a variety of “welfare institutions,” such as insane asylums, workhouses, and prisons designed to provide custodial care for the mentally ill. The housing of these individuals was well intended and developed from a genuine concern for the well-being and safety of the mentally ill. However, the underlying motive was to protect the public from real or perceived abnormal/antisocial behavior.

Nevertheless, little time elapsed before these institutions became severely overcrowded. They subsequently became characterized by their inhumane living conditions and for their insensitive treatment of the mentally ill. This reality combined with the growing concern for the mentally ill; the increased availability of revolutionary psychotropic medications (e.g., Thorazine); the economic cost associated with institutionalizing the mentally ill; and state legislative restrictions on involuntary commitment, permissible length of stay, and community mental health centers were all factors that contributed to an era of immense social reform during the second half of the twentieth century (Aderibigbe, 1997; Murphy, 1989). These driving forces became the foundation for what is known as the deinstitutionalization movement and resulted in a paradigmatic shift in treatment of the mentally ill from “long-term psychiatric hospitalization to more independent living environments” (Krieg, 2001, p. 367; see also Manderscheid, Atay, & Crider, 2009).

The principal humanitarian, treatment-focused, and fiscally efficient determinants, which fueled the deinstitutionalization movement, have since 436contributed to the displacement of the mentally ill from within the mental health system and into the criminal justice system. Over the past five decades, the number of mentally ill institutionalized in state psychiatric facilities has markedly declined, from approximately 560,000 in 1955, to fewer than 60,000 today (National Association of State Mental Health Program Directors Research Institute, 2000). Comparatively, there are now more people with mental illnesses institutionalized in our nation’s jails and prisons than in all the state psychiatric hospitals combined (Sigurdson, 2000). Roughly 1 out of every 15 individuals in United States’ jails suffers from a major mental disorder, such as a major depressive disorder, schizophrenia, or bipolar disorder (Walsh & Holt, 1999; Steadman et al., 1999). The dynamic changes in public policy regarding the mentally ill (e.g., deinstutionalization, budget cuts in federal mental health funding, and legislative changes concerning the rights of mentally ill individuals) now means that a fairly significant segment of the mentally ill population needs a specialized response on behalf of the police (Teplin, 2000). This situation is even further evidenced as there are now more than 5.1 million individuals living in the community on probation and parole (Pew Charitable Trusts, 2009), of which a significant amount have a documented mental health issue.

The purpose of this chapter is to begin with a brief overview of the impact of both deinstitutionalization and the criminalization of the mentally ill on law enforcement. We then examine police interactions with citizens, specifically, the level of discretion police exercise and the training for dealing with persons with mental health issues. The chapter then offers a brief discussion of crisis intervention teams and police officers’ use of tasers with the mentally ill. We conclude by providing specific policy modifications for law enforcement departments to better prepare their officers for future encounters with the mentally ill.

**The Impact of Deinstitutionalization**

According to Lamb and Bachrach (2001, p. 1039), deinstitutionalization comprises three procedural processes: 1) the release of mentally ill individuals from psychiatric hospitals to alternative placement in the community; 2) the diversion of new psychiatric hospital admissions to alternative facilities; and 3) the development of special services for the noninstitutionalized mentally ill.

There is little controversy regarding the “success” of the first two processes. The occupancy of state hospital beds has drastically declined since its height of 339 per 100,000 in 1955. As of 1998, there were only 57,151 occupied state hospital beds for the 275 million persons living in the United States (21 per 100,000). However, the adequacy and availability of quality care for the mentally ill varies substantially. The improved care and services range from facilitating the mentally ill individual’s ability to realize a relative degree of normalcy in his or her routine activities, achieve greater satisfaction with 437life circumstances, and promote positive development to what is more often the case, where community-based care for the mentally ill is either grossly inefficient or absent (Lamb & Bachrach, 2001).

