Contact with Law Enforcement

Law enforcement engaged in today's community policing efforts inevitably provide citizens with services that go well beyond enforcing laws or maintaining public safety and order. Police are first-line, around-the-clock, emergency responders, mediators, referral agents, counselors, youth mentors, crime prevention actors, and much more. Among their growing responsibilities have been responding to people with mental illness. All too often, individuals' inadequately treated mental illness is manifested in ways that can result in their contact with police—sometimes with tragic results.

What may begin as a call from a business owner to "do something" about the unkempt young man pacing in front of his store, or community demands to keep individuals from sleeping on park benches—to the more extreme 9-1-1 report from a frightened caller that his or her loved one is threatening to hurt someone, or him-or-herself—will prompt a police response that can result in myriad outcomes. Officers on patrol will themselves encounter those who seem to be in crisis or are in violation of some "quality-of-life" law, such as urinating in public or sleeping in doorways. How police respond to such individuals can have a tremendous impact on how encounters will be resolved and on what future these individuals can expect.

Many sections of this report focus on partnerships among criminal justice agencies, as well as between police and mental health professionals. Those partnerships may, indeed, have the greatest impact on police than on any other component of the criminal justice system. For it is police who will often provide the first contact with the criminal justice system for people with mental illness. Their actions and perceptions will often determine whether the individual will find much-needed treatment, continue in his or her current situation, or face the problems detailed in later sections that are inherent in a criminal justice system ill prepared to meet the needs of people with mental illness.

Police response at this critical first encounter will be shaped by whether they perceive a person's mental illness as a factor in the call for service; their knowledge of de-escalation techniques at the scene; and their understanding of when the nature of the crime necessitates criminal justice action or whether it is better to engage appropriate alterna-

tive resources. These and other decisions involve complex skills, knowledge, and other factors addressed in this chapter. But police simply cannot achieve meaningful reforms alone, no matter how well trained. They will need the kind of community-based mental health improvements, partnerships, and support outlined in this report if they are to have any success at all.

As mentioned earlier, it is the most sensational incidents, in which a person with mental illness kills an officer or citizen or is killed by police, that seem to shape policy, even though they are not the majority of cases that police see. In no way does this report minimize the importance of officer and public safety—they are of paramount importance. In fact, the policies outlined in this report are intended to prevent critical incidents through effective, earlier interventions. It also acknowledges those cases in which arrest is very appropriate, as with serious crimes. In those cases, the offender should be in the criminal justice system. This chapter, however, focuses most on what current policy often misses: the overwhelming number of cases in which minor nuisance crimes are largely the result of an individual's inadequately treated mental illness (and often co-occurring drug/alcohol abuse). These result in large drains on police resources, and often without any long-term solutions, for police, people with mental illness, or crime victims. This report is meant to address some of those gaps with practical guidelines for police professionals.

The following sections acknowledge that police cannot be diagnosticians or pseudo-mental health professionals—but they can help stabilize a situation, work to keep all involved parties safe (including responding officers), make effective referrals when appropriate, and improve the lives of people with mental illnesses and their loved ones by keeping them out of a system ill equipped to meet their needs. The policy statements and recommendations for implementation are meant to be tailored to the unique needs and resources of a community and police agency. They were developed to make more efficient and effective use of police resources. Most of all, they are designed to support all those police personnel who want to do the right thing, as part of their commitment to treat all citizens with dignity and fairness and to serve all members of their community.

2 Request for Police Service

POLICY STATEMENT #2

Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.

Requests for police service generally come in one of two ways: through a personal contact with an officer who happens to be near the scene or through a call to the department. This section concerns calls that are made to law enforcement agencies and handled by a dispatcher. The dispatcher is responsible for gathering information about the situation and dispatching the call to a patrol officer. The dispatch function can be managed by the police department alone or through a system shared with other emergency services.

While some law enforcement agencies will not have the power to affect dispatch policy directly, due to constraints such as shared dispatch, they may be able to change procedures through dispatcher training and memoranda of understanding between the police and dispatch service. The following recommendations address important dispatch protocols that should include policies for information gathering regarding whether mental illness is a factor in the call and the potential for violence, and using appropriate language when dispatching calls.[1]

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide dispatchers with questions that help determine whether mental illness is relevant to the call for service.

Determining that mental illness is a factor in a call for service is an essential first step to providing appropriate police response. The person with a mental illness may be a crime victim, an offender, a witness, or involved in a mental health crisis. Dispatchers should use standardized questions to aid the information-gathering process. These questions can appear on the computer screen or be provided in booklet format. These questions should also assess, when

1. Law enforcement agencies should document information about mental illness only when it is relevant to the encounter. Agencies should not develop databases that contain information about all people with mental illness in their community.

possible, if co-occurring disorders (especially involving substance abuse) or other issues are relevant to the call for service. Departments should collaborate with mental health providers to determine the appropriate questions dispatchers should ask callers.

Example: **Pinellas County (FL) Police Department**

Communications center personnel at Pinellas County Police Department receive training from the Mental Health Commission of Pinellas County on interacting with callers who may have mental illness. This training ensures that dispatchers are able to identify characteristics of mental illness and better inform responding officers.

Example: **Houston (TX) Police Department**

The Houston Police Department provides specialized training to its dispatchers to enable call takers to determine if the call involves a person with mental illness. This program has been combined with officer training to significantly reduce the time between the call for service and the officer arrival at the scene and to decrease the average time that people with mental illness spend in police custody.

b Provide dispatchers with tools that determine whether the situation involves violence or weapons.

As in all calls, dispatchers should gather information to assess safety issues that the responding officer might encounter, including whether weapons are involved, whether the person poses a danger, if the person with mental illness is at risk of being victimized, and whether there is a history of violence. To further facilitate effective information gathering, some departments "flag" certain locations in the Computer Aided Dispatch (CAD) system. These flags appear when a repeat call for service is made to that location. The dispatcher then reads the text of the "flag" when dispatching the call to provide additional information to the responding officers. These flags are placed *only* on those call locations that pose a particular threat or unresolved problem, such as potential for violence or as a repeat location. Personnel are designated to review these flags periodically to ensure a need for each flag remains.

Example: **Baltimore County (MD) Police Department**

In the Baltimore County Police Department, supervisors make written requests to the communications center to place a flag on certain locations where police have responded to repeat calls for service or where there is a significant potential for violence—as determined by knowledge of weapons in the home, previous reports of violence, or other information. These flags are used for a wide variety of calls, not just those related to mental health issues.

c Provide dispatchers with a flowchart to facilitate dispatch of the call to designated personnel.

Dispatchers should be given a flowchart that states clearly who should respond when calls for service may involve people with mental illnesses. Dispatchers should provide all of the essential information to the appropriate responding officer, including whether mental illness may be a factor, so that officers are able to respond effectively to a call for service.

d Use designated codes and appropriate language when dispatching the call.

Some agencies use a code system when dispatching calls for service over the radio, others use what is called "plain speech," and still others use a combination of the two. Some may be concerned that information broadcast over the radio violates the privacy of the person who is the subject of the call and who may have a mental illness. The police department does have an obligation, however, to provide officers with meaningful information on the type of call to which he or she is responding as a means of protecting the safety of both the officer and the consumer. To reduce possible harm that could come to the person who is the subject of the call, dispatchers and officers should avoid the use of slang terms and use only designated codes and/or appropriate language when communicating over the radio. Department personnel should concentrate on describing the person's behavior rather than guessing at a diagnosis or using a label that carries with it stigma and potentially misleading information.

3 On-Scene Assessment

POLICY STATEMENT #3

Develop 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 involved parties.

The police encounter people with mental illness of all ages in five general situations: as a victim of a crime; as a witness to a crime; as the subject of a nuisance call; as a possible offender; and as a danger to themselves or others. It is also true that the person with a mental illness may fall into more than one category at a time. It is critical for the officer who responds to the scene to recognize whether mental illness may be a factor in the incident, and to what extent, before deciding which response is best.

Several different approaches have been developed to enable officers to effectively assess situations involving people with mental illnesses that both reduce their contacts with the criminal justice system and ensure on-scene safety. The safety of all involved parties—the victim, person with mental illness, family members, bystanders and, police—is of paramount importance. The desired outcome of these contacts should be problem resolution that entails fair and dignified treatment of people with mental illness.

The first step for law enforcement in developing protocols is to learn about successful approaches adopted by other law enforcement agencies. A group of key stakeholders should be designated as a planning group to investigate and assess the different responses so that community leaders can develop response protocols that meet the unique needs of the community. (For more information on these committees, see the discussion in this report's Introduction as well as Chapter VI: Improving Collaboration.) Planning groups can accomplish this research and investigation using a variety of sources, including reviewing the literature; speaking with other law enforcement agencies about their promising approaches and any barriers to their success; or attending the training of a department that employs a response that could be effective in their community.

