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Improving High Risk Encounters Between People with Mental Illness and the Police

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Law enforcement agencies have traditionally provided the first line of response for crises involving potential violence and for mental health emergencies.[1–5] Over the years, the task of responding to people with mental illness in crisis has been enacted with reluctance, even resentment, by some officers and administrators who believe that these incidents do not properly fall in the purview of law enforcement responsibilities. Research suggests that many officers do not feel adequately trained or prepared to assess and respond appropriately to these encounters. The result is that officers in the field experience increased anxiety, irritation, and/or fear, and police departments incur increased liability for potential incidents of inappropriate use of force, including civil rights violations and wrongful death claims. Not surprisingly, law enforcement officers tend to perceive that people with mental illness in crisis pose a moderate to large operational problem for their agency.[6]

In a recent *Los Angeles Times*[7] article that served as an impetus for this and other commentaries in this issue of the Journal, Los Angeles Police Chief Bernard Parks is reported to have said that the issue more important than training is that "police should not have to handle so many mentally ill people on the streets." To the extent that these encounters do pose a significant operational challenge and increase civil liability, this view is certainly understandable. However, whether or not police should have to handle these calls, they currently do, and in the foreseeable future will, have to respond to them.

It is clear that official contacts between law enforcement and people with mental illness are very common. The results from a national survey of major police departments in the United States (those serving populations of 100,000 or more), estimated that approximately seven percent of police contacts involve people with mental illness.[8] Similarly, information coming directly from people with mental illness suggests that being arrested is virtually a normative occurrence. In a study that surveyed members of the Oregon chapter of the Alliance for the Mentally Ill, more than half of the respondents reported that their mentally ill family member had been arrested at least once, and on average it was more than three times.[9]

The proposed causes for this phenomenon are as varied as the hypotheses about why so many people with mental illness go without treatment in the community. In part, this may be a residual legacy of deinstitutionalization in the 1950s, when large numbers of people diagnosed with mental illness were released from hospitals into the community without an adequate community treatment infrastructure to support them. Some have even proposed that what actually occurred was a movement of "trans-institutionalization" in which this subgroup of mentally ill individuals was never truly diverted from institutional treatment;

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rather, they were simply shifted from the mental health system to the criminal justice system (see Penrose).[10] Interestingly, in 1955, .3 percent of the U.S. population was mentally ill and residing in a mental institution; whereas in 1999, .3 percent of the national population is mentally ill and is in the criminal justice system.[11] The conclusion is that contact between the police and people with mental illness is a long-standing and pervasive phenomenon.

While there continue to be some in the law enforcement profession who strongly contend that responding to mental health emergencies should not be a police function, there are other agencies and police administrators who have taken a different view, one that is more consistent with a philosophy of community policing. Within the past 15 years, the dominant paradigm in American policing has shifted from a traditional enforcement model to a community policing model that places greater emphasis on order maintenance and non-emergency services, in addition to, and often as a part of, the fundamental mission of crime control.[12, 13]

As part of this operational transition, many law enforcement agencies have begun to reconsider their mission and roles in the community. One result has been a formal expansion of the police function beyond traditional enforcement to include more service and assistance tasks,[14] particularly to assume greater responsibility for protection of and service to vulnerable populations, including people with disabilities.[15] Community policing responses to people with mental illness, however, can take a variety of forms ranging from training to the development of a specialized response capacity.

Training as an Intervention

Early research suggested that law enforcement personnel maintained negative attitudes toward people with mental illness and that this bias was largely due to a lack of information.[16–18] Thus, it was proposed that police officers should be trained in issues related to mental illness and crisis intervention so that they could improve their interactions with and service to this population. In a recent survey of major U.S. police departments, 88 percent of the responding agencies reported that they offered some form of training to their officers in how to deal with mentally ill persons in crisis.[8] The goals of this training are to enhance officers' understanding of mental disabilities and their symptoms, to increase the knowledge of available community resources and dispositional alternatives, and to help develop some basic crisis communication skills in a way that will make officers more confident in their use of nonphysical interventions.

In evaluating the effectiveness of these "mental illness awareness" programs, three primary outcome measures have been utilized: knowledge of mental illness, attitudes toward people with mental illness, and changes in job-related behavior and performance. These studies have produced some support for the ability of educational intervention to improve officers' knowledge of mental health issues[19] and ability to identify and describe features of mental illness.[20] It has been more difficult, however, to effect significant changes in attitudes (see Janus *et al.* for an anecdotal description of attitude improvement).[20]

Some studies, although notably imperfect, have also examined the effectiveness of crisis intervention training for police officers. Overall, empirical data on the efficacy of such programs have been fairly equivocal, despite a surge of interest and implementation.[21] Even one of the best controlled studies of crisis intervention training[22] produced only indeterminate findings. No significant group (trained versus control) effects were found on officers' attitudes, knowledge, or performance; however, both groups showed improvements over time. Thus, educational programs and crisis intervention training are probably not harmful and may be helpful, but there is good reason to believe that they are not sufficient to change fundamentally the nature of police encounters with mentally ill persons in crisis. Some agencies have attempted to extend these efforts by developing specialized programs to respond to mental health emergencies.

