The Police and Mental Health

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With deinstitutionalization and the influx into the community of persons with severe mental illness, the police have become frontline professionals who manage these persons when they are in crisis. This article examines and comments on the issues raised by this phenomenon as it affects both the law enforcement and mental health systems. Two common-law principles provide the rationale for the police to take responsibility for persons with mental illness: their power and authority to protect the safety and welfare of the community, and their parens patriae obligations to protect individuals with disabilities. The police often fulfill the role of gatekeeper in deciding whether a person with mental illness who has come to their attention should enter the mental health system or the criminal justice system. Criminalization may result if this role is not performed appropriately. The authors describe a variety of mobile crisis teams composed of police, mental health professionals, or both. The need for police officers to have training in recognizing mental illness and knowing how to access mental health resources is emphasized. Collaboration between the law enforcement and mental health systems is crucial, and the very different areas of expertise of each should be recognized and should not be confused. *(Psychiatric Services* 53:1266—1271, 2002)

Since the advent of deinstitutionalization and the exodus of persons with mental illness into the community, law enforcement agencies have played an increasingly important role in the management of persons who are experiencing psychiatric crises. The police are very often the first to be called to deal with persons with mental health emergencies (1—4).

The purpose of this article is to review the literature on the role of the police in responding to persons with severe mental illness in the community who are experiencing crises and on issues that often arise during the necessary interactions between law enforcement and mental health professionals. On the basis of both the literature and our own experience, we offer recommendations on how to optimize the collaboration between the law enforcement and mental health systems to improve the care of persons with severe mental illness who are in crisis.

Background

The rationale for the police to intervene in the lives of persons with mental illness derives from two common-law principles: the power and authority of the police to protect the safety and welfare of the community, and the state s paternalistic or parens patriae authority, which dictates protection for citizens with disabilities who cannot care for themselves, such as those who are acutely mentally ill (5,6). Often both principles are involved when police are dealing with persons with mental illness who pose a threat of danger to the community or to themselves.

Police officers have a legal obligation to respond to calls and to provide services 24 hours a day, seven days a week. With respect to persons with mental illness, police in all states have the power to transport persons for psychiatric evaluation and treatment when there is probable cause to think that they are a danger to themselves or to others because of their mental condition.

The police are typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness. They are responsible for either recognizing the need for treatment for an individual with mental illness and connecting the person with the proper treatment resources (7) or making the determination that the individual's illegal activity is the primary concern and that the person should be arrested (8). This responsibility thrusts them into the role of primary gatekeepers who determine whether the mental health or the criminal justice system can best meet the needs of the individual with acute psychiatric problems (9).

As a result, law enforcement officers may have assumed the role of "street-corner psychiatrist" by default. It would appear that many officers have grown accustomed to this role and consider it one of their duties (7); however, other officers do so reluctantly, and some with resentment (10). A major problem with having to fulfill this role is that the police have

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little training in performing this kind of triage (3,4,7,10—13). As we discuss, this lack of training is one of the factors that has played an important part in the criminalization of persons with mental illness.

Police discretion

The police have a great deal of discretion in the exercise of their duties, including determining what to do when dealing with a person with acute mental illness in the community (4,14—16). In most cases, the police use informal tactics, such as trying to "calm" the person or taking the person home. One study found that such arrangements occurred in nearly three-fourths of cases (1). Bittner (11) referred to this practice in the 1960s as "psychiatric first aid." In situations that cannot be handled informally, the police may have to take persons with mental illness to hospitals or to jails.

In some cases, however, public policy limits the police officer's discretionary ability. For instance, if the person with mental illness is alleged to have committed a major crime, the disposition is clear—that person is taken to jail because of the seriousness of the offense. In this situation, it is hoped that mental health evaluation and treatment will take place while the person is in custody.

A number of factors have been proposed to explain why, when minor offenses are involved, a police officer decides to arrest a person with mental illness rather than take the individual to a hospital. A person who seems to be mentally ill to a mental health professional may not seem so to police officers—who, despite their practical experience, have not had sufficient training in dealing with this population (7,17). In some cases mental illness may seem to the police to be alcohol or drug intoxication, especially if at the time of arrest the person has been determined to have been using drugs or alcohol. Another factor is that in the confusion that may accompany an encounter with the police and other citizens, in which the individual may be forcibly subdued, signs of mental illness may go unnoticed (18). It has also been shown that the occurrence of violence at the time of arrest increases the chances that the person with mental illness will be taken to jail (19).