In order to fully understand the impact of deinstitutionalization on law enforcement agencies and their personnel it is important to first identify the basic demographics of the mentally ill. Although it is difficult to ascertain the exact number of persons with mental illness because of the lack of a comprehensive mental health data collection system, some estimates indicate that as many as 1 in 10 persons suffer from some type of mental illness, and that there are between 1 and 4 million seriously mentally ill persons in the United States. The mentally ill live in an array of community settings with varying degrees of care and means of support, including private residences, halfway houses or group homes, bed and board homes, nursing homes, single-room hotels, jails and prisons, and homeless shelters (Murphy, 1989). The prevalence of mental illness and the often poor living conditions of the mentally ill lead almost inevitably to their increased involvement with law enforcement agencies.

**Officer’s Role as a “Gatekeeper”**

According to Lamb, Weinberger, and DeCuir (2002, p. 1266), there are two common-law doctrines that emphasize law enforcement’s role in taking the responsibility for persons with mental illness: 1) their power and authority to protect the safety and welfare of the community; and 2) their *parens patriae* obligations to protect individuals with disabilities. The public visibility and the 24 hours a day, seven days a week availability of the police contribute to their often one-dimensional decision making in dealing with persons with mental illness (Lamb et al., 2002). In addition, society’s negative attitudes, misperceptions, and general apprehension toward the mentally ill further increases the police’s obligation to either recognize the individual’s need for treatment and connect him or her with the proper mental health service provider (Husted, Charter, & Perrou, 1995) or determine that the individual’s illegal activity warrants an arrest (Arboleda-Florez & Holley, 1988). This assessment procedure places the officer in the position of “gatekeeper” between the mental health system and the criminal justice system (Lamb et al., 2002) and forces a determination that many argue the police are neither trained nor qualified to deliver (Ainsworth, 1995; Bittner, 1967; Green, 1997; Ruiz, 1993).

**Criminalization of the Mentally Ill**

Abramson first proposed the expression criminalization of the mentally ill in 1972. This has been interpreted as meaning that a criminal justice rather than a mental health response has been adopted (Patch & Arrigo, 1999). This refers to the process by which the mentally ill citizens involved in minor criminal offenses such as disturbing the peace, public drunkenness, and trespassing 438are disproportionately arrested and prosecuted through the county court system (Bittner, 1967; Lamb & Weinberger, 2001; Teplin & Pruett, 1992).

The principal issue that arises from this flawed method of social control is that the criminal justice system was neither intended or designed to be the initial point of entry into the mental health system (Teplin, 2000). However, there is some evidence to suggest that there has been a trend in mental health laws and legislation in moving some of the emphasis away from safeguarding rights to ‘refuse treatment’ in an effort to help individuals with a need gain access to the necessary and appropriate mental health services (Carney, 2003). Consequently a number of those individuals suffering from a mental illness are being labeled as a “criminal,” as opposed to being directed to suitable treatment resources. This label virtually ensures that such individuals are significantly more likely to be arrested in subsequent cases of disorderliness (Teplin, 2000). The initial arrest, therefore, is typically the precursor of a perpetual cycle that shuffles mentally ill citizens between jail and the streets (Perez et al., 2003). In order to more fully understand this revolving door hypothesis between jail and the streets, it is essential to understand the nature of the interactions between the police and the mentally ill and the options officers have when dealing with encounters of this kind.

**Police Interactions with Citizens and the Mentally Ill**

Wilson (1968) developed a typology that placed the calls for police intervention into four distinct categories 1) police-invoked law enforcement, 2) police-invoked order maintenance, 3) citizen-invoked law enforcement, and 4) citizen-invoked order maintenance.

Police-invoked law enforcement is a proactive, legally sufficient, and officer-initiated response. The officer’s decision to act is based solely on his or her knowledge, perceptions, and personal assumptions about the mentally ill. Given that a substantial portion of the mentally ill are homeless and, as a result of deinstitutionalization, are forced to live on the streets, it follows that they are much more likely to be the recipients of police-invoked intervention. This is due to the combination of their visibility, their behaviors, and their disproportionate concentration in urban environments (Murphy, 1989; Patch & Arrigo, 1999; Wilson, 1968).

