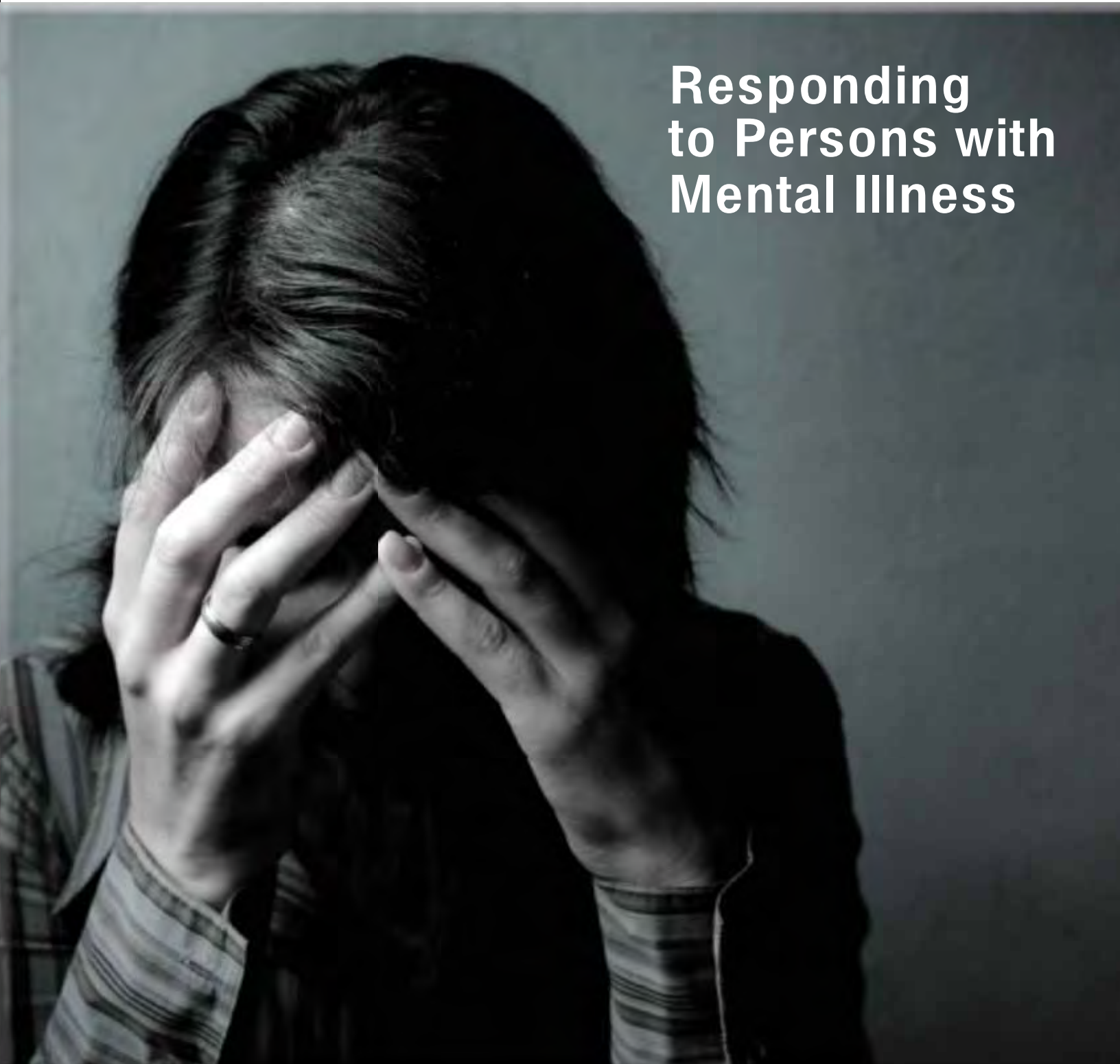




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FBI **Law Enforcement** **Bulletin**

**Responding
to Persons with
Mental Illness**





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Responding to Persons with Mental Illness

