The Bill Blackwood
Law Enforcement Management Institute of Texas

Advanced Training in Mental Health Crisis for Law Enforcement Officers

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A Leadership White Paper
Submitted in Partial Fulfillment
Required for Graduation from the
Leadership Command College

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May 2016

ABSTRACT

Police officers have been tasked with many difficult duties over the years. In the 1950's, the push to deinstitutionalize the mental health system began (Torrey, 1997). And with that, police officers from around the country were now given a new task to become street corner psychiatrist. No additional training was offered and on the job "learning" was expected.

Dealing with people with mental illness or mental health crisis is a difficult undertaking at best. To understand the complexity of the mental issues takes years of medical training for doctors who desire to practice in the mental health field. But yet there are officers who are on the street with little or no training in how to deal with this issue. Officers are making life and death decisions based on very little information to go on. The need to train officers in advanced techniques is obvious. The outcome of no or little training can be catastrophic. The death of an officer or a mental health consumer results in family tragedy and typical lawsuits assigning blame.

This research will show that there are good training opportunities that have had documented success in reducing injuries and death of those involved. Programs such as Crisis Intervention Team (CIT) training and Metal Health First Aide are two programs recommended by the International Association of Chiefs of Police (IACP). Both of the programs have had been in place for many years and have shown dramatic decreases in injury and death.

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INTRODUCTION

In the early 1950's, there was a movement across America and worldwide to deinstitutionalize people with mental disorders. The practice, up to that point, was to hospitalize the patient in long care facilities. While in these hospitals, mental health patients were subjected to many practices, such as shock therapy or lobotomies that have since been at best proven ineffective (Miller, 2014). As these patients were released from the hospitals, a large portion were simply released to the streets of America. Thus began the role of law enforcement as a crisis intervention officer.

It has been estimated that one in four Americans suffer from some type of mental disorder (NAMI, n.d.). The study went on to say that 1 in 17 suffer from serious mental disorder. Many times, it is a police officer who is making first contact with these mentally ill citizens. And many times, it is found that there are very few options available to the officer on how to handle this situation. So arrest and jail for petty offences is often the only option available

County jails have become the largest depository of the mentally ill. Cook County Jail in Chicago is one of the largest mental health treatment facilities in the United States. Cook County houses approximately 11,000 inmates with 3,000 of those classified with severe mental illness (Ford, 2015).

It is clear that law enforcement needs to do a better job of training its officers in how to handle these very complicated situations. There needs to be a collective effort by law enforcement, mental health professionals, corrections, judicial and the community to seek out better alternatives than jail to house our mentally ill. It is not a crime to be ill.

Currently, in Texas, there is such a model. The Travis County Sheriff's Department and Austin Police Department work in collaboration with a Crisis Resolution Team. This team contains officers that have their mental health certification through the Texas Commission on Law Enforcement (TCOLE) (G. Sizemore, personal communication, January 5, 2015). The team has two primary purposes: responding to calls with persons in mental health crisis and diverting consumers from criminal justice systems and connecting them with mental health services.

The purpose of this paper is to show through research and through the review of the best practices of law enforcement that there is training available and partnerships to be made with the community to better serve this thrown away population. Every law enforcement officer should be trained in in the latest and proven techniques in how to handle people with mild to severe mental illness. These tactics will be instrumental in the safety of officers and the citizens they are sworn to protect.

POSITION

When discussing the importance of advanced training in dealing with persons with mental illness and or people in crisis, one of the first things to come to mind is the safety of those involved. Officer safety is always a primary concern and should be. But it should also be viewed from the aspect of why the officer is there on scene. They are there to provide a service and maintain peace and safety for the citizens. A typical call for service to deal with a mentally ill person in crisis comes into the communications center as a suspicious person, disturbance, or an unknown type call. But, in fact, it can come in as just about any type of call.

On June 14, 2014, around 4:20 PM, officers of the Dallas Police Department responded to a call in a residential setting involving a mentally disturbed person. Moments after they arrive they made contact with the mother of the mentally ill person. The Dallas Police Department's body camera shows as his mother was walking out of the front door she told officers, "He's off his chain, saying he gonna chop people up." "Who," the officer asked. "My son, bipolar schizo," she replies and walks away (Martyn, 2015). At this point, her son, the mentally ill person, appears in the doorway with a screwdriver in his hands. The Dallas officers calmly tell him to drop the screwdriver. The subject does not respond to the request. The officers then repeat the order in a loud, stern voice. There is still no response from the subject. At this point, the subject lunges at one of the officer's and the officers respond by shooting the subject multiple times (Martyn, 2015). The subject died on scene. This shooting occurred approximately 1:30 seconds after officers arrived on scene. The officer's involved were cleared of any wrongdoing (Martyn, 2015).