Police-invoked order maintenance refers to situations where the officer perceives a need to intervene to allay some sort of social disturbance. Public drunkenness and disorderly conduct are the crimes most commonly associated with this type of intervention (Brown, 1981; Wilson, 1968). Citizen-invoked law enforcement is the type of intervention that is initiated when a citizen makes a complaint. The officer, who is frequently forced to act within what amounts to considerable departmental constraints, usually resolves these instances. In such situations, officers make an attempt to “satisfy” all the parties involved, including the citizen who filed the complaint, the officer’s departmental supervisors, and the general public.

439The fourth type of intervention, citizen-invoked order maintenance, is relatively devoid of departmental influences because the situations necessitating this type of intervention are isolated events and cannot be anticipated by the officer (e.g. loud music, marital squabbles that prompt neighbor complaints, etc.) (Wilson, 1968; Patch & Arrigo, 1999, p. 29).

Encounters between law enforcement and the mentally ill follow patterns relatively similar to all police calls for service. The majority of the encounters occur during the evening shift followed by the day shift, with the fewest incidents happening during the night shift. However, the mentally ill tend to be most vulnerable and responsible for an increased number of calls for service during the night and weekend hours, as well as on public holidays. This is primarily because this is the time when the primary service resources (e.g., mental health agencies) for the mentally ill are unavailable (Murphy, 1989).

Additionally, police encounters with the mentally ill tend to occur in several key locations, with the individuals displaying a similar pattern of behavior. The majority of police contact with the mentally ill occurs either at or near the individual’s place of residence. The most common location is in the street, but incidents also occur in halfway houses, mental health agencies, and public buildings. The behaviors that most frequently characterize the mentally ill during their encounters with law enforcement include bizarre or unusual behavior, confused thoughts and actions, aggressiveness, destructive or violent behavior, and/ or attempted suicide. Furthermore, mentally ill citizens are typically unattached, lack social support mechanisms (most notably family support), diagnosed as psychotic (primarily schizophrenia), difficult to manage (in denial about illness), and/or have alcohol or drug abuse dependency problems (Murphy, 1989).

Overall, Wilson’s (1968) proposed typology of police–citizen interactions and the specific characteristics that describe the typical encounters between the police and the mentally ill (Lurigio & Lewis, 1987; Murphy, 1989) underscore the extent of the role that the public, the officer, and the mentally ill have in determining the officer’s level of discretion and response. The public (i.e., the citizen) has the right to voice his or her concern or file a formal complaint to the police requesting a response to a situation involving a person with mental illness. The nature of this complaint is variable as is the degree of authenticity that can be attached to it (people can and do lie); however, a perceived and reported public threat necessarily demands a police response.

Despite the mixed research on the use of prediction tools in law enforcement (see Jennings, 2006), some research has revealed several factors related to recidivism among mentally ill persons that might be beneficial when assessing risk. For instance, Lewis, Lurigio, and Riger (1994) followed a random sample of persons with mental illness out of a state psychiatric hospital in Chicago, IL, for a period of 12 months. Their findings showed a 20% recidivism rate, measured by re-arrest one year after their release. Perhaps the more provocative finding was that 75% of all the crimes committed by the former patients were either city ordinance violations (e.g., trespassing, public 440drunkenness) or property crimes (e.g., theft, burglary). However, upon further analysis, their findings revealed that the former patients who were re-arrested upon follow-up were characterized as having extensive and serious criminal and hospitalization histories.

In a similar study using arrest data, Lurigio and Lewis (1987) categorized the criminal histories of persons with mental illness into three groups: 1) crimes were a by-product of their mental illness (e.g., disturbing the peace, trespassing, intoxication, expressing symptoms of mental disorder in public); 2) crimes were committed for survival purposes (e.g., shoplifting, theft, prostitution); or 3) serious crimes were associated with their manifestation of severe mental illness and alcohol and drug dependency problems (e.g., assault, rape, robbery).