In addition, law enforcement officers may be more inclined to charge persons with mental illness with a misdemeanor and take them to jail if they think that no appropriate alternatives are available (20), a practice that has been referred to as mercy booking. Despite the euphemism, the authors regard this as a major cause of criminalization. In jurisdictions that have few psychiatric inpatient beds or have limited community mental health services, psychiatric treatment may be more accessible in jail than in the community. Moreover, with the advent of strict civil commitment procedures, making use of the available treatment resources may be difficult with persons who do not want to receive treatment. Thus the relative availability of services in jail may influence police officers' decision on whether to arrest a person with mental illness. Although mercy booking may be viewed as unconstitutional, most states do not have laws against detaining in jail people with mental illness who are obviously not criminals (9,21).

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Even if the police consider a person's urgent problem to stem largely from mental illness, their choosing the mental health option can be both problematic and aggravating for them. There may be long waiting periods for psychiatric emergency services during which police officers cannot attend to other duties. Mental health professionals may question the judgment of police officers and refuse to admit the person, or they may quickly release a person who just a short time earlier was thought by the police to constitute a clear menace to the community (22,23).

On the other hand, the police are well aware that if they refer a person with mental illness to the criminal justice system, the individual will be dealt with in a more predictable way. He or she will be taken into custody, will probably be seen by a mental health professional attached to the court or the jail, and will probably receive psychiatric evaluation and treatment. Thus arrest is a response with which the police are familiar, one over which they have more control and one that they think will lead to an appropriate disposition (24,25). Moreover, when persons with mental illness who are socially disruptive are excluded from psychiatric facilities, the criminal justice system becomes the system that "can't say no" (26).

When the interaction between the police and the person with mental illness is initiated by the police themselves, police officers have the greatest amount of discretion. In such situations, there is considerable potential for the disposition to be influenced by police officers' personal attitudes or beliefs. There may well be no one—neither citizens nor the police officers' superiors—overseeing whether a situation is handled in a standardized fashion and in a way that protects both society and the individual. In these instances, the officers act freely and solve the problem in whichever way they deem appropriate, on the basis of their particular attitudes toward, perceptions of, and assumptions about persons with mental illness. The result is that some police officers are more prone to arrest persons with mental illness, some make a more vigorous attempt to have these persons hospitalized, and a few tend simply to release them with no further disposition (4).

Often, however, the interaction between the police and the person with mental illness is initiated by citizens. In such cases, the citizens' demands also may come into play and limit the discretion of the police (4). For example, many retail stores have a policy that anyone caught shoplifting should go to jail, and store managers are instructed to make a citizen's arrest and call the police without exception. In another kind of situation, people who have just been assaulted by a psychotic person frequently are not inclined to be sympathetic to their assailant, even when mental disturbance is evident. The result may be an angry citizen who insists on having the person arrested and taken to jail.

Coordination of police and mental health professionals

Generally, the potential for violence underlies the majority of psychiatric emergencies (27—29). A growing body of evidence suggests that a subgroup of persons with serious mental illness are significantly more dangerous than persons in the general population—particularly those who are psychotic, do not take their medications, and are substance abusers (30—35). This subgroup poses a considerable challenge both to mental health professionals and to the police.

From the standpoint of the police, it is clear that officers need and want rapid on-site assistance from mental health professionals when they are called on to deal with difficult or complex situations involving persons with mental illness who are acutely psychotic, behaving bizarrely, or exhibiting violent behavior or persons who have attempted suicide or made a suicidal gesture (36). Similarly, mental health professionals who are working as members of psychiatric emergency teams without police support may feel ill equipped to handle such individuals in the field (37-39). Thus it has become increasingly apparent in recent years that when persons with mental illness in the community are in crisis, neither the police nor the emergency mental health system alone can serve them effectively and that it is essential for the two systems to work closely together (3).

Mobile crisis teams

Psychiatric emergencies have been dealt with effectively in communities in which close formal liaisons between law enforcement and the mental health system have been established (3,40). These arrangements facilitate the resolution of crises of persons with mental illness in the field without the need to resort to hospitalization or incarceration. When resolution is not possible, the existence of these liaisons increases the number of persons with mental illness who are referred to the mental health system rather than jailed, thus reducing criminalization. For those who need psychiatric hospitalization, these approaches tend to increase the rate of acceptance by hospitals (7,37,41).

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Different strategies have been developed to provide a mobile team of police, mental health professionals, or both to respond to persons with mental illness in the community who are in crisis (42,43). Many jurisdictions use sworn police officers who have special mental health training to provide crisis intervention services and to act as liaisons to the mental health system (44). This approach is often referred to as the Memphis model. These persons may actually deal with mental health emergency situations on-site or act as consultants to the officers at the scene. This model places a heavy reliance on psychiatric emergency services that have agreed to a no-refusal policy for persons brought to them by the police (43). This strategy minimizes the participation of mental health professionals in the field.

