

Police Training and Specialized Approaches to Respond to People With Mental Illnesses

Judy Hails
Randy Borum

Eighty-four medium and large law enforcement agencies reported the amount of training provided on mental-health-related issues and the use of specialized responses for calls involving people with mental illnesses. Departments varied widely in the amount of training provided on mental-health-related topics, with a median of 6.5 hours for basic recruits and 1 hour for in-service training. Approximately one third of the agencies (32%) had some specialized response for dealing with calls involving people with mental illnesses. Twenty-one percent had a special unit or bureau within the department to assist in responding to these calls; 8% had access to a mental health mobile crisis team.

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Encounters between police and people with mental illnesses (PwMI) are common—comprising between 7% and 10% of all law enforcement contacts—and most are handled without incident (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Janik, 1992). Nevertheless, many officers and police managers perceive that these incidents pose a significant operational problem (Bittner, 1967; Borum, Deane, Steadman, & Morrissey, 1998; Deane et al., 1999; Gillig, Dumaine, Stammer, Hillard, & Grubb, 1990; Janik, 1992; Stroul, 1993). Calls involving PwMI often consume a disproportionate amount of patrol time (DeCuir & Lamb, 1996; Pogrebin, 1986-1987) and carry significant potential for departmental liability and for overloading correctional systems (jails and prisons) with relatively nonserious but high-maintenance offenders.

Many communities have experienced a high-profile incident in which an officer used force—often deadly force—against a subject who was actively experiencing symptoms of mental illness. As a result, some departments have

JUDY HAILS: Department of Criminal Justice, California State University Long Beach.
RANDY BORUM: Department of Mental Health Law & Policy, University of South Florida.

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been criticized or even sued for failing to provide adequate training for officers or to develop programs within their agencies to ensure appropriate response (Hill & Logan, 2001).

Even when the on-scene encounter is resolved without force, the officer is still responsible for providing a disposition that both serves the needs of the individual and maintains order and safety in the community (Finn & Sullivan, 1987, 1989). Law enforcement officers, however, often feel inadequately equipped or supported to deal with the crises involving PwMI and many times become frustrated in the time-consuming attempt to provide them access to professional assistance (Hanewicz, Fransway, & O'Neill, 1982; Perkins, Cordner, & Scarborough, 1999; Pogrebin, 1986-1987). As a result of these frustrated attempts, officers frequently—although not usually—resort to arrest to dispose of the case, even for relatively minor offenses such as trespassing, disorderly conduct, or other nonserious misdemeanors (Bonovitz & Bonovitz, 1981; Borum, Swanson, Swartz, & Hiday, 1997; Clark, Ricketts, & McHugo, 1999; Drake, Bartels, Teague, Noordsy, & Clark, 1993; Frankle et al., 2001; McFarland, Faulkner, Bloom, Hallaux, & Bray, 1990; Monahan & Steadman, 1983; Teplin, 1984). The national result of this trend is that approximately 685,000 people with severe mental illness are admitted to U.S. jails every year (Torrey et al., 1992). Numerous studies from around the country show that between 6% and 15% of all jail inmates have a severe mental illness (Lamb & Weinberger, 1998). This means that nationally there are more people with severe mental illness in U.S. jails than in state psychiatric hospitals (Torrey et al., 1992).

Problems arising from the overuse of arrest and the use of force during incidents involving PwMI have led a number of law enforcement agencies to develop specialized approaches or initiatives designed to improve their response to PwMI in crisis. Many of the first-generation efforts focused exclusively on training. Research evaluating these training efforts suggest that they did improve officers' knowledge of mental health issues (Godschalx, 1984) and their ability to apply that knowledge in identifying and communicating about mental illness (Janus, Bess, Cadden, & Greenwald, 1980); however, attitudes and performance were more resistant to change. Although it is generally acknowledged that almost all law enforcement agencies—88% in one national survey (Deane et al., 1999)—offer some training related to mental illness, the nature and extent of that training has not been systematically investigated. Moreover, although research suggests that these training programs “are probably not harmful and may be helpful . . . there is good reason to believe that they are not sufficient to fundamentally change the nature of police encounters with mentally ill people in crisis” (Borum, 2000, p. 333).