Approaches to consider include the following. They may be adapted to the specific needs of a community.

- **Crisis Intervention Team (CIT).** The CIT approach employs specially trained uniformed officers to act as primary or secondary responders to every call in which mental illness is a factor. Ideally, officers are chosen to participate based on their willingness to enhance services to people with mental illness within the community. CIT officers are available for each shift to provide assistance to consumers and their families and to facilitate emergency mental health assessments.

- **Comprehensive Advanced Response.** This response model can be described as a traditional response modified by mandating advanced, 40-hour training for all officers within the department. Some of the departments that use this approach address responses to people with mental illness as part of their training and responses to "special populations."
- **Mental health professionals who co-respond.** Some law enforcement agencies hire licensed mental health workers as secondary responders. These civilians serve in units that are either located in the police department—where civilian workers are under the chief's supervision—or reside outside the department because staffing is shared with other county or city mental health providers. These civilian workers may either ride along with officers in special teams or respond when called by an officer after the scene has been secured for various crisis calls, including those involving people with mental illness. The civilian employees are responsible for developing relationships with community-based organizations and finding available services within the community.
- **Mobile Crisis Team (MCT) co-responders.** Generally, Mobile Crisis Teams are composed of civilian personnel employed by mental health organizations, who are licensed mental health professionals. For an effective, safe response, MCTs should act only as secondary responders who are called out once the scene has been secured by law enforcement. Law enforcement officers call MCTs if it is believed that there is a person involved who may be a danger to him- or herself or others, or if the person needs services. Also, in some jurisdictions, if no crime has been committed, MCTs can provide transport to a mental health facility (if it appears the person might meet the criteria for civil commitment) or other services (such as counseling or drug treatment). MCT personnel are knowledgeable about criteria for involuntary commitment, bring extensive information to the scene, and are able to provide follow-up services.

Regardless of the particular approach chosen, the officers must ensure the following: stabilize the scene; recognize signs or symptoms of mental illness; determine whether a serious crime has been committed; consult with personnel who have mental health expertise; and, when indicated, determine whether the person might meet the criteria for emergency evaluation. Once these determinations have been made, the responders must decide what, if any, action should follow. (See Policy Statement 4: On-Scene Response; also Policy Statement 28: Training for Law Enforcement Personnel).

RECOMMENDATIONS FOR IMPLEMENTATION

a Stabilize the scene using deescalation techniques appropriate for people with mental illness.

Officers should approach and interact with people who may have mental illness with a calm, non-threatening manner, while also protecting the safety of all involved. Several de-escalation techniques (see Table 1) have been shown to assist in calming a person who is not rational or who is experiencing an emotional crisis.

Most people with mental illness are not violent, but for their own safety and the safety of others officers should be aware that some people with mental

Table 1. Deescalation Techniques

Officers should do the following:

- Remain calm and avoid overreacting.
- Provide or obtain on-scene emergency aid when treatment of an injury is urgent.
- Follow procedures indicated on medical alert bracelets or necklaces.
- Indicate a willingness to understand and help.
- Speak simply and briefly, and move slowly.
- Remove distractions, upsetting influences, and disruptive people from the scene.
- Understand that a rational discussion may not take place.
- Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds ("voices"), or the environment.
- Be friendly, patient, accepting, and encouraging, but remain firm and professional.
- Be aware that a uniform, gun, and handcuffs may frighten the person with mental illness, and reassure the person that no harm is intended.
- Recognize and acknowledge that a person's delusional or hallucinatory experience is real to him or her.
- Announce actions before initiating them.
- Gather information from family or bystanders.
- If the person is experiencing a psychiatric crisis, ask that a representative of a local mental health organization respond to the scene.

Officers should *not* do the following:

- Move suddenly, giving rapid orders or shouting.
- Force discussion.
- Maintain direct, continuous eye contact.
- Touch the person (unless essential to safety).
- Crowd the person or move into his or her zone of comfort.
- Express anger, impatience, or irritation.
- Assume that a person who does not respond cannot hear.
- Use inflammatory language, such as "crazy," "psycho," "mental," or "mental subject."
- Challenge delusional or hallucinatory statements.
- Mislead the person to believe that officers on the scene think or feel the way the person does.

illness who are agitated and possibly deluded or paranoid may act erratically, sometimes violently. If the person is acting erratically, but not directly threatening any other person or him-or herself, such an individual should be given time to calm down. Violent outbursts are usually of short duration. It is better that the officer spend 15 or 20 minutes waiting and talking than to spend five minutes struggling to subdue the person.

"I try to be as calm as I can around police, but I can't always. Just the sight of a police officer scares me to this day."

CAROL TRAXLER
consumer

Source: *Serious Mental Illnesses and the People Who Are Affected By Them: An Educational Videotape for Law Enforcement Officers*, 1992, Alliance for the Mentally Ill of Rhode Island

b Recognize signs or symptoms that may indicate that mental illness is a factor in the incident.

The officer responding to the scene is not expected to diagnose any specific mental illness but is expected to recognize symptoms that may indicate that mental illness is a factor in the incident. Symptoms of different mental illnesses include, but are not limited to, those listed in Table 2. Many of these symptoms represent internal, emotional states that are not readily observable from outward appearances, though they may become noticeable in conversation with the individual.

In addition to the symptoms outlined in Table 2, some specific types of behavior may also be signs of mental illness. These behaviors can include severe changes in behavior, unusual or bizarre mannerisms, hostility or distrust, one-sided conversations, confused or nonsensical verbal communication. Officers may also notice inappropriate behavior, such as wearing layers of clothing in the summer. It should be noted that these behaviors can also be associated with cultural and personality differences, other medical conditions, drug or alcohol abuse, or reactions to very stressful situations. *As such, the presence of these behaviors should not be treated as conclusive proof of mental illness.* They are provided only as a framework to aid those police officers who must under-

Table 2. Signs and Symptoms of Mental Illness

- **Loss of memory/disorientation.** Temporary or permanent memory losses may be symptoms of a disturbance. This is not the common forgetting of everyday things, but rather the failure to remember the day, year, where one is, or other obvious personal information.
- **Delusions.** These are false beliefs that are not based in reality. They can cause a person to view the world from a unique or peculiar perspective. The individual will often focus on persecution (e.g., believes others are trying to harm him or her) or grandeur (person believes he or she is God, very wealthy, a famous person, or possesses a special talent or beauty).
- **Depression.** Depression involves deep feelings of sadness, hopelessness, or uselessness.
- **Hallucinations.** It is not unusual for some people with mental illness to hear voices, or to see, smell, taste, or feel imaginary things. The person experiences events that have no objective source, but that are nonetheless real to him or her. The most common hallucinations involve seeing or hearing things but can involve any of the senses (e.g., a person may *feel* bugs crawling on his or her body; *smell* gas that is being used to kill him or her; *taste* poison in his or her food; *hear* voices telling him or her to do something; or *see* visions of God, the dead, or horrible things).
- **Manic behavior.** Mania involves accelerated thinking and speaking or hyperactivity with no apparent need for sleep and sometimes accompanied by delusions of grandeur.
- **Anxiety.** Feelings of anxiety are intense and seemingly unfounded. The person is in a state of panic or fright; may have trembling hands, dry mouth, or sweaty palms; or may be "frozen" with fear.
- **Incoherence.** A person may have difficulty expressing him-or herself clearly and exhibit disconnected ideas or thought patterns.
- **Response.** People with mental illness may process information more slowly than expected.

stand what questions to ask and to decide what services, resources, or support are needed to resolve the cause of the incident. Officers should obtain additional information at the scene from family, friends, or health professionals who are familiar with the individual's behavior.

Officers should be aware that substance abuse disorders can *mimic* many mental disorders; substance use can *mask* many mental disorders; and some somatic disorders, such as diabetes or Parkinson's, may seem to be mental and/or substance abuse disorders. To complicate matters, the co-occurrence of mental illness and substance abuse is also quite common (see Policy Statement 37: Co-occurring disorders). Due to the complexity of this diagnostic task, it will often be impossible for law enforcement officers to distinguish mental illness from substance abuse disorders. The officer who has observed unusual or erratic behavior should bring the individual to an assessment site that is capable of making an accurate determination of its cause.

Studies have shown that the potential for violence increases considerably when people with mental illnesses use alcohol or drugs.[2] For this reason, officers should be observant and note any signs (e.g., bottles, drug paraphernalia) of substance or alcohol use. At the same time, maintenance of a calm demeanor and use of de-escalation techniques can help to prevent violent behavior.

Officers will need to attend to the medication needs of some individuals with mental illness. If the encounter lasts for some time, or a person is being detained, people with mental illnesses may need access to their medication. Officers *must* follow departmental rules for verifying that any pills or capsules the person is carrying are prescribed, or to obtain the needed medication, so that they may authorize the individual to continue the prescribed treatment.

