

**SPECIAL CARE**

**IMPROVING THE  
POLICE RESPONSE  
TO THE MENTALLY  
DISABLED**

Gerard R. Murphy

The Police Executive Research Forum is a national membership organization composed of chief executives from municipal, county, and state law enforcement agencies. The Forum's goal is to improve the delivery of police services through professionalization of police executives and officers, development of new knowledge through research and experimentation, and open debate on criminal justice issues.

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GARY PRESCOTT HAYES

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This book is dedicated to the memory of Gary Hayes whose compassion for the disadvantaged and understanding of the problems facing the police profession were the impetus for this study. During the course of this project Gary provided insight, guidance and inspiration and, by his example, instilled in the Forum staff the dedication and perseverance to make our work the best it could be.



## PREFACE

The policies of deinstitutionalization, first implemented over fifteen years ago and designed to transfer the care of the mentally ill from hospitals to local communities, have affected many public and private groups of society. A few groups have found themselves with a disproportionate amount of additional responsibilities not always with a concomitant allocation of resources. Law enforcement is one of these segments.

Indeed, it is fair to say that law enforcement has been burdened with inappropriate responsibilities for the mentally disabled. The virtual absence of community mental health emergency services has left police agencies, by default, to answer the urgent and routine needs of the mentally ill. Their response to date has not always been exemplary, but, in fact, they have not received any significant guidance from the mental health profession on how to manage the mentally ill. Rather, police agencies have found themselves under attack for their handling of the mentally disabled. Local media, mental health professionals and judiciaries have stated that the police have failed in their attempts to manage these encounters and often exacerbate rather than mollify the problem. Yet, while these groups are quick to criticize law enforcement, they have failed to provide the police with any guidelines for improvement.

Other groups, such as the American Bar Association, have attempted to provide guidance but have also fallen short. Standards developed by the

American Bar Association rightfully have called for improved police training, policies, and coordination with mental health facilities, but without specifying how these improvements can be realized.

Special Care takes up where these other efforts leave off. It includes a comprehensive examination of the problems police agencies face and the factors causing the problems. Further, it examines current efforts of police agencies to address the problems and goes on to discuss characteristics of encounters from a law enforcement, legal, and mental health perspective. But most importantly, Special Care provides specific guidelines for police departments to follow in improving policy, training, operations and liaison with the mental health community. Relationships they develop with their mental health colleagues ultimately may be the most important aspect of improved police management.

Because, while the police have a mandate for handling certain aspects of these encounters, they simply cannot provide the mentally ill all the services they need. Community care, as envisioned, requires the efforts of a variety of community services, each bringing a special expertise to the problem. Improving the police function is one step towards improved community care. The other elements of the community care function must now recognize and accept their responsibilities.

Gary P. Hayes  
Executive Director  
Police Executive Research Forum

## FOREWORD

"The police ought to do something" is a phrase familiar to every law enforcement administrator. Traditionally, police have been frequently called upon to cure--or at least care for--a large number of society's problems. In recent years, one of the most vexing problems in urban areas is the task of dealing with the growing numbers of mentally disabled persons who have been discharged into the community. For many of the mentally ill and retarded, institutional release and return to the community setting has been a positive development. Others, however, have been removed from a sheltered environment only to wind up abandoned on the streets of our cities. There they have become victims or witnesses of crimes or the subject of complaints about their sometimes erratic or disorderly behavior.

For police, encounters with the mentally disabled can be particularly difficult. Indeed, officials testifying at National Institute of Justice hearings on law enforcement concerns reported that the police need special help in coping with such persons. As a former police officer who later served on the board of directors of the Alameda County, California, Board of Mental Health, I have observed the police and mental health professionals attempt to deal with the problems of the mentally ill in the community. And I too can personally attest to needs in this area.