Consequently, a second generation of specialized response approaches evolved that are more focused and sophisticated and show substantial promise. These approaches include training but do not rely on it exclusively. In a national survey of police departments, although training was ubiquitous, less than half (45%) the agencies reported having some type of specialized response to mentally ill people in crisis. Where specialized programs existed, they appeared generally to conform to one of the three following models (Deane et al., 1999).

Police-based specialized police response. These models involve sworn officers who have special mental health training, serving as the first-line police response to mental health crises in the community and acting as liaisons to the formal mental health system. Of the departments, 3% had this type of program.

Police-based specialized mental health response. In this model, mental health professionals (not sworn officers) are employed by the police department to provide on-site and telephone consultations to officers in the field. Of the departments, 12% had this type of program.

Mental-health-based specialized mental health response. In this more traditional model, partnerships or cooperative agreements are developed between police and mobile mental health crisis teams (MCTs) that exist as part of the local community mental health services system and operate independently of the police department. Of the departments, 30% had this type of program.

This study was conducted to update and extend the findings from the 1996 survey (Deane et al., 1999). Specifically, we intended to examine the nature and extent of training that police agencies provide on handling calls involving PwMI and the nature and prevalence of police-based specialized response programs.

METHOD

A brief survey questionnaire was developed to assess the following two issues: (a) the extent of recruit and in-service training for how to respond to calls involving PwMI and (b) the existence of specialized responses for these calls. The survey was pilot tested on the 25 largest police departments in Los Angeles County, California, that were not to be used as part of the study and was revised to improve clarity.

The final survey was sent to all law enforcement agencies in the United States with more than 300 sworn officers, based on their listing in the annual report of the Department of Justice's Uniform Crime Reporting Program (Federal Bureau of Investigation, 1998). For geographic diversity, the largest police department in a state was included if the state would not otherwise be represented. The resulting list was composed of 135 agencies: 126 included due to their size and 9 from states with small populations.

The survey was initially sent to all 135 agencies in October 1999, with two follow-up mailings. A total of 84 agencies (62.2%) responded with usable data. These respondents were located in 39 states and the District of Columbia. Agency size ranged from 82 to 37,219 sworn officers, with a mean of 1,602 and a median of 703; interquartile range was 410 to 1,392.

RESULTS

Training Relating to PwMI

A total of 70 agencies, as requested, reported the number of hours of recruit training devoted to responding to calls involving PwMI—the remaining agencies described their training without specifying hours. Departments varied widely in the amount of basic recruit training devoted to this topic, with estimates ranging from 0 to 41 hours. The median number of training hours was 6.5 (mean = 9.16; mode = 4). In many cases, agencies reported that, in addition to addressing PwMI, this block of instruction also covered substance abuse, other mental disabilities, and management of disorderly/unruly suspects.

Far fewer departments provided usable data on in-service training ($n = 42$). Among those agencies that specified training hours, the median amount was 1 hour (mean = 5.12; mode = 0), with more than a third of these not providing any postacademy training on responding to mental health calls. Among those agencies that did not specify hours, some suggested that the topic was addressed in roll-call training with no specified frequency, and others mentioned that it was included under a broader rubric of "advanced officer training."

Agencies reported that material for these trainings typically was derived from a course outline or curriculum prepared either by the department itself or the state agency responsible for police officer standards and training. In some cases, the training was developed in consultation with local mental health officials, and a few agencies relied on local mental health professionals to design the lesson plan and present at least part of the material. The latter

approach was more common in agencies that devoted the most time to training on this topic.

Specialized Response Programs

A total of 27 agencies reported that they had some type of specialized response for calls involving PwMI. This comprised 32% of the respondents to our survey.

Eighteen of the responding agencies (21%) indicated that they had a special unit or bureau within the department that assists patrol officers in handling people who display signs of serious mental illness. Although the nature of these specialized programs varied, one of the key distinguishing factors is whether the specialized responders were law enforcement personnel or mental health professionals.

