

Chapter 2

Best Practices in Law Enforcement Crisis Interventions with the Mentally Ill

Abstract This chapter describes the BPM for teaching police to recognize and avoid arresting the mentally ill and getting them the appropriate mental health services.

The first step in the Best Practices Model (BPM) is to triage between those mentally ill who continue to pose a danger to society and those who may have engaged in a criminal act that is associated with their mental illness and, therefore, would not benefit from punishment or would be deterred by legal consequences. The latter group should be referred to a mental health provider so that their needs can be determined and services delivered in the most efficacious manner for each individual given available community resources. Diversion, then, should be to an effective community program and not into the criminal justice system. In fact, the criminal justice system might never come into contact with these individuals if they are successfully diverted prior to arrest. A crisis intervention model, first developed by Memphis, Tennessee, Police Department, in collaboration with the University of Tennessee, is Crisis Intervention Team Training (CIT), which has become the BPM used across the country today. This model provides formal training for police officers in how to differentiate non-violent mentally ill from violent offenders, and then work in teams to help problem solving when a crisis arises. As part of CIT training, police are made aware of available resources for the mentally ill in their community and are able to direct individuals to the appropriate agency. The community agencies agree that they will have a no-refusal policy so that the interaction can occur efficiently and not take the officer away from his/her other duties longer than necessary. The goal for the individuals involved is to be directed to appropriate care and not have any further contact with the criminal justice system.

Police officers have become the first responders to the seriously and chronically mentally ill. Most people diagnosed with schizophrenia or bipolar disorder, the most common diagnoses among the seriously and chronically mentally ill, are able to be stabilized if maintained on their medication and provided with intensive case management. Problems may occur when they no longer take their medication and begin to act out; however, if caught early, most can be stabilized. Even when the mentally ill person engages in a non-violent minor infraction, the benefits of getting

them needed mental health treatment rather than arresting them are well documented. The model of community policing has been encouraging police to get to know people, including the mentally ill, in their neighborhood to resolve minor infractions and avoid making unnecessary arrests. However, police need proper training to better identify and interact with the non-dangerous mentally ill. In some communities, mental health professionals work directly with police to assist them. Many police departments also employ police psychologists to work within their department. In other communities, even those mentally ill who engage in a violent offense directly related to their illness may be deferred from jail and into community treatment.

Law enforcement is increasingly being charged with the management of severely mentally ill individuals in a crisis. Indeed, research indicates that most individuals with a serious mental illness will be arrested at least once, with many arrested more frequently (McFarland et al. 1989). For example, in an investigation of 331 hospitalized individuals with serious mental illnesses, 20 % reported being arrested by law enforcement within four months prior to their hospital admission (Borum et al. 1997). In addition to the responsibilities of management and detainment of mentally ill persons, police officers must continue to perform their primary duty of keeping the peace. These combined responsibilities present a unique challenge in their efforts to protect the public and deal with the mentally ill.

The Role of Community Policing

Over the past 30 years, law enforcement has placed greater emphasis on maintaining order and non-emergency situations, while still adhering to the primary duty of crime control (Kelling 1988; Moore 1994; Skolnick and Bayley 1986). The modern reform approach, known as community-oriented policing (COP), emphasizes partnerships, problem solving, and prevention (Bureau of Justice Assistance 1994; Mastrowski 1988). COP was based on research attempting to ascertain best practices in law enforcement. For example, Mastrowski et al. (1995) identified three COP strategies: the problem-oriented policing approach, the “broken windows” approach, and the community building approach. Problem-oriented policing encourages the utilization of resources and the involvement of civilians in crime solving activities (Goldstein 1990). The “broken windows” approach (Reiss 1985; Sykes 1986) acknowledges and adheres to the use of police attention (e.g., warnings, street stops) to minor crimes to identify problem individuals in the community. Finally, community building focuses on victim assistance (Braithwaite 1989; Crank 1994; Rosenbaum 1988) and provides instrumental services (e.g., neighborhood patrols, participation in prevention programs) to that community while deemphasizing traditional law enforcement activities.