This report responds to these needs. It examines the issues from the perspective of both police and mental health professionals, and it illustrates the problems the mentally ill may face in the community. The report also provides practical knowledge to the police in understanding the special needs of the mentally disabled. By explaining the rationale and history of the community mental health movement, it enables police managers and supervisors to view in context the problems they and their officers face in caring for the mentally ill.

Some communities have devised particularly effective methods for ensuring sensitive management of mentally disabled persons in the community. Their efforts are described here so that other jurisdictions can benefit from their insights and experience.

It is our hope that the policy relevant information presented in this report will benefit police managers in developing procedures for dealing with the mentally ill. At the same time, the report offers valuable recommendations for greater coordination between law enforcement and mental health agencies to help ensure that those recovering from mental illness are not only protected under the law but are given access to the services they need to help them live and function in their communities.

James K. Stewart  
Director  
National Institute of Justice

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Gerard R. Murphy  
September 1985

## EXECUTIVE SUMMARY

### Overview

For centuries society dealt with its mentally deranged by locking them away in what was euphemistically referred to as asylums. This approach effectively insulated law enforcement, and citizens, from the necessity of coping with the bizarre, the messy and, on occasion, the dangerous behavior of the mentally ill. More recently, however, a different approach has emerged--one which attempts to maintain substantial portions of the mentally disturbed population in community settings. And with that new approach have come problems for police.

To better understand these problems, and to aid law enforcement to better cope with them, the Police Executive Research Forum undertook a study of police handling of the mentally ill. This monograph is the result. Its focus is to aid law enforcement executives improve their department's handling of the mentally ill. It suggests ways in which police can reduce the time spent in processing mental health cases, cutback the number of repeat calls for service involving the mentally ill, and avoid unnecessary risk of injury when dealing with the mentally disturbed who also are violent. These same guidelines will facilitate more humane treatment of the mentally ill and reduce both inappropriate incarceration and unneeded hospitalization. Finally, reliance on

### Model Program Elements

The three programs differ in the respective roles played by police and mental health services in the method by which inter-agency coordination is achieved, and in the amount of resources invested in handling mentally ill cases. These differences, in turn, are by-products of normal variations in communities' needs, resources and priorities. However, each also incorporates a number of elements which appear to be essential to the effectiveness of any program or involving the police in the handling of mentally disturbed persons:

- Each program maintains a 24-hour, on-site response capability, so there is less "slippage" in resolving cases involving the mentally ill;
- Each program maintains 24-hour access to the needed resources, which also forestalls delays in resolution;
- Each program either provides trained mental health professionals (police or civilian) or provides line officers with thorough and appropriate training, which is necessary for the expeditious and appropriate handling of cases;
- Each program clearly delineates the separation of duties and responsibilities among the key actors from different agencies;
- Each program has developed procedures that reduce the time officers need to spend handling mentally ill persons; and
- Each program includes close and regular liaison between the participating agencies to ensure that operational information is shared, feedback is provided, and minor problems are addressed.

In Madison, WI the Police Department has not set up its own specialized unit. Instead, every patrol officer receives comprehensive and in-depth training in managing the mentally ill. All officers are expected to reach a disposition by themselves. Nevertheless, in particularly difficult cases, round the clock assistance is available from the county mental health staff. The mental health staff also provide feedback to patrol officers regarding the outcome of their referrals. A sworn officer with special training in handling of the mentally ill facilitates coordination of police and county mental health services, and serves as an in-house resource for the department.

Birmingham, AL lacks a service comparable to the county mental health center in Madison. The City does, however, operate a 24-hour program of emergency services for persons in difficulty and it is to this program which the Birmingham police turn for assistance. Staffed by Community Service Officers with training in social work, the program provides the police with on-site assistance and takes responsibility for case disposition. The program is reported to have reduced repeat calls, to have reduced the time patrol officers must stay on the scene, and has improved these officers' understanding of mental illness and the role of mental health services.