Another strategy that police departments use is one in which mental health consultants who are not police officers are hired by the police department (42). These consultants provide on-site and telephone consultations to officers in the field. Another widely accepted strategy uses psychiatric emergency teams of mental health professionals who are part of the local community mental health service system but have developed a special arrangement with the police department to respond to special needs at the site of an incident (42).

Another model that some jurisdictions use deploys teams composed of both specially trained sworn police officers and mental health professionals employed by the local community mental health department. These teams have been shown to be effective in resolving emergency situations in the community involving persons with mental illness and in diverting them to the mental health system rather than to the criminal justice system (37).

The major goals of these specialized mobile crisis teams are to resolve the crisis and to reduce criminalization. Studies that have evaluated such teams found that they had arrest rates ranging from 2 to 13 percent (with an average of less than 7 percent) (37,41), in contrast to an arrest rate of 21 percent for contacts between nonspecialized police officers and persons who were apparently mentally ill (45). This finding lends credence to the idea that a specialized response lowers the incidence of inappropriate arrests.

Regardless of whether police officers act as part of a team with members of the mental health system or whether police officers or employees of the police department deal on-site with emergency situations on their own, it is imperative that they obtain all available information about past police contacts with the individual when mental illness was thought to be present. Such information may in-

clude certain aspects of the person's actions during the previous police contact, such as suicide attempts, violence, and how the previous contact was resolved (38,46). In at least one program (37), this information as well as photographs of the individual are added to the police database and downloaded daily to laptop computers that are taken into the field by the mobile crisis team. A photographic record provides a clear view of what the person looks like and how he or she has changed from one police contact to another.

When mobile crisis teams comprise both sworn police officers and mental health professionals employed by the local community mental health department, it is possible for the complete mental health history of the person with mental illness—not only previous police contacts—to be made available to the mental health professional on the team. This history can be obtained from a centralized database operated by the local department of mental health. The information might include past psychiatric treatment, diagnoses, and the name of the person's case manager, if any. Mental health professionals working for the mental health department are legally entitled to this information. However, the importance of maintaining the confidentiality of mental health information cannot be overemphasized, and disclosure of this information must be scrupulously controlled, with the release of information limited to a need-to-know basis.

This arrangement offers important benefits. With access to information from the mental health department, the mental health professional on the team has more knowledge about persons with mental illness encountered in the field and is thus in a better position to make an accurate evaluation. Furthermore, if the team takes the person to a hospital, the mental health professional will have more relevant information to give to clinicians at the emergency department, which may allow appropriate and effective treatment to be initiated earlier.

A crucial part of developing and maintaining specialized mobile response teams is that a rigorous and ongoing evaluation of the program must be conducted. For instance, response times—the time from the call to the arrival of the team on the scene—should be measured on a routine basis (44). If response times are too long, police officers tend not to call on the mobile teams. Surveys should be conducted routinely among randomly selected police officers on their views of the usefulness and effectiveness of these teams. Such monitoring can allow for the ongoing correction of problems. Most important, the less useful the teams seem to the police officers in the field, the less they will be used. The teams' arrest rates, in addition to the mental health alternatives they choose, need to be evaluated regularly to be sure that appropriate dispositions are being made and that mental health facilities are cooperating with these efforts.

Training of police

There is evidence that police training generally is inadequate to prepare police officers to identify and deal with persons with mental illness (7,10,47). The police themselves think that they lack adequate training to manage this segment of the population (7). They want to know how to recognize mental illness, how to deal with psychotic behavior, how to handle violence or potential violence among these persons, what to do when a person is threatening suicide, and when to call the specialized mobile crisis team. They also want to know what community resources are available and how to gain access to them (48). This mental health training is needed for all police officers, not just for those who are part of the specialized mobile crisis teams (47).

Training led by both law enforcement and mental health professionals, with the active participation of police trainees, is thought to be the most effective teaching process (49). At a minimum, training for the police officers should include becoming familiar with the general classification of mental disorders used by mental health professionals; learning and demonstrating skills in managing persons with mental illness, including crisis intervention; knowing how to gain access to meaningful resources less restrictive than hospitalization; and learning the laws pertaining to persons with mental illness, in particular the criteria specified for involuntary psychiatric evaluation and treatment. In addition, considerable emphasis should be placed on deescalating situations that might lead to the use of deadly force on persons with mental illness (10). However, as Borum (10) has noted, training alone is not sufficient without the establishment of mobile crisis teams and changes in police academies in matters such as the use of deadly force.