COP involves law enforcement working closely with communities to address problems and prevent/reduce crime. This allows police officers to (1) gain a clearer understanding of activities in those areas, and (2) identify issues of concern for a

particular neighborhood or community. COP provides law enforcement the opportunity to form collaborative relationships with criminal justice and mental health professionals, allowing for streamlined voluntary/involuntary commitments and the identification of “breakdowns in the system” (Cordner 2000). Additionally, police officers are encouraged to focus on problem solving in order to identify and remediate issues or conditions that lead to critical incidents. Examples of COP include neighborhood watch programs, storefront policing stations, foot patrols, and working relationships with other identified community agencies (Weisel and Eck 1994).

As police officers continue to be involved in the community, they often come into contact with individuals suffering from mental illness. In fact, police officers have been described as “gatekeepers” to mental health services and “street-corner psychiatrists” (Cumming et al. 1965; Sheridan and Teplin 1981; Teplin and Pruett 1992). Based on the COP approach, police officers are also more likely to be involved not only with individuals with mental illness, but also their family members, medical/psychiatric facilities, community outreach programs, and situations requiring crisis intervention. It is in the latter that police officers will be the first responders; situations traditionally more suited to mental health professionals. However, law enforcement, in general, has become increasingly aware of the need to divert mentally ill persons to mental health facilities rather than incarceration. In addition, many law enforcement agencies are applying COP principles to enhance their response to the mentally ill when they are in crisis.

Models of Police Response

Law enforcement agencies applying COP principles to enhance their response to mental health crises in community settings have followed one of three models (Deane et al. 1998): police-based specialized police response, police-based specialized mental health response, or mental-health-based specialized mental health response. The police-based specialized police response model involves law enforcement officers with special mental health training who serve as the “first-line” police response to mental health crises within the community. These officers also act as liaisons to the mental health system. The police-based specialized mental health response model utilizes mental health professionals who are employed by a law enforcement agency to provide on-site and telephone consultations to police officers in the field. The mental-health-based specialized mental health response model consists of more traditional partnerships and cooperative agreements between law enforcement and mobile mental health crisis teams, which exist as part of the local community mental health service system and operate independently of the police department.

Lamb et al. (2002) proposed a fourth category which consists of a team of mental health professionals associated with a community mental health system,

who have made arrangements with local police departments respond in certain crisis situations when needed. While many departments in American cities with populations of 100,000 or more do not have specialized strategies to respond to mentally ill persons in crisis (Deane et al. 1998), those that do utilize one of the four specialized response models. Lamb et al. (2002) further delineate the different types of crisis response into four categories: police officers with specialized training in mental health, mental health professionals as consultants to police departments, psychiatric emergency teams of mental health professionals, and combination teams of police officers and mental health professionals.

Innovative approaches derived from each of the models are currently being implemented by police departments to more effectively deal with mentally ill individuals. An example of the police-based specialized police response is the Crisis Intervention Team (CIT). CIT utilizes police officers who have specialized mental health training and communicate directly with the local mental health system.

Program Effectiveness

According to research by Borum et al. (1998) on the three response programs for mentally ill individuals in crisis, officers from a jurisdiction with a specialized mental health team rated their program as being highly effective in meeting the needs of the mentally ill in crisis, keeping the mentally ill out of jail, minimizing time invested in mental health calls, and maintaining community safety. This investigation also found that police officers from departments rely on mobile crisis units, and on law enforcement-based social workers, both rated their programs as moderately effective on each dimension, with the exception of minimizing time invested in mental health calls (where mobile crisis units had significantly lower ratings).

Lamb et al. (2002) compared the utility of having mental health professional involvement versus training law enforcement. An advantage of a working relationship between police officers and mental health professionals is that when resolution is not possible, the number of people with mental illness who receive psychiatric referrals (as opposed to going to jail) increases as do admissions into psychiatric hospitals. Additionally, by including mental health professionals, there is potentially more information available regarding a particular individual's psychiatric history. Knowledge of prior arrest and psychiatric history can be invaluable when responding to an individual in crisis. Lamb et al. (2002) suggest that a downside to involvement of mental health professionals in crisis situations is their response time to such incidents. If response time is slow, law enforcement may not bother with requests for mental health professionals to be involved in a crisis situation.