- The primary subject of most police written directives is the procedure for implementing an emergency mental health detention. Over 50 percent of the directives failed to identify dispositions other than arrest or emergency detention. Only 12 percent discussed methods of interviewing mentally ill persons, and only six percent included techniques for recognizing the mentally ill.
- Fewer than 28 percent of the 172 agencies responded to the operational procedures portion of the survey and, of those, fewer than 20 percent had designated a special unit or individual to manage encounters with the mentally ill. Nevertheless, close to 50 percent of those responding reported having arrangements whereby officers could consult with mental health professionals.

Although the survey's findings suggest that the majority of the departments contacted are in need of substantial improvement, it also revealed that a smaller number had responded with some success and ingenuity to the problems created by deinstitutionalization. Three of these, inspected on-site, not only had devised relatively effective responses, but had done so in ways which differed markedly from one another. In Galveston, TX, for example, the Sheriff's Department created a special unit staffed 24 hours daily by peace officers who also are certified emergency medical technicians and mental health specialists. These mental health deputies will go to the scene of the incident if called by the responding deputy. Otherwise, the responding deputy transports the subject to a central location for screening by the mental health deputy who assumes responsibility for the disposition. Since 1975 the unit had reduced jail admissions by 99 percent and reduced the rate of involuntary hospitalization admissions to the lowest in Texas and one of the lowest in the nation.

## The Forum's Research

To assist law enforcement deal more effectively with the problems created by treatment of the mentally ill in the community the Forum undertook a four-part study. First, we reviewed the literature to learn what prior research had found regarding the deinstitutionalization movement and its consequences for law enforcement. Second, we reviewed the policies and training curricular of a sample of 172 police agencies to obtain an up-to-date picture of law enforcement's handling of the mentally ill. Third, we visited seven jurisdictions to study their operations at firsthand. And, fourth, staff also met with mental health officials and attended conferences on the issue.

## Current Police Response

By and large, police departments are not properly preparing their officers to handle situations involving mental health cases. Recruit training is inadequate, written policies and procedures provide insufficient guidance, in-service training is virtually non-existent, and operational procedures are ill-defined or not defined at all. The survey, for example, revealed the following:

- The average police recruit training curriculum in mental health is 4.3 hours (ranging from 1-1/2 to 22 hours)--scant time to cover such topics as types of mental disorders, recognizing and handling the mentally ill, the exercise of discretion, state and local laws, departmental policy, involuntary commitment procedures, rights of the mentally ill, and other issues.

agencies were not geared to handle persons who were violent, suicidal or otherwise dangerous to themselves or others, the delivery of services was often impeded by bureaucratic obstacles, and the mentally ill population itself resisted treatment.

The result was that persons unable to manage for themselves had no choice but to make it on their own. With little in the way of effective support and care, however, many of the mentally ill were incapable of handling interactions with other citizens. With increasing frequency police found themselves called upon to "do something" with persons whose offense, if any, was minor but whose aggravation value was major. In many instances the experienced officer would resort to an on-street disposition which had the virtue of resolving the immediate problem but did nothing to prevent the deranged individual from stumbling into other hassles subsequently. Should the officer, on the other hand, attempt to refer the subject to a mental health clinic or hospital he was likely to encounter time-consuming admission procedures. Even worse, admission might be refused altogether. Should the subject exhibited symptoms other than mental illness such as substance abuse for example, or become violent or otherwise indicate that he constituted a danger to himself or others the officer, as a practical matter might have no choice other than to lock him up or return him to the street.

these guidelines will improve police protection of citizens from the unnerving, unseemly or criminal actions of the mentally ill.

### Background

The problems that the mentally ill pose for law enforcement agencies originated in the mid-1960s, when the preferred mental health treatment, long-term hospitalization, was discarded in favor of treatment in the community. This new treatment practice was made possible by several factors, the most influential being the development of medications that controlled the non-functional behaviors of the mentally ill. Commonly referred to as "deinstitutionalization", the concept as originally conceived meant not only releasing hospitalized mentally ill patients to the care of family and friends or to special residential centers but also diverting patients to such facilities in lieu of placement in an institution. A crucial element of this approach was to be the establishment of networks of public and private agencies to provide mental health care and assistance in developing basic living skills.