Specialized Response Programs

Although most major police agencies offer some mental illness-related training for their officers, only 45 percent of departments reported having some type of specialized response to mentally ill people in crisis. For those who had specialized programs, most appeared to conform generally to one of the three models described below.[8]

Police-Based Specialized Police Response

This model involves sworn officers who have special mental health training, who serve as the first-line police response to mental health crises in the com-

munity, and who act as liaisons to the formal mental health system. Of the departments surveyed, 3.4 percent had this type of program.

Police-Based Specialized Mental Health Response

In this model, mental health professionals (not sworn officers) are employed by the police department to provide on-site and telephone consultations to officers in the field. 11.5 percent of the departments had this type of program.

Mental Health-Based Specialized Mental Health Response

In this more traditional model, partnerships or cooperative agreements are developed between police and mobile mental health crisis teams that exist as part of the local community mental health services system and operate independently of the police department. 30 percent of the departments had this type of program.

In a case study of three police agencies representing each of the above models, officers were asked to rate the effectiveness of their department's program in accomplishing certain objectives: meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing the amount of time officers spend on these types of calls, and maintaining community safety. Officers from the department with a police-based specialized police response assigned the highest ratings across all objectives. The other two showed comparable levels of perceived effectiveness for meeting the needs of mentally ill people in crisis, keeping mentally ill people out of jail, and maintaining community safety. The clearest difference was observed in officers' appraisals of whether the program helps to minimize the amount of time they spend on these types of calls; the ratings from the police-based specialized police response program were substantially higher.[8]

Managing High Risk Encounters

In committing resources to training or to developing a specialized response capacity, law enforcement agencies are typically attempting to effect two objectives: (1) to improve the quality of the field encounter and (2) to improve the outcomes of the encounter. If it is not the initial impetus for an agency's response, it is at least a critical consideration that these incidents not result in an officer using deadly force unless it is absolutely necessary. However, the circumstances in which police are most likely to be called to a mental health emergency are those in which the person with mental illness is actively experiencing symptoms and may be feeling agitated, frightened, threatened, and out of control. Sometimes the subject may even have a knife or some type of weapon. There are numerous cues that may alert an officer to potential danger in the situation, and in some of these cases, officers must make critical decisions about the use of deadly force.

The *Los Angeles Times* reports that between 1994 and 1999, there were 37 incidents in which officers from the Los Angeles Police Department shot an individual with mental illness; 25 of these were fatal shootings.[7] I am unaware of any existing data that estimate the national prevalence of deadly force encounters between law enforcement officers and citizens with mental illness; however, police use of deadly force generally is a rare occurrence.[23] Less than 1/20 of one percent of all police-citizen encounters result in a fatal shooting by a police officer.[24] Nevertheless, when these events do occur and involve a subject with mental illness, they tend to generate significant public attention. They also carry a strong potential to create tension and divisiveness between the police and the community, particularly mental health consumers and advocates. But, while unquestionably tragic, they may also create a climate of opportunity to share perspectives and explore solutions.

There have been and will be continue to be encounters involving people with mental illness in which deadly force is an officer's most reasonable and prudent response. Mental health advocates rightfully argue that the mere presence of a mental illness or evidence of psychiatric symptoms does not necessarily mean that the officer is at increased risk of harm in the encounter. However, it is also true that some people with mental illness will pose a significant risk of harm to an officer, and that the officer has a right and a duty to protect her/himself and the community. The goal of all parties should be, when possible, to prevent incidents from escalating to a deadly force decision and to eliminate incidents in which force is used inappropriately.

Deadly force encounters between police and civilians are tense and complex interactions. Mental illness, and its attendant associated characteristics, is only one factor in an officer's calculus during a decision of whether or not to shoot. Prior research sug-

gests that threatening behavior by the subject, the presence of a weapon, and the type of call (disproportionately, robbery and disturbance calls) are some of the most robust predictors of police deadly force decisions.[23, 25, 26] John Nicoletti[27] conducted a survey on the use of force among law enforcement agencies in Colorado and concluded that ". . . elevated stress levels, lack of training, lack of control over the situation and lack of self confidence were the most frequently cited causes for overreaction, while behaviors mentioned most frequently as being desirable for de-escalation of force were communication and mediation skills, attitude, self-defense and physical condition and anger control."