Police officers should be aware that some medications that treat mental illnesses have side effects that may also require attention. For example, medications may cause tremors, nausea, extreme lethargy, confusion, dry mouth, constipation, or diarrhea. Police officers should attend to needs for water, food, and access to toilet facilities. It is important not to mistake these side effects as evidence of alcohol or drug use.

C Determine whether a serious crime has been committed.

No individual should be arrested for behavioral manifestations of mental illness that are not criminal in nature. Arrest is generally appropriate when a felony has been committed or when the person has outstanding warrants. Arrest is also appropriate in cases in which the officer would normally make an arrest if the person did not have a mental illness, and if the current signs of mental illness are minor or not related to the violation.

In cases where the person with a mental illness has come to the attention of the police because of behaviors that result from the mental illness or nui-

2. H. Steadman et al., "Violence by People Discharged from Acute Psychiatric Inpatient Facilities," pp. 393-401.

sance violations, officers should engage referral mechanisms to mental health services and supports to address the mental illness in lieu of arresting the individual and engaging the criminal justice system. (See Policy Statement 4: On-Scene Response, for more on referral mechanisms.)

"Each time a person with mental illness is killed by police it has tragic consequences for everyone involved—the person with mental illness, their loved ones, and the police officer. Improving law enforcement's knowledge and skills in responding to individuals with mental illness can prevent many of these deaths."

CHIEF ROBERT OLSON
Minneapolis, MN

d Consult personnel with expertise in mental illness to enhance successful incident management.

On-scene expertise in mental illnesses and their manifestations is critical to effective incident management. This expertise can be provided by primary or secondary on-scene responders who are specially trained police officers or mental health professionals.

The following examples highlight the ways that departments around the country have chosen to include this type of expertise. As described previously, these include Crisis Intervention Teams (CITs), the comprehensive advanced approach, mental health professionals who corespond, and Mobile Crisis Teams (MCTs). The basic difference in these models is whether expertise is provided by police officers who are trained extensively in mental health issues, or by mental health professionals who either co-respond with law enforcement or respond after the scene has been secured. While mental health professionals are likely more knowledgeable than patrol officers about involuntary commitment laws and bring additional, perhaps confidential, data to the scene, they are not always available. (See Policy Statement 25: Sharing Information for more on agreements between mental health and criminal justice agencies.)

Examples of approaches that use specially trained police officers to supply on-scene expertise—either as a special team or as the whole department—follow:

Crisis Intervention Team

Example: **Memphis (TN) Police Department**

In a Crisis Intervention Team (CIT) approach found in the Memphis Police Department, uniformed officers, specially trained in mental health issues, act as primary or secondary responders to every call involving people with mental illnesses. CIT officers are available on every shift and are also available to mental health clients (consumers) and their families. The Albuquerque, New Mexico, Police Department, The Roanoke, Virginia, Police Department and the Houston, Texas, Police Department are among numerous agencies across the country that have also adopted the CIT approach.

Comprehensive Advanced Response

Example: **Athens-Clarke County (GA) Police Department**

In a comprehensive response, the Athens-Clarke County Police Department decided that its small size precluded the formation of a specialized team to respond to calls for service involving people with mental illness. Accordingly, the department decided that every officer would attend the advanced 40-hour crisis intervention training and thus be able to respond appropriately to these calls.

Mental health professionals who co-respond

Example: **Birmingham (AL) Police Department**

The Birmingham Police Department uses a Community Service Officer (CSO) Unit, which is attached to the Patrol Division. The unit is composed of social workers who respond directly to an incident location when requested by an officer. They serve a variety of populations, including people with mental illness. The CSOs are also certified law enforcement academy trainers and work closely with community groups and other components of the criminal justice system.

Example: **Long Beach (CA) Mental Evaluation Team**

In this program, a patrol officer from Long Beach Police Department is accompanied by a clinician to respond ten hours a day, seven days a week, to calls for service involving people with mental illness. The clinician provides on-scene assessment of the individual's mental health needs and ensures admission into a mental health facility, if necessary. This approach prevents unnecessary incarceration of people with mental illnesses.

Example: **San Diego County (CA) Sheriff's Office**

The Psychiatric Emergency Response Team (PERT) approach used by the San Diego County Sheriff's Office pairs a licensed mental health clinician with an officer or deputy in a marked car to respond to situations determined by the dispatcher or another officer to involve a person suspected of having a mental illness that is a factor in the incident. These teams conduct mental health assessments and process referrals to county providers if appropriate.

Mobile Crisis Team

Example: **Anne Arundel County (MD) Police Department**

The Anne Arundel County Police Department has arranged for access to a team of crisis workers from a local mental health center that works seven days a week. The responding officer must determine if a Mobile Crisis Team is warranted at the scene and will call accordingly.

There are several important differences between the approaches that involve mental health professionals. One main difference is how the mental health professional is paid and supervised, usually either through the police department or through the county mental health agency. For example, in Birmingham the social worker is located in the police department and is under the direct supervision of the chief, while in Anne Arundel County, Maryland, the mobile crisis team members are paid by a mental health organization. Another difference is whether the mental health agent works in a team with the officer, or responds as a separate unit. An additional distinction is whether the civilian workers respond to a variety of calls for service beyond those involving people with mental illnesses, such as domestic violence. Yet, in all models, the mental health professional is responsible for understanding community resources and finding services within the community.

Successful incident management is often dependent on information about the person's current and past behavior. If it is not possible to obtain this information from the person with mental illness or a responding professional, sometimes it can be obtained at the scene from those who are close to the person, and who are familiar with the situation and with the person's history.

In those rare events when a person's life or the life of a bystander is in jeopardy, in addition to following standard crisis procedures, law enforcement should also formally call on specially trained mental health professionals for assistance in resolving the critical incident. (See Policy Statement 4: On-Scene Response, for more information on handling critical incidents.) Law enforcement personnel should protect the confidentiality of medical or mental health information to avoid disclosures (see Policy Statement 25: Sharing Information) and should follow protocols for written documentation provided in Policy Statement 5: Incident Documentation.

e Determine, when warranted, whether the person may meet the state criteria for emergency evaluation.

The criteria for emergency evaluation are similar from state to state, although there is some variation in how they are interpreted. It is *not* the role of the police officer to make the sole determination that a person should be committed. However, being familiar with the criteria will help officers decide whether to detain the person and transport him or her for an emergency mental evaluation. This is not an arrest. Officers should be alert to the *behaviors, actions,* and *speech* of the person so that they can determine whether specific indicators of the criteria apply. Officers should also familiarize themselves with state law concerning emergency evaluation.

Most patients who receive inpatient or outpatient services for mental illness do so voluntarily. That is, when presented with their options—including the possibility of involuntary commitment—they choose to enter a hospital or to follow a course of outpatient treatment suggested by treatment professionals. In fact, in some states you cannot commit someone who is willing to admit him- or herself voluntarily. For a significant minority, however, there are times when involuntary commitment becomes the only available avenue to services and the surest way to ensure the safety of the person involved. Involuntary commitment involves deprivation of personal freedom and can be an indignity to the person being committed. In addition, it requires the participation of numerous professionals (including the certifying doctor, attorneys representing both the accepting facility and the patient, and a judge). For these reasons and the simple reality that commitment takes considerable time, in the majority of cases most clinicians will seek to offer voluntary admission to services before considering involuntary commitment.

Every state has a law that provides a clear path for those cases in which a person must be involuntarily committed to treatment. While the laws vary to some degree, they all attempt to define circumstances under which a person's unsupervised presence in the community poses a risk by reason of his or her mental illness. In almost all cases, it is the likelihood of a person's dangerousness to self or to others that is the primary trigger for involuntary commitment. In several states, the mental health law also includes language defining what is broadly known as the "gravely disabled" criterion, which is meant to cover instances in which a person's well-being is threatened by inattention to personal safety, failure to eat, exposure to extreme or dangerous conditions, or other evidence that he or she is in imminent danger if left untreated. Some state statutes also note a "need for treatment" or likelihood that a person will benefit from treatment as one of many criteria for commitment. Additionally, the laws covering involuntary commitment are subject to interpretation and, it should be noted, continued debate within the mental health community.

Traditionally, the treatment to which a person is involuntarily committed is provided in a secure inpatient facility. State law generally charges the department of mental health or its equivalent with regulating facilities to which involuntary commitment is possible. Not all hospitals are licensed to receive involuntary patients (although this does not always restrict their ability to conduct emergency evaluations). In addition, reimbursement issues may limit admission to some hospitals. It is important for law enforcement officers and others who might become involved in involuntary commitment proceedings to know which facilities are able to admit involuntary patients.