The mentally ill person in this case had a long history of contact with police. He had been arrested and detained in hospitals and jail several times. In an article in the Dallas Observer, it was reported that the subject's mother, "often called police…but the result was a repeated cycle – to jail, to a hospital and then back home" (Martyn, 2014).

On June 20, 2010, the girlfriend of a subject with a long history of mental illness contacted the Lancaster, Texas police department. She told them that her boyfriend was displaying, "psychotic behavior" and she also said he may be high on drugs. When Lancaster Police arrived, the boyfriend was not arrested but the girlfriend and her children were taken to the police department, where her father came and picked them

up. Seven hours later, the Lancaster police were called to the same apartment complex, where the same "boyfriend" was reported to be walking around in only his boxer shorts. The boyfriend made contact with an innocent bystander who he shot and killed. When Lancaster police arrived on scene, the boyfriend shot and killed a Lancaster officer. The subject was subsequently shot and killed by police officers (Eiserer & Goldstein, 2010).

The boyfriend in this story was the son of a prominent Texas police chief. He had a long history of mental illness and run in's with police. He had been hospitalized at the early age of 11 for depression. He died at the age of 27 (Eiserer & Goldstein, 2010).

The two incidents described are just examples of how quickly these types of calls can turn violent and put officers in very dangerous situations. Being able to recognize these types of calls can be imperative for officer safety as well as the safety of the person in crisis. Advanced training in dealing with mentally ill persons may have prevented the deaths that were previously described.

In October 2013, the President of the International Association of Chiefs of Police (IACP), Yoursy Zakhary, commissioned a panel of law enforcement, mental health professionals, and community stakeholders to look at how law enforcement responds to persons with mental illness. The panel reported to the IACP at its October 2014 conference in Orlando, Florida with its report, "Improving Officer Response to Persons with Mental Illness and Other Disabilities, a Guide for Law Enforcement Leaders". In that report it stated, "Sometimes crisis can occur because the disability was not recognized quick enough. Too often these encounters result in tragedy" (Davis, 2014, para. 1).

Two of the training programs recommended by the IACP report were Crisis Intervention Team (CIT) training and Mental Health First Aid. Both of the programs have been installed in departments throughout the country with documented success. CIT has its roots in Memphis, Tennessee. The program began in 1988 after a police shooting involving a person with severe mental illness. After the incident, there was a community collaboration that involved Memphis PD, NAMI, the University of Tennessee Medical School, and the University of Memphis. The program they conceived is referred to as the, "Memphis Model". There are over 2,000 communities that have adopted the "Memphis Model" (NAMI, n.d.).

There are several key parts of CIT. The three most important keys are community collaboration, 40 hour training for law enforcement officers, and the involvement of mental health consumers with family participation. CIT begins with collaboration. Law enforcement, mental health providers, and consumer advocates meet to examine what current systems exist and how are they accessed. They meet to determine strategies on the best ways to transport patients and organize police training. A key factor in the success of CIT is the 40 hour training block for law enforcement officers. This training consists of basic mental illness awareness and recognition, learning about the local mental health system in place, and de-escalation training (http://cit.memphis.edu/). Also key to its success is the involvement of consumers and families in all phases of the program. These stakeholders are involved in planning training and leading training sessions. Consumers and their families have unique insight into the struggles of the mentally ill. NAMI (n.d.) reported, "That after the introduction of the CIT program in Memphis, officer injuries sustained during responses

to ‘mental disturbance’ calls dropped by 80%” (p. 2). Albuquerque Police saw SWAT call up’s drop by 58% after beginning its CIT program (NAMI, n.d.).

The other program recommended by IACP was Mental Health First Aide. This program was founded in 2001 by an Australian nurse and a mental health literacy professor. The program offers eight hours of training in how to deal with people who may be suffering from panic attacks, suicide, or even problems with drugs. It teaches the officer how to detect mental health issues and to understand how to respond to persons in mental health crisis (Davis, 2014). Mental Health First Aide offers a more condensed version of training. But the program also highlights collaboration with community partners such as the local mental health authority and mental health consumers and families.

It should also be noted that the State of Texas does require that all new officers are given 40 hours of mental health training while they are in the police academy. Although the training is mandatory in the academy, there is no mandatory requirement for current officers to be trained in CIT or any other program. This has to change.

COUNTER POSITION

An issue often raised by opponents of advanced training in dealing with the mentally ill is the cost of the training and the time taken away from their duties of law enforcement officers. Many times, officers have to go out of town for training and have the additional cost associated with it. These are legitimate concerns due to the finite amount of funds and manpower. The argument has also been made that this is not a law enforcement issue but a clinical and medical issue. Officers should not serve in this capacity and the issue should be handled by the local mental health authority.