"Suicide by cop"

Probably no situation is more difficult for law enforcement officers to cope with than what has been called suicide by cop, or police-assisted suicide (50—53). In these situations, a suicidal individual engages in life-threatening behavior with a lethal weapon, or with what appears to be a lethal weapon, toward law enforcement officers or civilians specifically to provoke officers to fire at the suicidal individual in self-defense or to protect civilians.

In one of the most carefully conducted studies on the subject (52), it was found that suicide by cop accounted for 11 percent of all officer-involved shootings in a large metropolitan law enforcement agency. Although only 46 of 437 shootings during a ten-year period were examined, the criteria for inclusion were fairly rigorous in terms of evidence of suicidal intent, evidence that the individual specifically wanted officers to shoot him or her, evidence that the individual possessed a lethal weapon or what appeared to be a lethal weapon, and evidence that the individual intentionally escalated the encounter and provoked officers to shoot in self-defense or to protect civilians. Other studies have reported higher percentages (16 to 46 percent) of police shootings that may have been suicide by cop; however, the inclusion criteria in those studies were less rigorous (54,55).

Conclusions and recommendations

On the basis of both the literature and our experience, we think it crucial that police and mental health departments collaborate closely, that mental

health resources be more readily available and more easily accessible, that police departments participate in specialized mobile crisis teams, and that police officers receive better training. With these principles in mind, we offer the following conclusions and recommendations.

Neither the mental health system nor the law enforcement system can manage mental health crises in the community effectively without help from the other (40). If the collaboration between the two systems is to be successful, police and mental health professionals need to remember who they are. It is important that police officers be aware that their primary role remains that of law enforcement, even though they may have specialized mental health training. For instance, in one program in which police officers and mental health professionals work closely together in teams, the police officers' primary role is described clearly as providing security that reduces the threat of harm to persons with mental illness and to others as well as providing transportation to the most appropriate treatment center.

Likewise, it is important that mental health professionals who are members of mobile crisis teams not view themselves as or try to function as police officers. Mental health professionals may unwittingly identify with the power and authority conferred by society on the police officers with whom they collaborate, but they too need to remember who they are and why they are there. They need to understand law enforcement and what it entails while retaining and understanding that their primary role in dealing with psychiatric emergencies is assessment, crisis resolution, and appropriate disposition.

Obviously, there will be some overlap of responsibilities of police officers and mental health professionals, but their primary roles should reflect their specific areas of expertise. Each discipline needs to use the skills of the other if crisis intervention in the field is to work. Mental health professionals need to feel safe, and police officers need to rely on the clinical expertise of mental health professionals.

To further promote collaboration between community mental health departments and police departments, there should be regular and ongoing liaison meetings of representatives from the two agencies. The number of persons attending should be small, so that issues and problems can be discussed and resolved meaningfully and efficiently. The persons attending should have an understanding of the issues and be of high enough rank in their departments so that they have the power to make and execute decisions.

Another important element in resolving crises involving persons with mental illness in the community, as well as in reducing their criminalization, is the availability of adequate mental health resources. These resources include both outpatient and inpatient treatment facilities and therapeutic housing arrangements. This would decrease the number of persons who decompensate and come to the attention of the police. Acute inpatient beds are needed so that there is an appropriate place other than jail to take persons with acute mental illness. Long-term beds are needed for the minority of persons with severe mental illness who, even with active and competent treatment and supportive housing, cannot cope with living in the community (56,57). This would mitigate the revolving-door syndrome among many of these persons, who quickly decompensate after a brief acute hospitalization.

Resources also should be made available for every jurisdiction to have specialized mobile crisis teams. In our view, these teams should include mental health professionals. The effectiveness of these teams relies on rigorous and continuous evaluation.

There is a need for better training for all law enforcement officers on mental illness, on how to best meet the needs of persons with mental illness, and on how to use mental health resources. A key part of such training is learning how to distinguish which persons with mental illness who risk causing harm to themselves or to others can be managed more appropriately by the mental health system than the criminal justice system.

Clearly, much can be done by both the law enforcement system and the mental health system to better serve persons with mental illness. Furthermore, working with this population can be made more gratifying to police officers by giving them the ability to feel a greater sense of professionalism as they fulfill the responsibilities that have been thrust on them in the era of deinstitutionalization. At the same time, collaboration with the police can enable mental health professionals to feel a greater sense of confidence and competence in dealing with psychiatric emergencies in the field.

Across the United States, persons with mental illness have been killed or seriously injured during attempts to manage their crises. These events have outraged the community and frustrated law enforcement and mental health professionals, and rightly so. If we are to reduce these tragic mistakes and ensure better safety for all, we must develop an effective working partnership between the law enforcement and mental health systems. •

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