In some states, involuntary commitment to outpatient services is also possible under the law. As with involuntary inpatient commitment, there is considerable controversy within the mental health community with regard to the acceptable purposes and uses of this option. There is also considerable variability in the manner in which outpatient commitment is utilized. Not only do states have different standards in the law, but judges and doctors can and do differ widely in their understanding and use of discretion regarding the appropriateness of invoking outpatient commitment provisions.

To avoid the adversarial dynamics of involuntary commitment, in some instances crisis teams may consider the use of alternative dispute resolution (ADR). Crisis teams should consider including personnel trained in ADR techniques who can attempt to resolve conflicts short of involuntary intervention.

Many people with mental illness today have some broad understanding of involuntary commitment laws and of the rights they have under those laws. More broadly, many who have been in treatment have learned to understand their illness, to monitor their symptoms, and, ideally, to manage their condition. Patient education is a significant component of treatment in some mental health agencies. Some consumers have arranged to provide information to emergency responders (e.g., through wallet cards) on whom to contact in the event of a crisis. Officers should be aware that someone with a mental illness who is expressing a preference for particular actions, medications, or modes of treat-

ment may be speaking from experience. The person's requests should be relayed to any treatment professional called to the scene or consulted in follow-up to an incident.

"Advance directives" are legal mechanisms by which a patient's preference for particular medications or treatment alternatives can be expressed prior to a crisis, much as many in the general population execute "living wills" or other legal documents outlining their wishes should medical crises leave them unable to express themselves in this way. Officers should be familiar with this mechanism and should be aware of the possibility that a person with mental illness may wish to follow the steps outlined in his or her advance directive. In cases where the advance directive is followed, the person with mental illness may more readily agree to become engaged in services, thereby eliminating the need for involuntary commitment.

4 On-Scene Response

POLICY STATEMENT #4

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.

This section discusses the appropriate disposition options chosen by the officer based on the nature of the situation as determined in the assessment phase—including the behavior of the person with mental illness, established protocols, and the availability of community resources.

The availability of community resources is dependent on a complex set of circumstances. For example, the advent of managed care and other changes in the broader health care system, as well as in the delivery of mental health services, have resulted in hospital consolidation, the shift to ambulatory care, and changes in emergency room procedures in almost every community in the country. In many places, practices in place just a few years ago no longer apply today. Due to factors well beyond the control of mental health services, it can be difficult to admit patients to a hospital or other medical facility. For this reason, law enforcement officers and others should stay abreast of how mental health services are delivered in their community.

Spurred by the new health care realities, mental health service providers in many communities have developed protocols intended to ensure that appropriate professionals see emergency psychiatric patients in a timely manner. Models differ among communities due to numerous factors, but the most effective approaches seem to share certain characteristics, such as having staff who can respond quickly and make an assessment of the needs of each person who comes to them.

In rural settings, where hospitals or treatment centers may be located far from some communities, officers face challenges related to time and travel, in addition to the obstacle of identifying appropriate resources for someone they believe needs treatment. Increasingly, communities are using technology—"telemedicine"—for initial assessments. Alternatively, communities rely on general health care practitioners or lesser credentialed professionals to provide these assessments, which, while not ideal, may be the only means available with current system and resource constraints. Still, there are many instances in which long distances need to be traveled in order to connect a person in need of treatment with appropriate services. Generally, law enforcement agencies are called on for transportation in these cases. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for more on telemedicine.)

The range of response options should always include the option of disengagement when the person is not a danger to him or herself or to others and has not committed a serious crime. Disengagement from police contact should not be interpreted to mean that no assistance is offered. What it can be interpreted to mean is that officers can and should provide referrals to appropriate mental health services and supports in such instances.

Departments should be aware that the simple presence of a law enforcement officer implies a certain amount of power—many people interpret whatever an officer says as something they *must* do. Officers should make clear that it is *voluntary* for people with mental illnesses—those who are not a danger or have not committed a serious crime—to follow their suggestions for referral and treatment. True problem solvers will help the person with mental illness overcome such barriers to initial treatment as transportation problems or fear of traveling alone.

The following recommendations suggest ways to facilitate the appropriate disposition for the full range of people with mental illness who may encounter the police. The sections recommend procedures that enhance emergency evaluations, promote referral to support services, provide information to victims and families, and facilitate transportation and detention when necessary. Detailed policy recommendations on report writing and other incident documentation procedures are included in Policy Statement 5: Incident Documentation.

RECOMMENDATIONS FOR IMPLEMENTATION

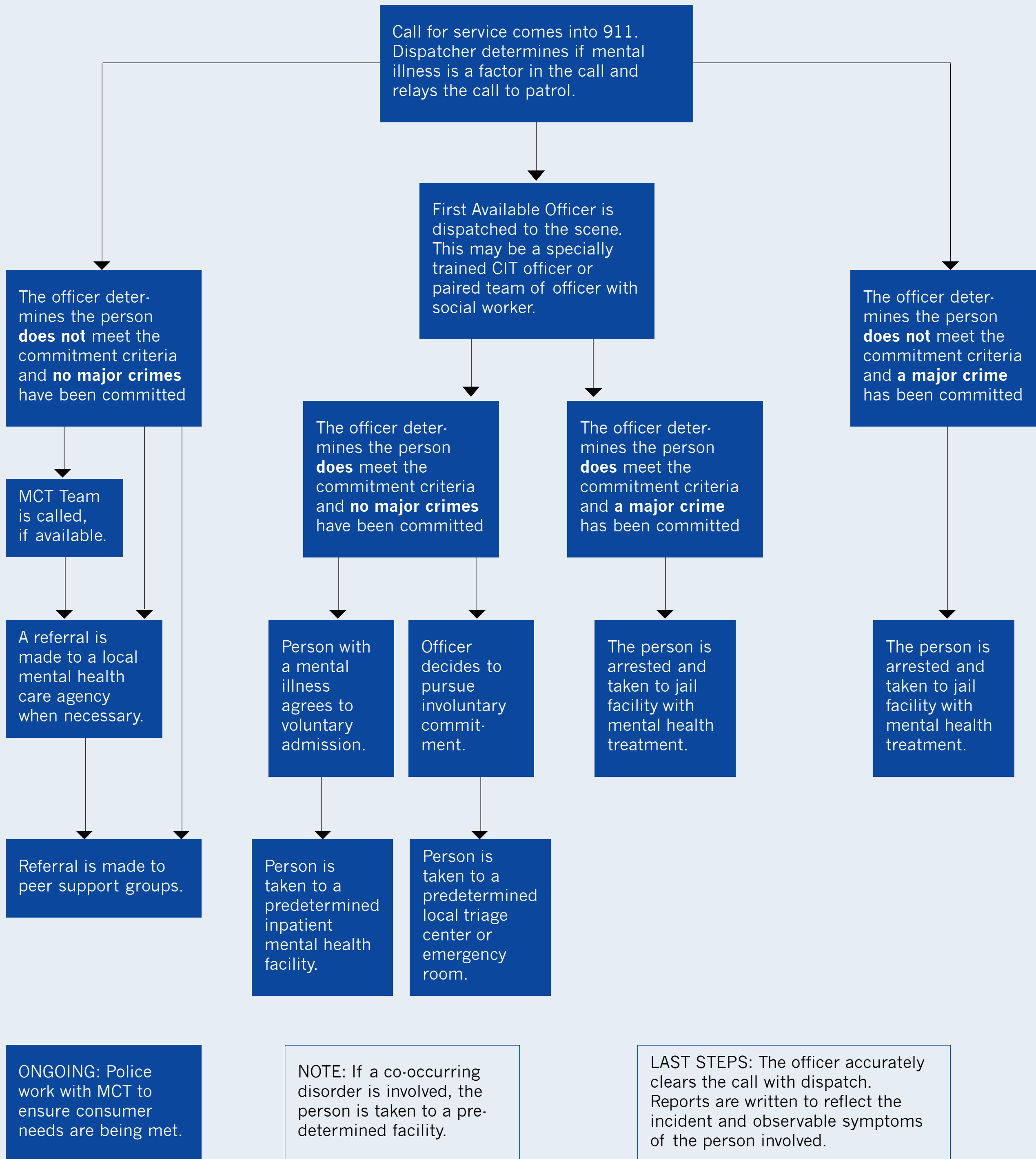
a Institute a flowchart that matches hypothetical situations with disposition options.

Because calls involving people with mental illness can be influenced by a wide array of variables, a clearly articulated flowchart is a good way to enhance officer response to people with mental illness. A flowchart such as the one in Figure 1 helps officers decide what options are best suited to each situation they encounter. In order to develop such a tool, people involved in each point of the system should identify the different response options available for each type of scenario typically encountered by responding officers.

Figure 1 shows a sample flowchart that might be used by a Crisis Intervention Team combined with a Mobile Crisis Team, an admittedly rare but effective response approach. The chart depicts multiple situations and next steps recommended for each.