What really happened, however, is that while large numbers of mentally ill persons were released or retained in the community, the networks of mental health and social services were slow to develop. Once developed, these services were frequently inadequate for the needs of the newly-released, many of whom could not live at home, had few social skills, were difficult to treat, and had limited or no financial resources. Community-based mental health and social

## Developing a New Response

Developing a police-mental health program to manage mentally ill persons requiring police attention should be a unique process for each department. The planning and implementation of a coordinated program must be consistent with the community's specific needs and resources. Nonetheless, there is a general framework that will guide police departments in revising their responses and which will facilitate the inclusion of the key elements. Police departments should join with mental health and other relevant resources in their community to examine the current response. This examination should identify the weaknesses of that response and then move to the development of corrective measures. Existing and additional resources essential to the new program should be identified and organizational arrangements must be specified. Implementation of the program requires the development of consistent policies and the provision of training for officers who encounter mentally ill persons.

To support the implementation of the new program operational procedures must be set in place. Procedures should exist for every possible contingency from the time a request for service is received until a final disposition is reached. Particular attention should be given to how police officers can recognize different types of mental disorders, and to how to handle persons with disorders. Procedures should also specify how to talk to, approach, escort, and

subdue the mentally disabled. A discussion on the use of force is essential.

The final two chapters and seven appendixes discuss how the new program can be developed and include recommendations for developing the appropriate policies, procedures and training described above.

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I  
OVERVIEW

The mentally ill have become an increasingly visible presence in the community. Much of the increase can be attributed to the change in mental health treatment philosophies and practices that occurred in the mid-1960s. Referred to as the deinstitutionalization movement, long-term hospitalization, which had been the preferred mode of treatment, was supplanted by placement in the least restrictive community setting wherein the mentally ill could be treated and cared for through a network of both public and private health and social services. The intent was to enable the mentally ill to develop basic living skills in the communities of which they were to be a part. Concurrent with deinstitutionalization, mental health facilities tightened their criteria for accepting new clients for in-patient treatment, in part a reflection of the new treatment philosophies and in part a reflection of new patient rights legislation that limited the conditions under which a person could be kept in a state hospital. The overall result of these trends was that mentally ill persons who previously would have been cared for "out of sight and out of mind" were now out and about in the community.

While the hospitalized mentally ill were being released from state institutions in great numbers and many of the newly ill were being declined admittance, the network of health and social services

that was essential to community-based treatment never fully materialized. Many of the mentally ill were released into communities that were unwilling or unable to provide the medication, treatment, structured living arrangements, training, and other support mechanisms essential to their well-being. Moreover, even in those communities in which service networks were established, the delivery of service was impeded by bureaucratic obstacles. Many mental health agencies, for example, are designed to treat only a specific type of mental disorder. Those persons with mixed symptoms, or whose illness is complicated by other factors, such as substance abuse, or who are considered dangerous are often unacceptable to these mental health facilities ... this despite one of the criterion for emergency psychiatric detention ("dangerous to himself or others") set forth in most mental health codes.

Changes in mental health policies and shortcomings in their implementation are not the only causes of the problem. The recession, lack of sufficient low-cost housing, cutbacks in federal subsidies and entitlement programs, the greater proportion of young people in the population, drug addiction and alcoholism among the young, and a dramatic increase in the incidence of schizophrenia (primarily a disorder of the young) have all contributed to the increased number of people adrift in the community. Many are adrift because of the lack of support services for the mentally ill, others develop a mental illness as a result of being adrift, still others are simply homeless, some by choice, most of necessity. Regardless of the particular cause, the

inevitable result has been an increasing number of calls for police assistance from family members no longer able to cope, from businesses being disrupted by street people loitering around their shops, from landlords of buildings in which mentally ill persons reside, and from members of the public who are alarmed by the shabby appearance or bizarre behavior of people they encounter in moving about the community. Depending on the nature and seriousness of the call, the police may have to locate a mental health agency that will care for the person or, failing that, arrest the mentally disturbed person simply to remove him from the community.