The CIT Model

The CIT Model was developed in 1987 following an officer-involved shooting of a mentally ill African-American male in Memphis, Tennessee. The incident involved an individual with a known history of mental illness, who was observed cutting himself with a knife and verbally threatening suicide. A 911 call was made, and police officers were dispatched to the scene; the only eminent danger appeared to be to the suicidal individual himself. However, once police arrived and instructed the individual to drop his weapon (a knife), he rushed the officers, causing them to open fire and kill him out of fear for their own safety (Vickers 2000). The officers involved in this incident were White, and the individual who was shot was African-American. Thus, public perception of the event was based on already existing racial tensions of the location and time period. In fact, the outcry from the public was instrumental in the development of the original Crisis Intervention Team (CIT).

Following this incident, the Memphis Police Department, with the support of the Mayor's office, formed a partnership with the Memphis Chapter of the Alliance for the Mentally Ill (NAMI), the University of Memphis, and the University of Tennessee to develop a specialized response unit within the department. In response to a directive indicating that services were to be provided voluntarily, and at no expense to the city of Memphis, the department initiated CIT (Cordner 2006; Steadman et al. 2000).

CIT is composed of selected police officers who receive 40 h of specialized mental health training. This advanced training is usually provided by mental health experts, family advocates, and mental health consumer groups, who provide information regarding mental illness, co-occurring substance abuse disorders, and crisis intervention techniques. These officers are also informed about community-based resources for the mentally ill, receive empathy training, and participate in role plays to prepare for interactions with this population (Lamberti and Weisman 2004).

CIT officers perform their usual patrol duties; however, they are dispatched immediately to deal with crisis situations involving individuals with mental illness. Upon the officers' arrival, on-scene command is assumed. In situations where a mentally ill person is in crisis, hospitalization may be necessary. At the discretion of CIT-trained officers, subjects may be brought to the University of Tennessee Medical Center, where emergency medical and psychiatric treatments are available. Through a "no refusal" policy, stating that psychiatric facilities cannot turn away mentally ill persons, officers are able to leave the subject at the appropriate facility and return to patrol quickly. In fact, response times have been noted to be less than 10 min, with CIT officers handling 95 % of all "mental disturbance" calls, and with most officers being supportive of the program (Cordner 2006). Additionally, time spent awaiting mental health admissions is reduced, arrest rates of individuals with mental illness have decreased, referrals for treatment have increased, police injuries occurring when responding to calls involving the mentally ill have declined, and

callouts for other specialized tactical response teams (i.e., SWAT) have been reduced (Borum 2000; Dupont and Cochran 2000; Reuland and Margolis 2003; Steadman et al. 2000). A recent evaluation of CIT in Louisville, Kentucky showed that CIT programs may be cost-effective and reduce psychiatric morbidity by referring seriously mentally ill individuals to appropriate treatment directly, rather than at a later point in time (Strauss et al. 2005).

In addition to the direct benefits of the CIT model, trained officers have reported benefits as well. For example, officers surveyed from each of the three previously described models rated how well prepared they were handling people with mental illness in crisis (Borum et al. 1998). Of the three sites (Birmingham, Knoxville, and Memphis), Memphis CIT officers were the least likely to feel that other officers were well prepared and were significantly less confident about the abilities of other officers than were their non-CIT counterparts. Borum et al. (1998) also found that Knoxville (mobile crisis team) officers reported that their mental health system was the least helpful. Further, Memphis CIT officers were significantly more likely to rate the mental health system as being more helpful than were the other sites or non-CIT Memphis officers. Borum et al. (1998) also noted that Memphis CIT officers were more likely to rate the emergency room as being more helpful than officers at the Birmingham (community service officers) and Knoxville sites.

Overall, it appears that officers from a jurisdiction with a police-based specialized police response capacity view their program as more efficacious in attending to the mentally ill in crisis, keeping the mentally ill out of jail, minimizing the amount of time officers spend on such calls and maintaining community safety. The Memphis CIT model appears to meet these demands and appears to be an effective program for transporting the mentally ill to appropriate treatment facilities.

Other cities, such as Houston, Portland, Seattle, and Albuquerque, have adopted the Memphis CIT model or use the Memphis model as a basis for development of CIT in their area (Lamberti and Weisman 2004). The Louisville Metro Police, with the assistance of the University of Louisville, developed one such approach based on the Memphis CIT model. Strauss et al. (2005) conducted an investigation to determine if CIT-trained officers were able to distinguish the mentally ill from other persons, and if the appropriate decision to transport the mentally ill to emergency psychiatric care was being made. Data from the investigation reflected that the trained CIT police officers adequately identified subjects in need of psychiatric services. Strauss et al. (2005) suggest that utilizing CIT programs provides an avenue for the mentally ill to receive treatment earlier, resulting in reduced costs and psychiatric morbidity.