A flowchart helps clarify when diversion from the criminal justice system is appropriate and when it is not. For example, in the rare event that the threat of violence exists, a flowchart developed by the individual department can reinforce the decision as to when treatment providers and police can address the problem or when other special response teams should be called in. This reference can assist in determining appropriate levels of response (which do not include SWAT teams unless absolutely necessary) that are based on the likely success of de-escalation techniques and accurate assessments of threat.

Figure 1: Sample Flowchart for Responding to People with Mental Illnesses*



*This chart reflects responses of a Crisis Intervention Team (CIT) combined with a Mobile Crisis Team (MCT) and concerns situations involving people with mental illness who are the subject of the call for service. It does not encompass situations where the person with a mental illness is a crime victim or witness.

b Designate area hospitals or mental health facilities as disposition centers that facilitate intake for people with mental illnesses who require emergency psychiatric evaluation.

It is critical for a successful diversion program to have a place where responders can take people with mental illness who require emergency evaluations. The most common difficulty encountered by police is the lack of available facility space or long waiting times for intake procedures. Consumers with co-occurring disorders or additional special needs may not seem to fit any access requirements. Agreements between law enforcement and mental health facilities can result in designated centers for drop off, procedures at the center that shorten the wait for police referrals, and coordinated efforts to identify available beds and hard-to-access services (such as for co-occurring disorders) from a wide range of options. Given the difficulties in sorting out whether a person's symptoms are due only to mental illness or to substance abuse, these facilities must have the capacity to work with both disorders.

Example: **Memphis (TN) Police Department**
A key element to success for the Memphis Police Department has been the relationships developed with the mental health community. For example, the local psychiatric emergency room agreed to provide emergency evaluations to all people with mental illness brought in by the police. The hospital also assumes immediate responsibility for assessment and referral—to either community-based or inpatient treatment at the local state hospital—while officers return to police service in as little as 15 minutes.

Example: **Florence (AL) Police Department**
The Florence Police department liaison, with the help and support of the chief, negotiated an agreement with the director of the local emergency room to "fast track" medical assessments conducted on people with mental illnesses who were brought in by police. These assessments now take less than 30 minutes.

Example: **Anne Arundel County (MD) Mental Health Facility**
In Anne Arundel County, Maryland, the county mental health facility maintains a countywide bed registry to assist law enforcement in easily locating an available bed.

Example: **Seattle (WA) Crisis Intervention Team**
Crisis Intervention Team officers from the Seattle Police Department may transport individuals who appear to have a mental illness to a Crisis Triage Unit at a Seattle-area hospital. King County health care providers developed the unit, which is open 24 hours a day, 7 days a week to respond to people in crisis.

Long drives to mental health facilities may remain the rule in rural areas, but it is possible for officers to be assured that the effort will be worthwhile. For instance, telemedicine gives officers and psychiatrists or other mental health professionals an opportunity to ensure that preliminary assessments are per-

formed in a timely manner. These preliminary assessments help to guard against transportation that is ultimately unnecessary, and they ensure that proper arrangements are made to receive the individual.

"If you don't have appropriate access to treatment and services, the only option that most law enforcement officers have in most situations is the county jail"

MAJOR SAM COCHRAN
Coordinator, Memphis Crisis Intervention Team, TN

Source: "Memphis Police Look to Help, Not Lock Up, Mentally Ill." June 8, 1999, available at: www.cnn.com/health/9906/08/mental.health

C Ensure that comprehensive emergency psychiatric services are available to law enforcement agencies for around-the-clock intake, 24 hours a day, 7 days a week.

In most communities today, there are a limited number of clearly designated emergency intake centers—perhaps just one. Each intake center should have staff on hand or on call that can respond quickly and make an assessment of the needs of each person who comes to them. It is less important where the intake center is—in a hospital or in a community mental health center, for example—than that the staff at the center be informed of what resources are currently available and have the authority to place the individual in the appropriate services. Investing staff with these "gatekeeper" functions is very important both for ensuring a smooth and rapid "hand-off," and for coordinated follow-up—whatever form it may take. Most important for police, of course, is that mental health staff be able to rapidly assume responsibility for an individual brought to them so that the officer can resume his or her duties.

Additionally, the community mental health center in some communities may operate an on-site emergency intake service only during business hours. Police and others would use the center at those times. After hours, the emergency intake service may shift to a local hospital, providing mental health workers with medical backup and laboratory services. In many settings, the mental health workers at the hospital also answer the overnight emergency telephone calls coming into the mental health center and thus have a sense of the demand for services. If services are lacking, mental health, police, and other criminal justice system professionals should lobby with consumer advocates for proper appropriations for such facilities.

In any setting, it is important that mental health workers be dedicated to emergency services, instead of being called away to treat accident victims or others coming to the emergency room for nonpsychiatric reasons. In many settings, it should be noted, the staff on hand may not include a psychiatrist. In all cases, however, a psychiatrist must be on call and available on short notice.

Example: **The Providence Center (RI)**

In Providence, Rhode Island, the Providence Center, a community-based, non-profit mental health provider, maintains an emergency services center at its main treatment site that operates during extended business hours, Monday through Friday. During other hours, emergency services are provided at a nearby hospital, where a Providence Center employee answers the emergency telephone line and makes on-site assessments of individuals who come to the hospital or are transported by police or others.

Erratic behavior can be caused by drugs or alcohol and other medical conditions as well as by a mental illness. While police may suspect the cause of erratic behavior, the actual factors may not be known for days or weeks. It is therefore important for the receiving mental health staff to be knowledgeable about the distinctions between mental illness, other medical conditions, and drug or alcohol involvement. The intake staff must have access to laboratory services and other diagnostic technology to accurately assess detainees' needs for treatment. Easy access to emergency medical care is similarly important. Staff must also be able to connect with needed drug and alcohol services and/or professionals with the ability to treat substance abuse and mental illness simultaneously if such services are called for (see Policy Statement 1: Involvement With Mental Health System).

Staff at the intake center must also be able to determine whether the individual meets criteria for involuntary commitment and, more important, be authorized to take appropriate steps in the event that commitment is warranted.

When the person with mental illness does not meet the criteria for involuntary commitment, it is especially important that law enforcement and staff at the intake center identify some short-term housing options for those who are homeless. Without a linkage to some type of housing, the police are likely to encounter the person on the streets not long after dropping him off at the intake center. Programs that make short-term housing available for individuals who do not meet the criteria for involuntary commitment should also work to connect clients with long-term housing opportunities.

Example: **Baltimore Crisis Response, Inc. (BCRI), Baltimore City (MD)**

Baltimore Crisis Response, Inc. (BCRI) manages mental health crisis beds within Baltimore City that are available on a voluntary basis to individuals who do not meet criteria for involuntary admission to a hospital and have not been charged with a crime that requires detainment. BCRI staff work closely with emergency rooms, the Baltimore Police Department, and mental health agencies to afford access to these beds as a form of pre-booking diversion. BCRI case managers work with individuals admitted to the mental health crisis facility to connect them to long-term housing and other services.

The type of insurance coverage an individual has can affect efforts to gain access to emergency psychiatric services. Private insurance, especially, may be governed by "medical necessity" criteria that can be interpreted to exclude someone with mental illness from emergency admission to some hospitals. Publicly funded mental health centers may be excluded from preferred provider lists developed by private insurers, which in some instances can complicate or even eliminate the possibility of admission. If an individual is an active Medicaid or Medicare patient, admission is still likely to be governed by some level of managed care admission criteria. While many hospitals and mental health centers receive funds allowing them to accept uninsured individuals, the absence of

any coverage complicates admission and, at a minimum, can cause further delays. None of these insurance issues are unique to mental health service delivery, but when they arise in instances involving someone who is psychotic or deeply suspicious they can stand between that person and the services he or she needs.

d Formalize agreements between law enforcement and mental health partners participating in protocols.

Chapter V: Improving Collaboration, discusses the importance of formal agreements between the criminal justice system and mental health system components on the roles and responsibilities of each partner. The following checklist outlines particular areas of such agreements that are specific to the concerns of law enforcement and mental health professionals when developing agreements. (See Policy Statement 26: Institutionalizing the Partnership, for more on elements of successful agreements.)