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While police officers may not consider providing services to persons with mental illness one of their primary functions, they respond to challenges and dangers that ordinary citizens and social service agencies are not equipped to manage. In addition to their roles as investigators and protectors, police still must keep the peace.¹ However, a review of case records illustrates

the frustrating and often tragic outcome of police calls for assistance pertaining to mental illness. A closer look at these instances demonstrates that officers usually serve as an initial contact for both the criminal justice and the social service systems. Unfortunately, a disconnect exists in the process from the first police response to the next level of appropriate care due largely to a lack

of proper training, resources, and collaborative community support.²

HISTORICAL PERSPECTIVES

The trend toward deinstitutionalization between the 1960s and 1980s contributed to the increased contact between police and individuals with mental illness.³ Further, the curtailment of federal mental health

funding and the introduction of legal reforms have given these persons the right to live in the community without treatment.⁴ However, many of the legal reforms in the 1970s affected people with mental illness by instituting laws for involuntary treatment, as well as those for nondangerous offenses (e.g., responding verbally to auditory hallucinations in public parks, sleeping on park benches). Beginning in the 1950s, officers adhered to the *professional model*, which used experts from other fields (e.g., psychologists, advocacy lawyers) to bolster police reform and response to mental illness.⁵ Such goals, while highly commendable, often were not realized by police agencies due to financial constraints, a lack of realistic

application, and the inability of the consulting professionals to offer useful guidelines.

Upon confrontation with individuals with mental illness, police have three main options: 1) transport them to a receiving psychiatric facility; 2) use informal verbal skills to de-escalate the situation; or 3) arrest the individual.⁶ These possible actions stem from basic concepts that guide police in all citizen encounters—the duty of the officer to protect and serve the community and the governing reforms that stipulate the power of an officer to involuntarily protect those behaving irrationally who may harm themselves or others.⁷

Recently, more comprehensive and flexible approaches have arisen; however, they

are in the minority. Examples include specialized police training and units, community-colaborative programs, and crisis intervention training. As widespread media coverage in the past decade has underscored, these limited options can lead to cases resulting in death or injury. Even more tragic is the increase in *police-assisted suicide*, defined by Police Officer Standards and Training as “an incident in which an individual engages in behavior which poses an apparent risk of serious injury or death, with the intent to precipitate the use of deadly force by law enforcement personnel toward that individual.” Research shows that a significant number of persons committing this act have some form of mental illness.⁸



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SPECIALIZED POLICE RESPONSE MODELS

Officers often receive blame for lethal outcomes in situations involving mental illness. Four decades ago, police were described as often being pigeonholed into making medical decisions with little training and few, if any, response options.⁹ Ironically, this conclusion still proves largely relevant today.

As one possibility, law enforcement agencies can employ police-referral programs. An examination of a police-referral program that designated an intake unit at a community mental health center (CMHC) found that streamlining the process of how officers refer individuals with mental illness to hospitals bolstered the program's effectiveness.¹⁰ Additionally, the analysis showed that a collaborative response between police and the CMHC reduced recidivism rates in referred psychiatric patients.

Police also can incorporate specialized programs. One report noted that although more than 50 percent of departments nationwide do not have such a program/response, most rate themselves as effective in managing service calls pertaining to mental illness.¹¹ This contradicts research that points to the efficacy of specialized response programs.¹² In an encouraging trend, more recent efforts suggest that the number of law

enforcement agencies reporting specialized training and units for dealing with persons with mental illness is increasing.¹³

Crisis Intervention Teams

The Memphis Model of Crisis Intervention Team (CIT) provides a framework for a police-based specialized officer

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response now well established in the field. CIT was created in Memphis, Tennessee, in 1988 following the tragic death of a suicidal man with schizophrenia.¹⁴ Although many officers of the Memphis Police Department knew of his mental illness, the ones responding to the particular incident were unfamiliar with him. When police confronted him and demanded that he drop his knife, the young man became upset and made a sudden move toward the officers, forcing them to shoot

(as they had been trained to do in such situations) and fatally wound him. Following this incident, the community demanded a response.

Unfortunately, this does not represent an isolated incident; law enforcement interactions with persons with a mental illness more frequently result in the use of force by police than incidents involving individuals who do not suffer from a mental condition.¹⁵ This can lead to injury of both the individuals and the officers. However, some of the incidents that result in the death of citizens at the hand of law enforcement personnel cannot be avoided, as in the case of individuals who commit suicide by cop. CIT offers investigators insight into these persons and, perhaps, options to pursue during their exchanges with them. The CIT model incorporates two main components: 1) a collaborative framework between the community mental health resources, recipients of those services, and local law enforcement agencies; and 2) specialized training for CIT officers in mental health issues, crisis intervention, and de-escalation.¹⁶

Collaborative Framework

Collaborations between policy makers, law enforcement, the regional division of the National Alliance for the Mentally Ill (NAMI), persons

with a mental health issue, and others from the community began to form in the initial CIT planning stages. One example of these collaborations in Memphis was the formation of a single-location mental health care facility for police drop-offs, called the Med.¹⁷ This facility enacted for police a no-refusal policy for officer referrals and streamlined the intake process to allow them to admit someone with mental illness and get back on patrol within about 30 minutes.