Eleven agencies (13%) stated that they had one or more mental health professionals "in house" who could assist officers as a specialized response to calls involving PwMI (the police-based specialized mental health response model). Nine (11%) reported having a cadre of specially trained police officers to provide a specialized response (the police-based specialized police response model). An additional seven agencies (8%) did not list any in-house specialized response but said that they contacted a mobile mental health crisis team, based in the local mental health center, when a specialized response is needed (the mental-health-based specialized mental health response model).

Regardless of response type, only 12 agencies indicated that they attempted any follow-up for calls involving PwMI. Nearly all of these departments did so by referring the case to a local mental health agency.

Interestingly, those agencies with no specialized response reported fewer academy hours devoted to training future officers to deal with people with mental illness (mean = 7.62) than agencies with some type of specialized response (mean = 11.7). It should be noted, however, that neither the overall difference, nor any comparisons for specific response types, reached statistical significance.

DISCUSSION

Police are frequently called to respond to situations involving PwMI in crisis. Police departments, therefore, are required to provide officers with adequate training and to develop reasonable policies and procedures to respond to these calls. This study examined the extent of this training and the

specialized responses used in medium-large agencies throughout the United States.

Results cohere with—and differ from—prior surveys in some interesting ways. A prior study of all medium-large U.S. police departments conducted in 1996 found that 88% provided some type of training for handling calls involving PwMI (Deane et al., 1999). Similarly, among the 84 medium-large agencies responding to our survey, almost all provided some training pertaining to the topic, broadly conceived; however, this look offered some additional insight into the nature and extent of that training.

It is difficult to determine whether the training given to recruits for responding to PwMI is adequate in any absolute sense. Certainly, the time allotted (median = 6.5 hours; mode = 4 hours) does not appear substantial given the frequency with which these calls occur, the operational challenge that they pose, and the serious consequences of bad outcomes. Moreover, although we did not probe this issue systematically, many indicated that the allocated block of training covered generally unruly suspects and all conditions that could impair an individual's mental functioning, not just mental illness. The 6 hours, for example, would often include content related to substance abuse, intoxication, dementia, delirium, and developmental disabilities. These various conditions and disabilities are, of course, not interchangeable, and information about the nature of the symptoms, associated behaviors, and course of these problems often will not generalize to understanding of serious mental illnesses, such as schizophrenia, bipolar disorder, and major depression. In addition, the strategies for intervention and disposition of a so-called disorderly conduct case may differ substantially for a person with a psychotic disorder whose condition has deteriorated and is actively hearing voices and struggling with paranoid delusions, as opposed to a person who has mental retardation or may just be intoxicated or even just angry. Indeed, understanding the differing needs in these distinct situations is, or arguably should be, a fundamental tenet of this block of instruction.

Thus, based on the limited content information available to us, it is difficult to distinguish which, or even how many, agencies have adequate training. What we do know, however, is the following: that the time allotted seems limited—falling considerably below the 16 hours recommended in the model curriculum recommended by the Police Executive Research Forum (Police Executive Research Forum, 1997); that some of the agencies responding to the query (14 agencies did not quantify training hours) provided little or no training on the topic; and that only a portion of that time in many instances is actually devoted to mental illness.

Regarding the trends in specialized response to police calls involving PwMI, the overall proportion of agencies that reported having a specialized

response was lower than in the 1996 survey, but some approaches had become more common. In 1996, just less than half (45%) of departments reported having some type of specialized response to people with mental illnesses in crisis, but in the present survey only a third (32%) of agencies had such a response.