- What emergency detention authority do officers have and how will custodial transfer occur? It must include protections for taking the person into custody and provide liability protection as long as they are in custody. Partners will need to know what existing authority (local laws, indemnity clauses, and state statutes) may impact rights and obligations.
- What information can be shared under what circumstances? Confidentiality provisions for verbal or document exchange should address what will happen when information is included in either police or mental health reports that relates to an ongoing criminal investigation or to a mental health treatment plan. (See Policy Statement 25: Sharing Information.)
- How do law enforcement officers make the determination whether or not to place a person with mental illnesses in custody for transport to a mental health facility? It is important to specify rules based on how the person gets to the facility—in custody or voluntarily.
- When does responsibility actually shift from the on-scene responder to a mental health professional? (This could be at the scene, by phone, in a waiting room, etc.) There must be clarification of the point at which the responsibility to provide services transfers from one entity to the other.
- What intervention (such as an advocacy service) is available when a person suspected of having a mental illness is being held in a holding cell and is in need of services but who does not qualify for emergency evaluation?
- What liability protection is in place? Liability suits are related to practice, custom, policy, or accepted standards of care. The premise under liability law is that an officer cannot be sued for general duty to protect someone from being victimized, injured, or killed. However, if through a partnership a law enforcement agency creates a new special duty that

it is later unable to fulfill, departments and/or officers can be held liable. Law enforcement counsel should consider whether any agreement creates a new special duty to the individual that would create liability if breached. Each party should be held liable for its own agents' actions. If the memorandum of understanding (MOU) is carefully structured, a breach resulting in litigation would not focus on it being a joint venture with shared liability.

- What are the budgetary considerations? Cost or funding responsibilities must be addressed.

e Ensure that mental health services and supports are available for every person in need.

Ideally, any person brought to a mental health provider by police officers will be someone already known to the system or will be able to easily fit into existing services. Unfortunately, such cases appear to be more the exception than the rule. Perhaps because people who are not already engaged in the system come into contact with the police more frequently than others who are successfully engaged in treatment, they face a number of obstacles in entering the system. Because contact with police may, in fact, turn out to be a person's introduction to the mental health system, it is important that the system's door be open at this critical juncture and engagement not be made more difficult by bureaucratic concerns. Establishing protocols that allow a case to be opened or reopened smoothly can help with this process.

An important test of the partnership between police and mental health providers is the ability of officers and providers to agree on who needs mental health services. If police officers bring an individual they perceive to be in need to a provider, they expect the provider to offer appropriate services to that individual. Mental health providers must respect the observations and judgments of police officers charged with making quick decisions in the field. By the same token, police officers must respect the assessment of mental health providers about which cases they are able to address and which cases are beyond their capacities. If the law enforcement and provider agencies have not worked together before, it may take a period of trial and error for a balance to be struck. The important thing is for police and providers to ensure that they will learn as they go along and that every effort will be made to meet each individual's needs in the process. There must also be an understanding that if an individual's needs cannot be met, there is a shared plan for getting those resources established.

Even with appropriate training, police officers will occasionally seek services for someone who cannot be helped by the local mental health provider. It is important in such instances, however, that providers *not* simply turn the individual away or leave him or her under the responsibility of the police. Protocols should be developed that delineate how police and providers should work together to find some assistance for the individual, even if it is not in the mental health system.

One source of assistance for people with mental illness is peer support programs. Several types of peer groups exist to help consumers, including Drop-In Centers, Warmlines, and Clubhouses. "Drop-in centers" are informal social and recreational programs that serve as information clearinghouses and meeting locations for other peer support groups, including 12-step groups. Traditionally, people with mental illness fill staff positions. "Warmlines" are telephone support systems staffed by consumers trained to listen empathetically, provide information about appropriate resources, and act as a link to needed or desired supports and services. Warmline staff does not provide suicide intervention or crisis intervention, but they are trained to recognize the need to engage the more critical support offered by a suicide hotline. The staff also makes outgoing calls, contacting consumers who have asked to be called regularly to stay connected to a support system. "Clubhouses" are collaborative efforts between professionally trained staff and consumers who provide vocational support and prepare consumers to enter into or return to the workforce.

In many instances, law enforcement officers may deliver a person with a mental illness to a mental health provider only to discover that any of a number of complicating factors may make it difficult to connect that person with appropriate services. For example, the provider will want to determine whether the person has insurance or qualifies for Medicaid or other benefits or entitlements. Similarly, the person may have more than one diagnosis or display no interest in receiving services. In these instances, too, protocols must be in place to ensure the delivery of appropriate services or responses.

In some communities, ACT programs have been put in place or adapted to provide or arrange for comprehensive treatment and supports for people with mental illness whose behavior has brought them to the attention of law enforcement. The concentrated individual attention that characterizes the ACT model can provide assurance that a person in need will receive appropriate services. In other instances, it may be that clinical services aren't needed, and the most effective connection can be made with peer services, either at a drop-in center or through individual contact with a peer counselor who is trusted because of the shared experience of mental illness.

Regardless of the model used, mental health providers should take steps to ensure thorough follow-up for any individual who is brought to them under mutually agreed conditions by law enforcement authorities. Follow up may help stop the cycle of repeated involvement with the criminal justice system, while offering mental health providers a ready barometer of conditions and situations that receive police attention. "Follow-up" in this case means, at a minimum, a thorough examination, which may result in a referral to a more appropriate provider. The protocols developed to ensure services must also include a component that allows providers and police to regularly assess the appropriateness of referrals. In addition, each participating agency should designate a liaison to work with counterparts to resolve problems.

Example: Anne Arundel County (MD) Mobile Crisis Team

The Mobile Crisis Team (MCT) approach is successful in Anne Arundel County because the MCT is connected to a local clinic, emergency shelter beds, and an In-Home Intervention Team. The MCT has the resources to ensure that people with mental illnesses get the intervention necessary. The Broken Arrow, Oklahoma, Police Department is among other agencies using a similar approach.

f Ensure that specially trained mental health professionals are available to respond to scenes involving barricaded or suicidal suspects.

To respond as appropriately as possible in the incidences of barricaded subjects or violent situations, effective communication must exist between police, special responders and department negotiators. While agencies are often under pressure to resolve situations quickly, it is often the best approach to allow time for communication to work in these crisis situations. Hostage negotiators will likely be called to a scene when initial efforts by responding officers to resolve a critical incident have failed.

The effective resolution of these encounters is also dependent on the involvement of specially selected and trained mental health professionals who have expertise in crisis negotiation and familiarity with police operations. State-level mental health agencies will likely know of individuals suited to this role. These mental health professionals will be able to assist law enforcement in understanding the motivation for the incident, which is critical to defusing the situation.

g Provide information to victims with mental illness and their families to help prevent revictimization and increase understanding of criminal justice procedures.

Research has shown that people with mental illness, like many people with disabilities, are at a greater risk for victimization.[3] People with mental illnesses have been shown to be vulnerable to sexual assault as well as other violent crimes.[4] These crimes are also disproportionately unreported, probably because these victims fear reprisals or retribution from their abusers for coming forward or fear the police won't believe them.

People with mental illness who have been victimized repeatedly may confuse events in their reports to law enforcement. This confusion does not negate their victimization and the importance of investigating the crime. In fact, people with mental illness may experience the trauma of victimization more acutely than other victims, partly because it triggers memories of past abuse. This history of abuse is relevant to case investigation and should be explored.

3. Virginia Hiday et al., "Criminal Victimization of Persons with Severe Mental Illness," pp. 62-68; also J.A. Marley and S. Buila, "When violence happens to people with mental illness: Disclosing victimization," *American Journal of Orthopsychiatry* 69:3, 1999, pp. 398-402.

4. D.D. Sorensen, "The Invisible Victims," available at: *www.ncvc.org/newsltr/disabled.htm.*

Unfortunately, when victims with mental illness do report their crimes, they are frequently viewed as unreliable witnesses and their cases are often dropped. Law enforcement must become more aware of the complexities of working with victims who have mental illness and should collaborate with their mental health partners to increase the reliability of evidence. These professionals can help law enforcement sort out these complex issues and improve case outcomes. Resources for responding to crime victims who have disabilities can be obtained through the Department of Justice's Office for Victims of Crime.[5]

Law enforcement agencies should provide information to these victims about available services that can help reduce their vulnerability and promote positive contacts with the criminal justice system agents who can inform them of case progress. Law enforcement can also work with consumers and their advocates to conduct crime prevention outreach.

h Inform affected third parties, including victims, minors and the elderly, about what to expect and what community resources are available.

Affected third parties can include victims, family members, employers, or others who share a home or part of their lives with people with mental illness. As in other similar situations, these individuals need a variety of supports and may look to law enforcement for help in accessing resources. In particular, victims (who may also be family members) should be apprised of the course of action to be taken by law enforcement and mental health agencies, and what they can expect the outcomes of the actions to be. They should also be made aware of national resources for victim assistance, including the National Organization for Victim Assistance, the National Center for Victims of Crime, and the Office for Victims of Crime.

In many instances, families try to maintain normalcy when dealing with one of their own who has a mental illness. It may be that the incident resulting in police involvement is the first public acknowledgment of mental illness in the home. Or it may be that the incident is the first manifestation that has clarified mental illness as a problem. In any case, the incident may represent the first time the family has reached out for help and thus the first opportunity for necessary supports to be made available to them. It is important, therefore, for police officers and mental health workers to be knowledgeable about the full range of resources that are available for families and others close to the affected person.