If one's objective is to reduce inappropriate or excessive force by police toward people with mental illness, the most logical approach would be not just to increase knowledge and sensitivity but to apply existing knowledge on deadly force encounters to develop tailored approaches for training and program development. These efforts may be further informed by reviewing prior encounters between law enforcement and people with mental illness. This could conceivably be done as a collaborative effort between police and mental health consumers and advocates, but a neutral facilitator might be necessary to assure that the process remained focused on constructive problem solving rather than derogation and assignation of blame.[28]

It is too easy in retrospect to be highly critical of the actions taken by an officer in a high risk encounter. Advocates and representatives from the community may not fully appreciate the complexity of these potentially lethal incidents and may be quick to conclude that the handling of the encounter or the decision to shoot was inappropriate simply because the subject was demonstrably mentally ill. The Los Angeles Times reports that they reviewed the Los Angeles cases and concluded that "in many of those shootings since 1994, the actions of the police contributed to the situation turning deadly."[7] It is certainly possible for an officer arriving on a scene to make a situation worse, and it is true that sometimes officers make bad decisions or act inappropriately; however, one should be cautious about arriving at conclusions about the contribution of the officer and the appropriateness of his or her actions in a given situation.

Even as those outside of law enforcement need to be guarded about rushing to judgment, those in the law enforcement community need to be open to the possibility that police response to high risk encounters involving people with mental illness can be improved. The most prudent approach to improving this response is to focus on prevention. James Fyfe,[29] one of this nation's leading scholars on police use of force, does not support the view that deadly force encounters are essentially "split second" decisions. He advocates that efforts to reduce excessive force should not focus primarily on what the officer did during the encounter, but rather what she/he did in the approach to the encounter.[29]

The recommendation for additional training has become an almost reflexive public response to most problems that people perceive with the police. Training is important; however, based on current research evidence, it is not a panacea, nor is it a sufficient solution for improving outcomes in high risk encounters between police and mental health consumers. I believe that it is helpful to train officers to identify and understand symptoms of mental illness and to counter popular misconceptions that could negatively effect their perceptions or attributions during a stressful encounter. Research on the effects of training suggests that this basic education is attainable. I also believe that it is essential to train law enforcement officers in verbal skills to de-escalate conflict. This is not a recommendation specific to managing mental health emergencies; officers and deputies should have the skills to attempt to de-escalate any tense or potentially dangerous situation. This recommendation is fundamental to developing effective use of force training.

Even if all officers receive the same training, they will not all be equally skilled at de-escalation or at interacting with mentally ill subjects in a crisis. Thus, when law enforcement personnel are called to the scene of a situation in which a person with mental illness is tense, fearful, suspicious, delusional, and holding a knife, the resolution of that encounter may depend on the luck of the draw of who was dispatched to respond to that particular call. All officers should be trained, but all officers will not be equally effective.

Fundamentally changing an agency's response to mental health crisis calls involves more than just training. Departments that have created a specialized response capacity, such as the Memphis Police Department's Crisis Intervention Team (CIT), have taken an approach that optimizes the likelihood that the officers who are most highly skilled and trained in

dealing with people with mental illness will have responsibility for handling those calls.

The CIT is a police-based program staffed by police officers with special training in mental health issues. The team operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" crisis calls in addition to their regularly assigned patrol duties. For general patrol, the officers are assigned to a specific area; however, CIT officers have city-wide jurisdiction for these specialized calls. Patrol officers volunteer for the program, and are carefully screened and selected to receive an initial 40 hours of specialized training from mental health providers, family advocates, and mental health consumer groups providing information about mental illness, substance abuse, psychotropic medication, treatment modalities, patient rights, civil commitment law, and techniques for intervening in a crisis. The training is provided by professionals, advocates, and consumers in the community at no charge to the police department. This approach identifies the officers with the greatest interest, most amenable attitudes, and best interpersonal skills and then provides them with intensive training and deploys them specifically as a first line of response to these specialized calls. This approach has changed fundamentally the police response to mental disturbance calls in Memphis.[30] Results from a recent study funded by the National Institute of Justice suggest that the Memphis CIT program has a low arrest rate for mental disturbance calls, a high rate of utilization by patrol officers, a rapid response time, and results in frequent referrals to treatment.[31] The CIT program also reports that the approach has reduced officer injuries during these calls.

Conclusion

It is unquestionably a tragedy when an encounter between a police officer and a person who has come to police attention solely because of symptoms of mental illness ends in a fatal shooting. Given that police-citizen encounters involving people with mental illness occur frequently, some agencies have adopted a problem-solving orientation to handling these calls. For some departments, this means enhanced training, while for others, the development of a specialized response. Regardless of the approach, members of law enforcement agencies need to be open to examining ways to improve their response to mental health emergencies and not just complain that they should not have to respond at all. Conversely, mental health consumers and advocates should be thoughtful and cautious in second-guessing the decisions of police officers during high risk encounters and in heralding reflexive cries for "more training." Both of these constituencies are working toward a common objective of improving these encounters. To the extent that they can listen to and learn from each other, they may move more quickly toward that goal.