Additionally, the behavior and demeanor of the officer and the person with mental illness are also situationally specific. Nevertheless, regardless of the frequency of contact or the nature and type of police–citizen encounter, recent research has noted police officers’ frustration in handling mentally ill offenders and found evidence indicating that officers often cite the lack of coordination between the police and mental health professionals as one of the reasons for their frustration (see Cooper, Mclearen, & Sapf, 2004; see also Borum et al., 1997).

**Police Discretion with the Mentally Ill**

Generally, an officer has three possible choices upon encountering an irrational person creating a social disturbance. The officer’s first response option is to transport the person to a mental hospital. This alternative is usually employed whenever the mentally ill individual is either a danger to him- or herself or to others, or lacks the ability to protect him- or herself from victimization. However, this option often results in a frustrating and time-consuming experience for the officer as he or she has to spend a significant amount of time in the emergency room or the hospital waiting room, and, at times, the mental health professional at the hospital may not necessarily agree with the officer’s assessment/“diagnosis” for the individual that the officer transported to the facility. This situation can lead to a decision on behalf of the mental health representative/s of the facility to refuse to admit the individual or release him or her fairly quickly (Lamb et al., 2002, p. 1267; Steadman et al., 2001).

The officer’s second alternative is to make an arrest. This decision may appear to be the most severe, however, to many officers, it is preferable as it at least ensures that the individual will be provided with treatment; often the individual is either not dangerous enough to satisfy the strict hospital criteria for admission or was defined as too dangerous by the hospital’s standards. The officer’s third alternative, which is generally the least invasive and most preferred option, is to informally resolve the problem. However, responsibility for the subject’s continued conduct can fall squarely on the officer in 441today’s litigious society. At first glance these may appear to be three distinct alternatives, but the officers still exercise a great deal of discretion when determining which response is appropriate in any given situation (Teplin, 2000, p. 9; Patch & Arrigo, 1999).

Bittner’s seminal study on police discretion (1967) found that in encounters with the mentally ill, officers were reluctant to make psychiatric referrals unless an individual was perceived to be violent or a potential harm to him- or herself or someone else. Otherwise, in the majority of police encounters with the mentally ill, the officer chose the more informal alternative of “calming” the individual down.

Since Bittner’s (1967) study there have been a host of other researchers who have addressed the factors involved in an officer’s decision to arrest a mentally ill individual rather than transport him or her to a mental hospital. These determining factors include the level of the social disturbance, the strictness of legal requirements for involuntary commitment, the willingness of mental health facilities or state hospitals to accept intoxicated patients, the relative complexity of admission procedures, the length of waiting periods in the emergency room, and an officer’s perception that there are no other viable community alternatives (i.e., a “mercy booking’) (Durham, 1989; Gillig, Dumaine, Stammer, & Hillard, 1990; Laberge & Morin, 1995; Ogloff & Otto, 1989; Teplin, 1984). Regardless of the initial justification for the decision to either arrest or refer a person with mental illness to the state hospital, officers exercise a great deal of discretion and authority when determining which system, either criminal justice or mental health, is employed and by which means, either arrest or civil commitment, the mentally ill citizen will be processed (Patch & Arrigo, 1999). And, Morabito (2007, p. 1586) has gone even further to argue that the previous literature in this vein has “oversimplified police discretion” by not having specified parameters for scenic and temporal variables that are indeed important components of this interaction between the police and persons with mental illness.

**Police Training**

Most police departments in the early 1980s made attempts to incorporate specialized approaches and specific training curricula for how to more effectively deal with the mentally ill. Deane, Steadman, Borum, Veysey, and Morrissey (1999) found that as many as 88% of law enforcement agencies have some sort of training related to mental illness. Although the training has been proven to change officers’ attitudes toward the mentally ill, to enhance their knowledge of mental health-related issues, and to improve their relationships with mental health professionals, the content and quality of the training has not yet been quantitatively evaluated (Borum, 1999; Godschlax, 1984; Hails & Borum, 2003; Murphy, 1989).