Officer Training

In addition to collaborations and policy changes, certain officers are selected or volunteer to receive specialized training as part of the 40-hour CIT training program. The CIT curriculum includes recognition and understanding of the signs/symptoms of mental illnesses (e.g., schizophrenia, depression, personality disorders); pharmacological interventions and their side effects; crisis intervention and de-escalation skills; and knowledge of the user-friendly mental health resources available to individuals. In addition, role playing gives officers opportunities to practice crisis situations involving persons with mental illness. Feedback and reinforcement are provided concerning the officers' verbal and nonverbal behaviors in these scenarios.

Mental health professionals from the community teach the majority of the course components; patients and their families also participate in educating the officers on relevant mental health challenges and issues to add perspective. Police learn how to recognize severe mental illness and how these different disorders affect the individuals.

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At the end of the course, officers graduate with CIT certification and receive a pin to wear on their uniforms, identifying them as CIT officers. This allows persons with mental illness in crisis to recognize CIT officers and also serves as a source of pride for the law enforcement professionals.

Research Support

Experts evaluated the Memphis CIT model by comparing perceived preparedness, quality of response to persons with mental illness, diversion from

jail, officer time spent on these calls, and community safety and found empirical support for the effectiveness of this approach.¹⁸ Additional researchers expanded on this work by using arrest rates and feedback from referral sources.¹⁹ Their results provided further support for the Memphis CIT model with findings of higher response rates and fewer arrests. Also, it appears that an integral component of CIT training is the use of crisis intervention and active listening skills (e.g., paraphrasing, reflecting emotions, asking open-ended questions), which are critical for de-escalating crisis situations in general and situations involving individuals with mental illness in particular.²⁰ Apparently, psychological evaluation concerning mental health issues, as well as crisis intervention skills training, both comprise important aspects of CIT.

Barriers and Concerns

One barrier in the development of police-based specialized officer response is the definition of training in the field of law enforcement. Basic officer training will prove inadequate in addressing this growing and volatile problem without ongoing review and skill maintenance. Researchers note the common misperception that all police officers have the same mandated training and available resources.²¹ Other experts

contend that for specialized response programs to work effectively, training is a crucial element. Law enforcement training is most effective when it includes consultation with mental health professionals and other administrative and social service systems.²²

The mental health care system itself appears to be another barrier to policing progress involving mental health situations. Social service agencies often refuse to admit intoxicated or psychotic persons referred by police. In addition, the “revolving door” phenomenon of recidivism supports the reality of overworked and underpaid staff in receiving facilities, such as hospitals and community mental health centers. Specifically, many treatment facilities require police custody in the waiting area for individuals transported for a mental disturbance. Also, no systematic and hierarchical structure exists that links first responders (e.g., police, EMS) with the appropriate level of care in the mental health system (e.g., medical versus psychiatric hospitals, social service shelters versus drug rehabilitation centers).

FINDINGS

Overall, research supports the use of a specialized law enforcement response to address the needs of persons with mental illness. In particular, the

Memphis CIT model is functional, generally accepted by police departments, and, most important, effective.²³

The utility of such programs is enhanced by the use of collaborative drop-off sites. These allow for greater flexibility, provide ease and speed in application, and serve as a more

“...research supports the use of a specialized law enforcement response to address the needs of persons with mental illness.”

economical option. However, a few important guidelines can make a substantial difference in effectiveness. For example, researchers recommended police-friendly procedures that include a no-refusal policy, an intake process with streamlined paperwork, and consistent procedural steps.²⁴

CONCLUSION

Police officers maintain and enforce public order. Their role as both first responders and peacekeepers remains a challenge in many ways. The law

enforcement response to mental disturbance calls with ethical, practical, and effective strategies requires interagency collaboration. Numerous examples attest to the efficacy of police-based interventions and collaborative policies and procedures. In particular, current research supports the use of a specialized law enforcement response to meet the needs and demands of persons with mental illness while ensuring their safety and dignity. ♦

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