Compton et al. (2006) investigated whether officers who received mental health training changed their attitudes toward individuals suffering from schizophrenia. These investigators found that the trained officers reported increased knowledge about schizophrenia, were more supportive of treatment programs, and experienced a change in their beliefs regarding violence and schizophrenia. These results suggest that training in CIT may reduce stigma that law enforcement officers have toward the mentally ill, result in better understanding of the mentally ill, and dispel existing myths regarding this population (Compton et al. 2006).

The CIT program in Akron, Ohio includes a 40-hour overview of mental disorders, information regarding the local mental health system, de-escalation skills, and role plays of crisis situations. Officers also train with case managers by accompanying them as they perform their duties in psychiatric emergency service centers and a consumer-directed social center. Teller et al. (2006) analyzed dispatch data following the implementation of CIT program to determine the impact of training. Results demonstrated that CIT-trained officers were more likely to transport individuals for psychiatric treatment than those officers who did not receive the training. Furthermore, results demonstrated that the trained officers were less likely to complete calls without arranging transportation of the individual in crisis. Interestingly, data from this investigation revealed that individuals with mental illness and their family members reported an increased comfort level in requesting assistance from law enforcement.

Jail diversion programs recently have been developed, in which the interaction between CIT-trained law enforcement professionals and the mentally ill is now viewed as the first phase of intervention/prevention of the mentally ill entering the criminal justice system (Lamerti and Wersman 2004). Along these lines, Munetz and Griffin (2006) developed the Sequential Intercept Model as an interface for addressing concerns about the criminalization of the mentally ill in five phases of inception: (1) law enforcement and emergency services, (2) post-arrest (initial detention and initial hearings), (3) post-initial hearings (jails, courts, forensic evaluation, forensic commitments), (4) re-entry from jails, state prisons, forensic hospitalizations, and (5) community corrections and community support. This model stresses the importance of the pre-arrest phase as the first line of interception and the point where CIT programs may impact the remaining three phases of the model.

Conclusions and Future Directions

Based on the development and subsequent investigation of CIT program models, and taking into account historical and recent trends in crisis intervention, the most effective practice for crisis intervention appears to be the implementation of the police-based specialized response program, known as the Memphis CIT model. Such programs appear to adequately prepare law enforcement officers not only for interaction with the mentally ill, but also with addressing their potential treatment needs in lieu of detaining and incarcerating this challenging population. Although there are several issues warranting further attention, (e.g., continued stigma of the mentally ill, and a lack of cooperation between police and medical/mental health facilities), utilization of the Memphis CIT model appears to be an initial step toward addressing such issues.

Despite the positive results from available research regarding CIT, there are many avenues for additional research remaining. We concur with the implications for future research outlined by Tucker et al. (2008), including advancements in

assessment, the expansion of sample populations, longitudinal studies, and applications of existing research. For example, Sellers et al. (2005) found that the actual and perceived effectiveness of the Newark Police Department's strategy of treatment-focused response is equal to, and in some cases more effective than, that which has been observed in agencies with a specialized response program. Such findings suggest that specialized training may not be necessary when there are traditional, treatment-focused responses to individuals with mental illness.

Borum (2000) notes that CIT programs typically identify officers who appear to be most interested, have good interpersonal skills, and have amenable attitudes. We believe that providing comprehensive training to carefully selected CIT recruits will be beneficial by providing information regarding the differing needs of mentally ill subjects who may be in crisis at the point of contact.

There is a consensus that police departments employing a CIT model may reduce the number of situations involving unnecessary force and/or arrest. Hails and Borum (2003) found that approximately one-third of the law enforcement agencies they surveyed had some form of specialized response for dealing with the mentally ill, and the number of agencies employing a CIT program is steadily growing across the country. CIT is clearly beneficial, although continued research and training is required to foster further development of these programs. Continuing to encourage police agencies to utilize such an approach will undoubtedly improve the responses to the subjects who are mentally ill in their communities.

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