In one such example, Deane et al. (1999, p. 100) administered a survey in 1996 to the police departments in the 194 cities in the United States with a 442population of 100,000 or more to determine the prevalence of specialized responses in dealing with the mentally ill. They found that 96 of the 174 departments that responded to the survey did not have any procedure in place for dealing with the mentally ill. The 78 departments that indicated the presence of specialized response strategies were categorized into one of the three following models:

1. *Police-based specialized police response:* This strategic response involves sworn officers who have special mental health training who can provide crisis intervention services and act as liaisons with the mental health system;
2. *Police-based specialized mental health response:* This strategic response utilizes mental health consultants, hired by the police department. The consultants are not sworn officers, but they provide on-site and telephone consultations to the sworn officers in the field; and
3. *Mental-health based specialized mental health response:* This strategic response is a combination of any other type of response and includes departments that rely solely on mobile crisis teams. The teams are part of the local community mental health service system and provide a response to any special needs at the site of an incident.

Hails and Borum (2003) performed a similar study in an attempt to update the findings from the 1996 survey (Deane et al., 1999). Their questionnaire was administered and responded to by a total of 84 of the 135 medium and large-sized police departments that were surveyed. Hail and Borum (2003) arrived at a similar conclusion to Deane et al. (1999). They found that very little attention and training, especially with new recruits and veteran law enforcement officers, was directed toward understanding and dealing with the mentally ill. This result was alarming considering the amount of media coverage, community tension, and legal liability that arises from situations where the police use deadly force against mentally ill individuals (Hails & Borum, 2003).

Despite the relative national inattention to the need for training officers in dealing with the mentally ill, several model programs do exist. Steadman et al. (2000) provided an analysis of three different study sites, each representing one of Deane et al.’s (1999) previously identified models for emergency response to the mentally ill. The Birmingham Police Department (Birmingham, Alabama) employs the police-based specialized police response model. The department utilizes community service officers to assist police officers with incidents involving the mentally ill. These community service officers are civilians, with some degree or professional training in social work or a related field, who provide 24-hour coverage, seven days a week (including holidays).

The Memphis Police Department (Memphis, TN) illustrates the police-based specialized mental health response model. This department utilizes a crisis intervention team, comprised of specially trained officers, to deal with situations involving the mentally ill. The officers on this team receive 40 443hours of specialized training from mental health professionals, family advocates, and mental health consumer groups, and are issued crisis intervention team medallions for immediate identification. Once a member of the crisis intervention team arrives on the scene he or she is automatically designated as the officer-in-charge. This Memphis model has since been replicated in various cities throughout the country.

The Knoxville Police Department (Knoxville, TN) utilizes the mental-health-based specialized mental health response model. This department has a mobile crisis unit that responds to calls from the community, as well as telephone calls and referrals from the jail regarding situations with the mentally ill. The Knoxville mobile crisis intervention unit was able to effectively link almost three-fourths of the mentally ill they encountered with the necessary treatment services, and only 5% of the incidents resulted in an arrest.

Acknowledging the positive results, these three programs were not without their flaws. For example, the findings indicated that they were frequently delayed and that their response times were lengthy, especially on nights and weekends. The limited number of trained staff and poor attendance at other similar assignments was also an issue. However, Steadman et al. (2000) still regarded these innovations as an overall success. More specifically, only 7% of the mental disturbance calls resulted in an arrest and more than half of the mentally ill individuals were either transported to or directed to appropriate treatment services. In addition, the officers were able to facilitate a resolution that enabled the individual to remain in the community without the additional impact of sanctions from the criminal justice system (Steadman et al., 2000).