For example, police departments and their mental health partners can provide information on peer supports, such as consumer-managed neighborhood projects, drop-in centers, and warmlines, which offer nonemergency support to consumers by telephone. Regional NAMI affiliate organizations, com-

5. C.G. Tyiska, "Working with victims of crime with disabilities," available at: *www.ojp.usdoj.gov/ovc/publications/factshts/disable.htm*.

munity chapters of the Depressive and Manic Depressive Association, and local United Way organizations are all good resources for peer support and services. Families may also contact statewide consumer-managed organizations, an example of which is the Tennessee Mental Health Consumer Network.

If police have been called to a home as a result of a threat or threatening action, they should be able to inform family members in the home on ways to protect themselves. Even in instances where the individual is placed in treatment, voluntarily or involuntarily, it can usually be expected that he or she will be at liberty in the community within perhaps a matter of days. Families should be made aware of the process for obtaining a protective order, the associated risks and benefits, as well as what to expect should the order be obtained and violated by the ill family member.

In many instances, of course, members of the family may represent classes given special status or protection under the law. Children of a person with mental illness, for example, may be subject to actions taken by the child protection authorities intended to remove them from the risk of harm. If elderly individuals or spouses have been threatened or harmed, police may be required by law to arrest the individual family member or to notify other authorities. (It should be noted that mental health workers who uncover evidence of elderly, spousal, or child abuse may also be obligated under the law to notify certain authorities.)

Families that report and deal with incidents have great need for support. They may feel isolated and not know where they can turn for information that will help them provide the best care for their relative and for themselves. It is helpful for police to be aware of the resources available to assist families in these situations, such as NAMI. However, it is essential that mental health providers be prepared to provide complete information on support and education resources to families.

In some places, mental health agencies provide classes or resource centers stocked with information for families. More generally, community mental health providers rely on separate nonprofit organizations to provide information and support. Most commonly, these local organizations are affiliated with such previously cited national organizations as NAMI, the National Mental Health Association, or the National Depressive and Manic Depressive Association and are able to offer information and programs developed by these organizations. By meeting and communicating with others who have been through similar situations, families are able to learn skills that will help them to be effective advocates for themselves and for their relatives.

Law enforcement agencies should work with their mental health partners to prepare packets of information on available community-based resources for people with mental illnesses and substance abuse disorders and for their families. These packets should accommodate the full range of cultures and languages present in the community.

Example: Community Mental Health Centers

Community mental health centers in many communities have prepared packets of information for families of clients receiving emergency services. These packets include information about the services the center provides, the rights of patients, payment options, and materials from the local NAMI affiliate and the statewide Mental Health Association. In addition, counselors who meet the families in these initial encounters encourage the families to make contact with one of the organizations, taking time to allay their concerns about privacy, shame, and cost. The organizations, in turn, provide useful information, including Web addresses, book lists, schedules of classes or events, local contact information, as well as descriptions and contact information for area provider agencies.

i Disengage or transport the person to the appropriate facility with the least restrictive restraint possible.

Depending on the nature of the response chosen, officers will either leave the person at the scene, transport the person to a mental health facility, transport the person to their home or to the home of a friend or family member, or transport the person to a detention facility.

If police are requested to transport the person to the mental health facility for a *voluntary* admission, this is *service,* not a custodial transport. In general, police can take a person with mental illness into custody, only (1) when the individual has committed a crime; (2) the individual is at significant risk of causing harm to self or others and meets the state's criteria for involuntary emergency evaluation; or (3) in response to a court order or directive of a mental health or medical practitioner who has legal authority to commit a person to a mental health facility.

Before agencies revise policies on custodial and noncustodial transfer of people with mental illness, pertinent laws and liability issues should be explored. However, it is possible to decrease stigma and enhance the dignity of people with mental illness during the transport process.

Example: Washington, D.C., Police Department

A Washington, D.C., policy states that if the responding officer is asked to transport someone for voluntary admission and the officer deems the person to be nonviolent, the officer can provide transport to the facility without handcuffs.

If a person's behavior poses an imminent risk of serious harm to self or others, officers may need to take reasonable steps to physically restrain the person. If time permits, guidance from a mental health professional should be sought about the best restraint methods for the person and situation. Unless there is immediate danger to the individual, others, or officers, responding officers should move slowly and allow the person time to calm down in an effort to gain voluntary cooperation before resorting to physical restraints.

In some communities, police are able to call mental health staff to handle transport. Often known as mobile crisis teams, these mental health units are able to assume responsibility for the individual in question on the scene, allowing officers to return to patrol.

Example: **Montgomery County (MD) Police Department**
In Montgomery County, Maryland, the Police Department's Crisis Intervention Team works closely with the county mental health agency's Crisis Response Team. In many instances, the Crisis Response Team is called to the scene by the CIT, allowing police officers to transfer responsibility for an individual without accompanying that person to a mental health intake center or hospital emergency room.

j Conduct suicide screening for all people with mental illness who are detained for a short time in a police lock-up or jail.

Depending upon the jurisdiction, a person taken into custody for a criminal offense is brought either to a police holding facility or to the local jail pending the initial appearance in court. While this stay in custody awaiting the court appearance is usually brief—in most instances less than 24 hours—it can be a vital time for a person with mental illness. Research has shown that most suicides that occur in custody take place within the first 24 hours.[6] In addition, the behavior that led to the arrest may be the manifestation of an individual experiencing a mental health crisis.

As a result, intake procedures into these facilities should screen for a risk of suicide and assess the need for emergency psychiatric evaluation. Staff should also be trained in suicide prevention and crisis management procedures. These screening procedures are for the purpose of providing appropriate treatment, not for gathering evidence for a criminal proceeding. Agency staff should also note that people with mental illness may need access to their medication. Officers must follow departmental rules for verifying that any pills or capsules the person is carrying are prescribed, or to obtain the needed medication, so that they may authorize the individual to continue the prescribed treatment should they be detained.

As mentioned earlier, police officers should be aware that some medications that treat mental illness have side effects that may require attention. For example, medications may cause tremors, nausea, extreme lethargy, confusion, dry mouth, constipation, or diarrhea. Police officers should attend to needs for water, food, and access to toilet facilities. It is important not to mistake these side effects as evidence of alcohol or drug abuse. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more information on intake procedures.)

6. L.M. Hayes, Prison Suicide: An Overview and Guide to Prevention, National Institute of Corrections, 1995, available at: *www.nicic.org/pubs/1995/012475.pdf*

5 Incident Documentation

POLICY STATEMENT #5

Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery.

While not *all* contacts with the public result in documentation, law enforcement agencies do collect information about most of their encounters with the public at several points: when the call comes in to the agency; when the officer clears the call and returns to service; when an official report is filed; and when supplemental reports are submitted. Many agencies maintain sophisticated computerized systems, while others rely on more traditional paper-based systems. Regardless of the level of sophistication, however, it is critical that data be reliable, accurate, and consistently entered.

When the call comes in to the agency dispatch, some agencies use a Computer Aided Dispatch (CAD) system that maintains important data elements on all calls for service. These systems keep track of calls based on their geographic location, and can show numbers and types of calls over time. When the officer has completed the call, he or she contacts the dispatcher to clear the call and can update the nature of the call at that time. Although not all departments have a CAD system, all do maintain some system for tracking calls for service.

Many agencies also maintain additional computerized data systems, often called Records Management Systems, or RMS, which capture information submitted on incident or arrest reports. These data may be used by police to manage a great deal of information about contacts with the police, up to and including arrest. These data are analyzed to detect crime patterns and evaluate the police response. Supplemental reports for particular types of incidents may also be maintained in computerized formats, or in file cabinets, depending on the quantity of the information and its intended use.

Law enforcement agencies must consistently and accurately document their contacts with people who have mental illness, just as they should for all encounters—for consumers' protection and to provide better law enforcement service. Just as information has certain benefits, however, it also has risks to the consumer and his or her family. For this reason, privacy laws protect personal medical information, including information about a person's mental health, and limit the occasions when a medical professional can share that information without consent. A full discussion of protected information and its disclosure is provided in Policy Statement 25: Sharing Information.

The recommendations in this section address how law enforcement should capture data and under what circumstances. Ultimately, departments that develop effective internal information-management systems will depend less on mental health system information protected by privacy laws and be better prepared to address the needs of people with mental illness in the long term.

RECOMMENDATIONS FOR IMPLEMENTATION

a Capture information related to mental illness consistently in calls-for-service data.

Regardless of agency size, law enforcement agencies should use special numerical codes when storing data to indicate when mental illness was a factor in the call for service.[7] Smaller departments may document incidences using index cards while some larger departments may use computer equipment. In smaller jurisdictions without advanced Computer Aided Dispatch (CAD) systems, dispatchers must be specially trained to collect detailed information that can be stored in location files or similar data sources.

