Mental Illness and Law Enforcement:

Current Procedures and Practices

Gissell Reyes

The College of Saint Elizabeth
Since the 1950’s, after the discovery of the first antipsychotic medicines, there has been a shift in the world of psychiatric care. The deinstitutionalization movement was powered by the idea that community based treatment would be a more effective way of managing mental illness than in an institution (Barker, 2013). This, along with financial and legal developments (i.e. lack of community resources and changes in legislation) resulted in a mass exodus from psychiatric facilities. This alone is sufficient reason for the increase in interactions between law enforcement and the mentally ill population. However, an additional component that might have contributed to this increased interaction could be American policing’s paradigm shift from the traditional response and enforcement model to a community-based model (Borum, et al, 1998; Sellers, et al, 2005).

As a result of the changes mentioned above, the country’s top three mental health facilities are Cook County Jail, Rikers Island, and Los Angeles County Jail (Barker, 2013). According to Barker (2013), approximately 16% of federal prison inmates, 10% of jail inmates, and 18% of state prison inmates suffer from severe mental illness. Severe mental illnesses “include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder” (National Alliance on Mental Illness, 2014). It is apparent that in many instances law enforcement officials are the first responders. Recent years have seen a spike in instances where police use excessive force in situations with mentally ill suspects. The U.S. Attorney’s office conducted a 14-month long investigation into the Portland Police Bureau and found that law enforcement officials were guilty of a “pattern and practice of excessive use of force, particularly against mentally ill suspects”
(The Oregonian, 2012). More recently, ex-police officers involved in the brutal 2011 beating and subsequent death of Kelly Thomas, a homeless man diagnosed with schizophrenia, were acquitted of all charges in January of this year (Conder, 2014). It is the opinion of this researcher that violent situations could be avoided if law enforcement officials had better training and education when it came to interacting with the mentally ill population. In order to justify this theory, we will look at four different models of law enforcement training for interacting with mentally ill suspects.

We will look at three models of law enforcement that specialize in interacting with the mentally ill. Borum, et al (1998) administered surveys to police departments in Birmingham, Knoxville, and Memphis. These surveys were created to measure how well or how badly officer’s perceived: a) their ability to handle situations involving mentally ill people, b) the department’s specialized response effectiveness, and c) local mental health services. Each of these cities follow a different model for interacting with the mentally ill populations. The four-point scale ranged from 1—not at all to 4—very, similar to a Likert scale (Borum, et al, 1998).

Memphis uses the Police-based specialized police response. According to Borum, et al, (1998), “these models involve sworn officers who have special mental health training who serve as the first-responders to mental health crises in the community and who act as liaisons to the formal mental health system”. The city of Memphis has a Crisis Intervention Team (CIT) specially designated to respond to calls placed by emotionally disturbed persons. In the study, the Memphis officials were divided into CIT officials and non-CIT. Those who had the specialized training in the CIT rated themselves as well prepared with 100% of responders checking this category compared to 65.4% of the non-
CIT responders thinking they were well prepared (Borum, et al, 1998). Compared to non-CIT officials, the Memphis CIT officers rated the mental health services to be more helpful (40.3% and 69.4% respectively) (Borum, et al, 1998).

Birmingham Community Service Officers (CSO) follow the Police-based specialized mental health response. Borum, et al, (1998) stated “in this model, mental health professionals (not sworn officers) are employed by the police department to provide on-site and telephone consultations to officers in the field” About half (52.1%) of the Birmingham officers surveyed felt they were well prepared to handle instances where mentally ill persons are involved and 37% perceived the local mental health systems as helpful (Borum, et al, 1998).

Knoxville’s Mental-health-based specialized mental health response program has a created a Mobile Crisis Unit (MCU). This follows the more traditional model where “partnerships or cooperative agreements are developed between police and mobile mental health crisis teams that exist as part of local community mental health services system and operated independently of the police department” (Borum, et al, 1998). Officials in Knoxville responded that 78.1% felt well prepared but only 14.5% responded that they found the local mental health systems as helpful (Borum, et al, 1998).

Since the original study did not use a comparison group without a program in place, Sellers and collaborators (2005) decided to build on the Borum, et al (1998) study. Sellers and his associates used a subsample of 182 Newark, NJ police officers and added the sample to Borum and colleagues’ previous sample of 452 officers. The Newark Police Department follows guidelines and procedures propagated by the New Jersey Police Training Commission, in addition to N.J.S.A. 30:4-27 et seq. which has found that the
state of NJ has the responsibility to provide care and treatment, as well as rehabilitation services to those who cannot provide themselves with basic care or are a danger to themselves, others or property (Sellers, et al, 2005). The NJ Police Training Commission has developed a standard training curriculum that is mandatory at all police academies in the state of New Jersey (Sellers, et al, 2005). In order to gain more insight into New Jersey police procedure with mentally ill suspects, an interview with Sgt. John Doyle of the New Brunswick Police Department (NBPD) was conducted. Sgt. Doyle confirmed the above training is needed in order to successfully graduate from a New Jersey police academy (Doyle, 2014). In regards to continued education, Sgt. Doyle reported,

In addition to the computer based training [detailed power point presentation], the department reviewed this information in person for the entire department in a question and answer session during our in-service training week. All officers, regardless of rank are to attend eight hours of in-service training twice a year. In addition, we purchased a video "The Community I Serve", from the organization National Alliance on Mental Illness of New Jersey (NAMI-NJ) which went over specific scenarios in which law enforcement dealt with mentally ill individuals from the community as well as ‘Do's & Don’ts’ Cards which are a pocket sized cards for officers to carry when dealing with persons with mental illness (Sergeant Jack Doyle, February 18, 2014)

Sgt. Doyle did say that the goal of the NBPD was always to de-escalate the situation without the use of force while diverting the mentally ill person away from the criminal justice system when possible.

The NBPD’s officer training model goes along with the goals of the Newark Police Department (NPD). According to Sellers and associates (2005), the NPD prefers to deal with mentally ill offenders informally (treatment) rather than formally (arrests). The NPD procedure is unlike the programs examined by Borum, et al (1998), because it relies on unspoken agreements between mental health services (i.e. hospitals, EMTs) and police
officials rather than a formal special response program or organizational agreement (Sellers, et al, 2005). Sellers and his colleagues found that NPD officers believed they were about as prepared as the officers in Knoxville; however, they found that NPD officers perceived mental health services to be as helpful or more helpful than in other cities. Overall, Sellers and colleagues (2005) found that, compared to cities where specialized response programs are present, NPD had “a lower arrest rate (roughly compared) and similar attitudes toward preparedness and departmental effectiveness”.

This is an interesting and significant finding because “these results indicate that a community with a traditional ‘treatment as usual’ response to persons with mental illness can be effective in dealing with this special population” (Sellers, et al, 2005). While the Memphis program seems to be the most effective model, it is important to take note that the Newark approach works as well as the Birmingham and Knoxville structures. The NPD is effective without using the funds and resources available to the other cities police departments. This suggests that while there are various ways to decrease negative interaction between police officials and the mentally ill, educating our first responders is the foundation for change.
References