More recently, Teller, Munetz, Gil, and Ritter (2006) examined police dispatch data logs for two years before and four years after the implementation of a crisis intervention team in Akron, Ohio. Members of the crisis intervention team included police officers and representatives from the local mental health systems. Their results indicated that since the implementation of the specialized training program (i.e., the creation of the crisis intervention team), there was an increase in the number and proportion of calls involving mentally ill persons, an increased transport rate (including voluntary transports) of mentally ill persons experiencing a crisis to local emergency treatment facilities, and no significant differences in the arrest rates pre and post intervention.

In addition, Morabito et al. (2012) provided an analysis of police–citizen encounters with crisis intervention-trained officers (CIT) in Chicago and reported that CIT training yielded some benefits in terms of a reduction in use of force. However, recognition of this benefit was complex as a number of relevant variables (e.g., demeanor, district characteristics, and subject resistance) affected this outcome as well. Furthermore, this benefit was not observed in all areas. Nevertheless, these findings along with the others reviewed above have significant implications for departmental and public policy, especially considering the success demonstrated when the police department and the mental health system work together in a collaborative effort and when CIT training is implemented.

**Police Use of Tasers with the Mentally Ill**

444Considering all of the legislative and policy changes targeting the mentally ill, it is no surprise that the police are now typically the first respondents to a mentally ill individual experiencing a crisis. While the probability of a fatal injury resulting from a police–mentally ill person encounter is rather low, law enforcement experts suggest that the police are often on “heightened” alert when responding to a call involving a mentally ill person because of the perception that the individual is likely to be carrying a weapon (usually a knife) for his or her own protection. Thus, in an effort to reduce the occurrence of fatal injuries and still make the officers feel safe, many police departments are now equipping their officers with tasers.

Tasers are an electroshock device that is considered a “less-than-lethal” weapon (similar to the classification of police batons, etc.). Although tasers vary in size and voltage depending on the brand etc., tasers deliver an electric shock via shooting two darts from the device that are attached with a tether. The range of a police-issued taser is approximately 20 feet, and this distance allows the officers to use this less-than-lethal weapon to de-escalate a potentially dangerous confrontation. Furthermore, this is an alternative to having to put themselves at risk of injury through direct personal contact with the mentally ill individual whose behavior demonstrates a threat and when previous attempts at verbally de-escalating the situation have been unsuccessful.

Munetz, Fitzgerald, and Woody (2006) have provided one specific study examining the deployment of tasers by Akron, OH, police officers who were members of a crisis intervention team. Despite the fact that the Akron CIT police officers responded to over 500 incidents involving mentally ill disturbances, the officers only reported deploying their tasers in 35 instances over the course of the 18-month period. More specifically, 21 of these individuals were already known to the public mental health system, and in most of the incidents the individuals were either considered acutely psychotic or had demonstrated suicidal tendencies. In addition, nearly 1 out of every 3 of these individuals possessed a weapon at the time the taser was administered. Overall, the findings in Munetz et al.’s (2006) study, such as the low prevalence of taser use and the absence of serious injury to any of the mentally ill individuals that were tasered, are also promising results.

Thus, although a considerable amount of public attention has been devoted to a few select cases where an officer either overuses or misuses his or her taser, there can be little argument that deploying a taser is certainly a more favorable option than discharging a firearm in less dangerous confrontations between the police and the mentally ill. Still, researchers often caution and recommend that tasers should only be used when dealing with a person with a mental health issue when it is clear that this “individual is imminently likely to sustain or to cause grievous bodily harm” (Edinger & Boulter, 2011, p. 589).

**Policy Implications**

445The fact that the mentally ill are being criminalized is a dual indictment of the failure of the mental health system and the criminal justice system, neither of which is effectively and appropriately dealing with persons with mental illnesses (Teplin, 2000). The reality of the situation is that neither system has proven itself able to manage mental health crises alone (Wolff, 1998). An integrated and collaborative effort between both systems might therefore prove to be the most beneficial for all parties (i.e., the mentally ill, law enforcement, the courts, corrections, and mental health treatment providers).