Officers should also be required to update this numerical code when clearing the call to change the nature of the call if they determine that mental illness is an issue. For example, if an officer is called for a noise complaint and finds a man having a psychotic episode who is a danger to himself, the call should be cleared to reflect this new information. If the officer determines that mental illness is *not* a factor in a call that was dispatched as such, he or she should also denote that change for dispatch.

Many CAD systems have only one field that captures the type of call and officers are asked to pick the most relevant code. Agencies will need to provide guidance to officers as to how and when to prioritize the mental illness as the critical feature of the call. By using appropriate clearance codes in the CAD system, law enforcement agencies can track information (such as repeat calls involving a person with mental illness) and assess agency responses.

Some departments also choose to place "flags" on certain locations in the CAD system (see Policy Statement 2: Request for Police Service). These flags appear when repeated calls for service are made to that location. The dispatcher then reads the text of the flag when dispatching the call to provide additional information to the responding officers. These flags are placed *only* on those call locations that pose a particular concern, such as potential for violence or as a repeat location. Personnel are designated to review these flags periodically to make sure the flags continue to reflect current issues or problems.

Example: **Baltimore County (MD) Police Department**
In the Baltimore County Police Department, supervisors make written requests to the communications center to place a flag on certain locations where police have made repeated calls or where there has been a history of weapons use or violence. These flags are used for a wide variety of calls, not just those related to mental health problems.

7. Law enforcement agencies should only document information about mental illness when it is relevant to the encounter. Agencies should not develop databases that con-

b Collect information related to mental illness accurately in police reports and supplemental forms, focusing on observable behavior.

Although information about a person's mental illness on written police reports is important for accuracy and to clarify officers' response choices, it has the potential to influence criminal case outcomes negatively. For that reason, care must be taken in the way that information pertaining to mental illness is documented.

Most important, officers should be trained to concentrate on documenting *observable* behavior, not pseudo-diagnoses or damaging slang. For example, reports should never include a box stating that a person is mentally ill, but could instead list indicators of mental illness involved (see Policy Statement 3: On-Scene Assessment, for examples of indicators of mental illness).

Report forms should also allow room for officers to include their own observations. However, officers should not draw conclusions in their observations about what they believe has caused the behavior, such as that the person is "off his meds," without supporting information. Whenever possible, local mental health professionals should participate in training officers about the type of information to be included in a report based on federal, state, and local laws. Confidential information shared by mental health professionals should not be documented in police reports.

Departments may also want to consider using supplemental forms that capture additional information about police contacts with people with mental illnesses. These forms should not become part of the charging documents and should be kept confidential. This documentation can provide information about the nature of the problem, mental health resources that were accessed, and the way police responded. This information will be helpful to internal decision-making processes, such as the allocation of resources, but will not be part of the individual's arrest record.

> Example: **Memphis (TN) Crisis Intervention Team**
> The CIT approaches used around the country employ a report form that is completed by the responding CIT officer and maintained by the coordinator for review and tracking. Memphis, Tennessee, and Montgomery County, Maryland, Police Departments use such a form to document incident specifics such as the living arrangement of the person, the use of restraints, and the disposition chosen.

Police observations related to a person's mental illness are also collected on commitment forms, which in many jurisdictions give only two lines to report observations. Commitment forms must be useful for police, which means short and fast, but they should have sufficient space to record observations that would be useful to mental health providers. These forms are used to indicate probable cause for emergency holds of individuals thought likely to meet criteria for involuntary commitment and will be presented to judges during civil commit-

"In terms of information, law enforcement needs to know enough to resolve the situation and keep people safe, but some of the detail and nuance are better kept confidential. If law enforcement has certain information, it can stigmatize the person with mental illness, and that can stay with the person for a long time."

CHIEF CHARLES MOOSE
Montgomery County Police Department, MD

ment proceedings. Often, police officers have had the best opportunity to observe behaviors that may indicate need for involuntary treatment, so an accurate and professional description in such instances is important.

C Document information relating to a person's mental illness only when that information is relevant to the incident.

Officers should document information about mental illness only when that illness is relevant to the police contact. For example, a suspect may have depression that is not relevant to the crime he or she is accused of. Similarly, for some victims of crime who have a mental illness, that illness is not relevant to the situation and thus should not be recorded.

6 Police Response Evaluation

POLICY STATEMENT #6

Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement.

An important goal of any police response is to ensure that people with mental illness are well served by the services that are brought to bear and that approaches being implemented have the effect of reducing contacts with the criminal justice system. The way to assess how well services are working involves doing two things: consulting with service providers to evaluate referral mechanisms and identifying individuals who continue to come into contact with the police. It is important when conducting any kind of assessment for the participants to have clearly articulated the program goals. Chapter V: Improving Collaboration and Chapter VIII: Evaluating Outcomes also address these topics.

RECOMMENDATIONS FOR IMPLEMENTATION

a Consult with service providers to evaluate rates of success in engaging people referred by the police.

Law enforcement agencies should consult with service providers (including those who focus on minors and victims) to gather information on the outcome of the police referrals. It is important, as always, that private information about the individuals seeking treatment be kept confidential. Consulting with providers serves as an evaluation tool to assess whether services were made available and accessed following encounters with law enforcement. Agencies should examine in-house protocols to ensure that referrals were made and to identify other resource issues.

This consultation can be conducted during routine partnership meetings where police and mental health practitioners review data they have collected. It is very important that these data be presented in the aggregate rather than

for each individual.[8] For example, the law enforcement representative can provide the number of people who were referred for services, which can be compared to the mental health representatives' notes on how many people contacted the service. In this way, confidentiality is maintained, yet problems with the protocol can be examined.

b Analyze police data to identify individuals who have repeat contacts with law enforcement and collaborate with mental health partners to develop long-term solutions.

A proactive approach is fundamental to the philosophy of community policing. This involves identifying problem situations and working with community partners to craft long-term solutions. "Problem" situations involving people with mental illness are those that result in repeat calls to the police. These situations may not be resolved by existing protocols, may escalate in seriousness, and require a more in-depth look into the underlying causes of the problem.

To identify these cases, agencies must review internal databases designed to capture information on situations involving people with mental illness. As mentioned previously, some departments review CAD system data to reveal locations that previously have involved violence or that result in frequent calls for service. Other agencies review supplemental data forms collected by crisis intervention teams.

Once the case has been identified, law enforcement personnel should work closely with their mental health partners to identify the precise nature of the problem and the possible causes.[9] Together police and mental health providers can then determine a course of action to help the person avoid further contacts with the police. It is always preferable for mental health personnel to conduct follow-up visits, should they be required, although some departments have paired a mental health professional with an officer who is not in uniform.

Example: **Anne Arundel County (MD) Mobile Crisis Team**
Mental health professionals from the Mobile Crisis Team in Anne Arundel County provide follow up for people with mental illness who have come in contact with local law enforcement.

8. This does not preclude police involvement in problem-solving teams, when requested to do so by mental health partners.

9. Many law enforcement agencies around the country use the Scanning Analysis Response and Assessment (SARA) model of problem solving. For more information about the SARA model, see Goldstein, Herman, *Problem-Oriented Policing*, McGraw Hill, Inc., New York, 1990; also M. Reuland, C.S. Brito, and L. Carroll (Eds.), Solving Crime and Disorder Problems: Current Issues, Police Strategies and Organizational Tactics, Police Executive Research Forum, Washington, DC, 2001.

CONCLUSION

Those in law enforcement are continually bombarded with demands from constituents who want their concerns to be given top priority, mandated training, new resources, or revised protocols. Officers and other police personnel are frustrated with repeat calls for service that have no satisfactory resolution for anyone involved. They want to address problems before they escalate into confrontations that can have deadly consequences. They want to use their resources effectively and efficiently. At the end of the day, they want to improve the lives of people who struggle with mental illness as well as all those touched by the consequences of unmet mental health needs. It is for them that this section has been written.

Police are frequently the only 24-hour service providers citizens in a community know to contact for help. Many police departments lack the resources or mental health networks to reduce the costs—in human lives, quality of life, and dollars. It is hoped that this report will assist them in finding more immediate help to divert those who are better served by the mental health system, without threat to public safety. For those individuals whose needs continue to go unmet, there is still hope that the reforms suggested in the following sections on courts and corrections will prevent them from cycling back to the streets, no better off than when they started.

These subsequent chapters, in addition to the chapters in Part Two: Overarching Themes, will help police professionals and others fully understand how the actions of one component of the criminal justice system can so significantly affect others. The report presents creative strategies for collaboration and propose the kind of mutual support that can convince policymakers to make the reforms that each of them has unsuccessfully pressed for individually.