In a study about crisis intervention team training for police officers responding to mental disturbance calls, the authors, Teller, Munetz, and Gil (2006) did a review of the Akron, Ohio Police C.I.T. program which began in 2000. It was noted, "Police officers are recognized as first responders for individuals who are experiencing mental illness crisis" (Teller, Munetz, & Gil, 2006, p. 234). The study notes there is an increase in the criminalization of persons with mental health crisis. With the absence of CIT training and without the knowledge of what treatment options are available in the officer's jurisdiction, officers tend to seek out incarceration over treatment.

In a 1992 article, it was stipulated that the involvement of police dealing with the mentally ill is based upon two basic legal principles. The first principle is the police responsibility to protect and provide safety and the second is to protect the safety and welfare of the disabled person (Teplin & Pruett, 1992). They went on to cite the California Welfare and Institutional Code which found that police are mandated by law to act on behalf of the mentally ill person when they are a danger to themselves or others, or when due to their illness, they are not able to take care of them self and unable to protect them from serious harm.

The fact is that training does cost money, whether it is money in the form of officers' salaries or expenses associated with travel for training. But this is truly training that is an officer and public safety issue. Officers will continue to respond to these cases without prior knowledge of the history of the mentally ill person involved. As they arrive on scene, they will have to interpret the actions of the person involved and asses the threat level to themselves and the others. To deny these officers the proper tools to help

in that assessment is a failure on the part of the agency. The results could be catastrophic for the officer and for the department in the form of liability.

On a June morning in 2013, a Massachusetts State Trooper came across a distraught man on the side of a busy road. The man began to shout at the trooper to kill him. After the trooper sprayed him twice with chemical spray, he finally shot the unarmed man, killing him. Although cleared of any criminal wrong doing in the tragic incident, the trooper and the head of the state police were sued. The suit claims that the head of the state police, "failed to provide the agency with policies, procedures and equipment allowing citizens with mental health crises to be treated through humane and nonlethal means" (Russell, 2015, para. 3).

In May of 2013, the wife of a mentally ill man had called 911 for help with her husband, who suffered from schizophrenia and bipolar disorder. When officers of the New Rochelle Police Department arrived, she told them he was unarmed and needed help. The officers subsequently broke the door down and shot and killed the subject. The family of the dead man filed a lawsuit in federal court that accuses the City of New Rochelle of "failing to adequately train police in procedures to safeguard emotionally or mentally disturbed people" (McVeigh, 2013, para. 11). Both of these stories drive home the tragedy and loss of life and the litigation that can come in the aftermath. The argument of the expense of the training is far outweighed by the loss of human life and the possible lawsuit that usually follows in these situations.

In the 2010 Texas state budget report written by the Legislative Budget Board entitled, "Managing and Funding State Mental Hospitals in Texas, Legislative Primer," submitted to the 82nd Texas Legislature, it was concluded that there were three major

challenges for state mental hospitals in Texas; the growing forensic population, longer waiting times for admission, and total expense for outside medical cost ("Managing and funding," 2013). A clearer interpretation of this is that as law enforcement determines the need to hospitalize a mentally ill person more and more, there will be no place to admit them. This means that officers may have long waits at hospital ER's and then may have long travel to get one of available beds in one of the ten state hospitals in Texas.

One of the key points of CIT training is recognizing issues with severe mental illness prior to getting into a crisis situation. An officer then may have the option of getting the patient stabilized and moving them out of crisis and into outpatient care, thus avoiding travel to a state hospital and the expense associated with it. It also provides for the basic mandate for police officers to protect the person when they are unable to protect themselves.

RECOMMENDATION

Training officers how to respond to persons in mental health crisis is imperative to the safety of all involved. Officers must learn the important techniques of de-escalation and other aspects of CIT or Mental Health First Aide. Once this is done, officers will be better equipped to handle these very volatile situations. Once law enforcement agencies take the first steps to seek out collaborations with the community stakeholders as prescribed in CIT and or Mental Health First Aide, officers will be able to better respond to the crisis situation and be effective on the their mandate to protect all persons, even those citizens with mental health issues.

Advanced training in mental health response is important. But also just as important is the collaboration between mental health providers, law enforcement, community stakeholders, and the families and consumers of mental health services. All parts need to work together. Law enforcement should now live up to its mandate to serve and protect all persons including those with mental health issues. The jails can no longer be the make shift hospitals for people in mental health crisis. Law enforcement needs to service this throw away population. It is not against the law to be ill.

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