The police need to be aware of, and accept, that their primary role in dealing with the mentally ill is law enforcement. Their foremost concern should be ensuring the safety of the individual and the community. Having said this, once they have minimized the disturbance their objective should then shift to locating and transporting the mentally ill individual to the most appropriate treatment facility. Likewise, mental health professionals need to realize that their primary role is to assist the officer in conflict resolution and recommend the most beneficial treatment response. The two agencies would thus benefit from developing an ongoing and reciprocal understanding of the occupational expertise the other possesses (Lamb et al., 2002).

The Criminal Justice/ Mental Health Consensus Project was one of the most comprehensive and involved attempts to investigate police responses to persons with mental illness. Its purpose was to develop recommendations, with bipartisan agreement, to enhance the response of the criminal justice and the mental health systems in dealing with persons with mental illness. Stakeholders included state lawmakers, police chiefs, officers, sheriffs, district attorneys, public defenders, judges, court administrators, state corrections directors, community corrections officials, victim advocates, consumers of mental health services, family members, county commissioners, state mental health directors, behavioral health care providers, and substance abuse experts. The final report was released on June 11, 2002 (Council of State Governments et al., 2002), and Thompson, Reuland, and Souweine (2003) summarized the seven policy statements most germane to mental health professionals and law enforcement agencies for improving their response to the mentally ill:

1. Improve availability of and access to comprehensive, individualized services, when and where they are most needed, to enable persons with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement (mental health);
2. Ensure that people with mental illness who are no longer under the supervision of the criminal justice system maintain contact with mental health services and have support for as long as is necessary (mental health);
3. Provide dispatchers with training to determine whether mental illness may be a factor in a call for service, and use that information to dispatch the call to the appropriate responder (law enforcement);
4. 446Develop procedures that require officers to determine whether mental illness is a factor in the incident, and whether a serious crime has been committed, while ensuring the safety of all parties involved (law enforcement);
5. Establish written protocols that enable officers to implement an appropriate response based on the nature of the incident, the behavior of the person with mental illness, and available resources (law enforcement);
6. Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery (law enforcement); and
7. Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement.

**Conclusions**

As noted by Hails and Borum (2003; see also Morabito et al., 2012), understanding the problems regarding traditional police responses to persons with mental illness has resulted in the provision of a better service to the community. Unfortunately, when officers and agencies are not prepared and mistakes are made, lawsuits claiming negligence or deliberate indifference to these citizens are often filed. Nevertheless, properly trained officers or specialists can offer assistance and provide a specialized response in situations where time permits. These respondents are often part of a team and can react when called upon for support. In a barricaded suspect scenario, for example, or in a situation where a citizen needs help, these crisis intervention teams or trained individuals can provide much needed assistance to those in potentially dangerous situations.

Unfortunately, and quite often, officers face real and immediate threats from mentally ill individuals, and it is this threat to the officer or to a citizen that becomes critical and more important than dealing with the mental illness itself. When an individual, whether mentally ill or not, pulls a weapon on an officer, it is clear that the weapon is the most serious threat and must be dealt with for the safety of all those in the area including the mentally ill individual as well as the officer.

Additionally, officers would benefit from realizing that dealing or negotiating with a mentally ill person requires a more specialized and directed response than is generally employed in similar threatening situations involving a “normal” individual. For example, people with mental illnesses may be more apt to respond to and cooperate with an officer who recognizes the issues relevant to their life circumstances. The officer needs to be aware of how to best respond to the individual’s threatening behavior in a nonconfrontational and/or nonadversarial manner. Any immediate or aggressive action taken by the officer may inadvertently increase the mentally ill individual’s confusion and thereby intensify any abnormal/antisocial behavior. In an excellent review of these issues, Murphy (1989, pp. 9–10) has provided suggestions for officers, should they find themselves in such a situation.