References

1. Bittner E: Police discretion in emergency apprehension of mentally ill persons. Soc Probl 14:278–92, 1967
2. Cohen NL, Marcos LR: Law, policy, and involuntary emergency room visits. Psychiatr Q 61:197–204, 1990
3. Finn P, Sullivan M: Police response to special populations. Washington, DC: U.S. Department of Justice, National Institute of Justice, 1987
4. Pogrebin MR: Police responses for mental health assistance. Psychiatr Q 58:66–73, 1986–87
5. Stroul BA: Psychiatric crisis response systems: a descriptive study. Rockville, MD: National Institute of Mental Health, 1993
6. Borum R, Deane M, Steadman H, Morrissey J: Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. Behav Sci Law 16:393–405, 1998
7. Meyer J, Berry S: Lack of Training Blamed in Slayings of Mentally Ill. Los Angeles Times. Nov 8, 1999, pp A1, A19
8. Deane M, Steadman H, Borum R, Veysey B, Morrissey J: Police-mental health system interactions: program types and needed research. Psychiatr Serv 50:99–101, 1998
9. McFarland B, Faulkner L, Bloom J, *et al*: Chronic mental illness and the criminal justice system. Hosp Community Psychiatry 40:718–23, 1989
10. Penrose L: Mental disease and crime: outline of a comparative study of European statistics. Br J Med Psychol 18:1–15, 1939
11. Borum R, Rand M: Mental health diagnostic and treatment services in Florida's jails. J Correctional Health Care, in press
12. Kelling G: Police and community: the quiet revolution. Perspectives on Policing, No. 1. Washington, DC: National Institute of Justice, 1988
13. Moore M: Research synthesis and policy implications, in The Challenge of Community Policing: Testing the Promises. Edited by Rosenbaum D. Thousand Oaks, CA: Sage, 1994, pp 285–99
14. Cordner G: Community policing: elements and effects. Police Forum 5:1–8, 1995
15. Trojanowicz R, Buceroux B: Community policing: a contemporary perspective. Cincinnati, OH: Anderson, 1990
16. Nunnally JC: Popular Conceptions of Mental Health. New York: Holt, Reinhart, and Winston, 1961
17. Patrick MEM: Policeman's attitudes toward mental illness and the mentally ill. Issues Ment Health Nurs 1:1–19, 1978
18. Lester D, Pickett C: Attitudes toward mental illness in police officers. Psychol Rep 42:888–91, 1978
19. Godschalx SM: Effect of a mental health educational program upon police officers. Res Nurs Health 7:111–17, 1984

20. Janus SS, Bess BE, Cadden JJ, Greenwald H: Training police officers to distinguish mental illness. Am J Psychiatry 137:228–9, 1980
21. Lieberman DA, Schwartz J: Police programs in domestic crisis intervention: a review, in The Urban Policeman in Transition: A Psychological and Sociological Review. Edited by Snibbe JR. Springfield, IL : Charles C. Thomas 1973, pp 421–72
22. Mulvey EP, Repucci ND: Police crisis intervention training: an empirical investigation. Am J Community Psychol 9:527–46, 1981
23. Stock H, Borum R, Baltzley D: Police use of deadly force, in Lethal Violence 2000: Fatal Domestic, Acquaintance, and Stranger Aggression. Edited by Hall HV. Kameula, HI: Pacific Institute for the Study of Conflict and Aggression, 1996, pp 635–62
24. Federal Bureau of Investigation: Uniform Crime Reports Supplement: Law Enforcement Officers Killed and Assaulted, 1990. Washington, DC: FBI, 1991
25. Alpert GP, Fridell LA: Police Vehicles and Firearms: Instruments of Deadly Force. Prospect Heights, IL: Waveland Press, 1992
26. Donahue ME, Horvath FS: Police shooting outcomes: suspect criminal history and incident behaviors. Am J Police 10:17–34, 1991
27. Nicoletti J: Training for de-escalation of force. Police Chief 57: 37–9, 1990
28. Hanewicz WB, Fransway LM, O'Neill MW: Improving the linkages between community mental health and the police. J Police Sci Admin 10:218–23, 1982
29. Fyfe JJ: Police/citizen violence reduction project. FBI Law Enforcement Bull 58:18, 1989
30. Cochran S, Borum R, Deane M: Improving police response to mentally ill people in crisis: crisis intervention teams. Psychiatr Serv, in press
31. Steadman H, Deane M, Borum R, Morrissey J: Comparing outcomes of major models for police responses to mental health emergencies. Psychiatr Serv 51:645–9, 2000