The largest difference was in the number of agencies using a mental-health-based specialized mental health response model such as the mobile crisis team (MCT) from the local mental health center. This was very common in the earlier survey, with nearly a third of agencies (30%) reporting that they used them for calls involving PwMI. In the present survey, only 7 agencies (8%) reported using this form of specialized response. Why the discrepancy? It may be that—despite a surge of interest in the 1960s and 1970s—mental health mobile crisis teams have become less common or less popular over the intervening 5-year period. Just before the early survey, Geller, Fisher, and McDermeit (1995) surveyed departments of mental health in all 50 states and found that 37 (72.5%) of them had some mobile crisis response capacity. However, given that most mental health budgets have been reduced substantially, and that little data have been available to support the effectiveness of MCTs, they may have been eliminated in some jurisdictions.

Another very likely cause of the marked variation between the two surveys is the difference in the survey methodology. The Deane et al. (1999) study asked specific and systematic questions about the existence, availability, and use of MCTs by the police agency. This survey did not. Rather, we asked whether the department had a specialized unit or bureau to assist officers in responding to calls involving PwMI. Some respondents may reasonably have read this to exclude MCTs or other specialized units not located within the police department. Thus, it may underestimate police use of MCTs as a specialized response.

Despite these survey variations, however, it is interesting to note that the proportion of agencies using a police-based specialized mental health response model was very similar between the two surveys (12% in 1996 vs. 13% in 1999). The use of the police-based specialized police response model (such as the Crisis Intervention Team—CIT model), however, had increased substantially. At the time of the first survey, only 6 agencies (3%) had these programs, but—despite a smaller sample—9 agencies (11%) had them in place in 1999. This change is likely due to the increased popularity of Memphis Police Department's CIT program and its use as a model for police departments nationally (Borum, 2000; Cochran, Deane, & Borum, 2000; Dupont & Cochran, 2000). Results of a preliminary case study on the three models of specialized response suggest that—compared to other programs—the Memphis CIT program has a very low arrest rate for mental disturbance

calls, a high rate of utilization by patrol officers, a rapid response time, and results in frequent referrals to treatment (Steadman, Deane, Borum, & Morrissey, 2000).

At the time of the first survey, there were only three to four CIT programs in existence. Currently, at least 18 police departments across the United States have adopted—or are implementing—a model of specialized response based on the CIT program (Sam Cochran, personal communication, August 22, 2001). One challenge to these efforts has been the emergence of intensive training (e.g., 40 hours) programs called crisis intervention training (often inappropriately designated as CIT) that are offered as stand-alone courses and are not part of a systemic agency effort to develop and deploy specialized first responders to calls involving PwMI. The importance of that distinction has been previously emphasized:

Fundamentally changing an agency's response to mental health crisis calls involves more than just training. Departments that have created a specialized response capacity, such as Memphis Police Department's Crisis Intervention Team (CIT), have taken an approach that optimizes that likelihood that the officers who are most highly skilled and trained in dealing with people with mental illness will have responsibility for handling those calls. (Borum, 2000, pp. 335-336)

Providing intensive training to all officers may be helpful in some ways, but it does not inherently create a specialized response. The key distinction is this: Training all officers assumes that—as a result—all officers will be equally skilled in responding to these specialized calls. Research and experience suggests that this is not the case (Borum, 2000). In contrast, the CIT program identifies the officers with the greatest interest, most amenable attitudes, and best interpersonal skills, then provides them with intensive training and deploys them specifically as a first-line response to these specialized calls.

The findings from this survey are both sobering and encouraging. Overall, throughout the country, there still appears to be very little attention given to training police recruits and veteran officers to understand and intervene with people who have mental illnesses. This deficiency exists despite the fact that news headlines regularly record tragic events in which a person with mental illness is shot by police. Departments involved in such a confrontation may experience a surge of community tension and legal liability.

Although officer training is an important component of effective response to calls involving PwMI, without further efforts, it may not be sufficient. There is great promise in the trend of law enforcement agencies to create a specialized first response to these specialized calls (Panzarella & Alicea,

1997). Programs such as CIT have strong potential to reduce unnecessary arrests and uses of force, yet they require very little change in staffing or organizational structure and are fairly inexpensive to develop and maintain. We hope that this signals a new and continuing trend toward improving police training and specialized responses by law enforcement to people with mental illnesses.

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