447What officers *should* do when managing an encounter with a mentally ill person:

1. Check for any weapons that could be perilous to the officer.
2. Gather as much information as possible before arriving on the scene.
3. Be discreet and avoid attracting attention.
4. Be calm, avoid excitement, and portray a take-charge attitude.
5. Remove as many distractions or upsetting influences from the scene as possible—this includes bystanders and disruptive friends or family members.
6. Gather as much information as possible from helpful witnesses, family members, and friends.

What officers should not do when managing encounters with the mentally ill:

1. Do not become or allow excitement, confusion, or upsetting circumstances. These may frighten the person, inhibit communication, and increase the risk of physical injury to the officer, the subject, or bystanders.
2. Do not abuse, belittle or threaten. Such actions may cause the person to become alarmed and distrustful.
3. Do not use inflammatory words such as “psycho” or “nut house.”
4. Do not lie to or deceive the person. This can also cause the person to be distrustful. It may also limit any chances for successful mental health treatment and make any future management of the person by officers more difficult. It can also endanger the safety of other officers.
5. Do not cross-examine the person with a flurry of close-ended (e.g., “yes” and “no”) questions. Instead, the person should be asked questions that allow him to explain the problems that are bothering him.
6. Do not dispute, debate or invalidate the person’s claims. Do not agree or disagree with the person’s statements. Rather, legitimize the person’s feelings. For example, if the person claims a waitress is poisoning his/her food, the officer should say: “You believe that other people are trying to kill you?”
7. Do not rush the person or crowd his personal space. Do not touch the person unless you are prepared to use force. Any attempt to force an issue may quickly backfire in the form of violence.
8. Avoid being a “tough guy.” Tough methods will usually frighten the person and cause a defensive reaction and possibly violent behavior.
9. Do not let the person upset or trick you into an argument. Ignore any attacks on your character, personal appearance or profession, as these will undermine your ability to communicate and will also provide the person with ammunition for future attacks.

448Although these suggestions are not exhaustive (see Landsberg et al., 2002) and do not ensure a noncombative resolution in all situations, they remain useful, and serve to offer some guidance in dealing with the mentally ill.

This chapter has illustrated the profound impact that the process of deinstitutionalization has had on the treatment available to the mentally ill, and the duties and responsibilities of law enforcement. The ensuing and seemingly inevitable criminalization of the mentally ill has further exacerbated their plight. Not only do they suffer from often debilitating illnesses but they are also labeled “criminal,” often as a direct result of their illness.

In the midst of a mental health crisis, there is no disputing the existence of a genuine threat to the officer and any individuals in the vicinity. It is therefore the officer’s duty to take appropriate action to protect him- or herself and those in harm’s way, be it the mentally ill person and/or an innocent bystander. Police departments need to implement ongoing training for their officers to help them recognize the signs of mental illness, training that would include education on the different types and symptoms of various mental illnesses. For example, a situation involving a suicidal individual or a paranoid schizophrenic certainly requires a more immediate and cautious response than a situation involving an individual displaying only mild symptoms of depression. However, a misdiagnosis can and occasionally does have dire consequences: knowing when to act and when to stand back are therefore equally important, and are decisions that become far easier to make with comprehensive training.

Recognizing that characterizing police officers as “street-corner psychiatrists” is often viewed negatively, officers must nonetheless be provided with the necessary tools so that they can best deal with situations involving the mentally ill. Without training, and through no fault of their own, police officers run the risk of mishandling situations, and increasing the risk of injury to themselves, to the public, and also to those citizens who stand to benefit the most from such measures, the mentally ill individuals themselves. Some of the preliminary evidence indicates that using crisis intervention teams and equipping police officers with tasers may likely be successful initiatives when dealing with mentally ill individuals. Yet, more research is needed before departments wholeheartedly accept this practice of carrying tasers. Having said this, considering the lethality of an officer-involved shooting this may be a more acceptable alternative, particularly for officers that are in frequent contact with the mentally ill.

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Prepared especially for *Critical Issues in Policing* by Wesley G. Jennings and Edward J. Hudak.