The official mandate of the police encompasses dealing with the mentally ill from a law enforcement, civil, and social service perspective: law enforcement in that public order may have been disturbed or a crime committed; civil in that an emergency detention for examination may have to be initiated; and social service in that referral to a community service agency may be required. From a law enforcement perspective, the problem of managing the mentally ill has five interrelated aspects:

- the persons who request police action or service,
- on-scene management,
- the mentally ill,
- the disposition process, and
- mental health resources.

In regard to the first aspect, it is not so much the requests that are problematic as the reasons underlying them, as these guide the

public in their demands on the police. First, the general public has a misperception that the mentally ill are dangerous, violent, and even homicidal. These misperceptions stem from lack of information about the causes and effects of mental disorders and how they can be treated. In addition, the public's tolerance for bizarre or deviant behaviors is quite limited, especially when exhibited by someone who appears to be mentally ill. And third, the public does not have a clear understanding of the role of the community in providing mental health treatment and care.

The combination of these factors often results in the police being called when the public is fearful or uncertain about the behavior of the mentally ill. Although some calls are the result of criminal activity, which is usually minor in nature, the majority of requests are for situations requiring an order-maintenance or service function, not a crime-control function. A problem arises, however, because the only means for addressing the problem is to treat it as criminal in nature.

The second aspect of the problem involves on-scene management of the mentally ill. On-scene, officers are often uncertain of their objectives because they are inadequately prepared for managing this population. Recruit and in-service training for managing the mentally ill is lacking in many agencies, inadequate in others, and has yet to be required by several Police Officer Standards and Training (P.O.S.T.) Boards. Written policy and procedures to guide officers are also

frequently inadequate or lacking in many agencies. Moreover, law enforcement agencies have rarely attempted to work with local mental health agencies to develop lines of communication to improve the understanding of each system or to develop a coordinated system of management.

The third aspect, closely allied with the second, that causes problems for officers is the variety of mental disorders that can be encountered. The officer not only has to determine if the person is mentally ill but also must try to ascertain the severity of the disorder and whether there are any complicating aspects, such as physical ailments or drug or alcohol abuse. Also, the officer must apply legal definitions of "mentally ill" and "dangerous", terms that are not well defined, to the behaviors in question. Further the officer must try to determine the person's mental health history. All of this must be accomplished quickly and usually without the assistance of mental health or legal experts.

When gathering this information the officer is faced with the fourth aspect of the problem--determining the appropriate disposition. An informal disposition, such as providing referral information or just separating the individuals involved, is the most frequent outcome, although not always the most appropriate. Although the most familiar and probably the quickest formal disposition, arrest is often inappropriate as well, even when it is a last resort or an attempt to protect the person. The third possible disposition, a voluntary mental

health examination, is a desirable disposition in many cases but is also one that is difficult to achieve. The fourth disposition, an involuntary mental examination, is often chosen simply because the problem is of a mental health nature. The common element in this process is determining which disposition is the most appropriate given the condition of the mentally ill person, the context of the encounter (time, location, behavior exhibited, relationship of the mentally ill person to the complainant), and available mental health resources.

If an involuntary examination is sought, the officer faces the fifth aspect of the problem--the mental health facility. Lacking official guidance in many instances, the officer undertakes what can be an epic journey in search of the appropriate mental health facility. If the appropriate facility is found and if it is open, obtaining a psychological examination for the subject is often a time-consuming process. It is quite possible that the mentally ill person will be refused an examination, in which case the officer must seek another disposition. It is also possible that even after an examination, the person will not be hospitalized because current commitment criteria are stringent. If the person is to be hospitalized, the officer frequently must then obtain the necessary legal documents from a judge or magistrate.

Mental health professionals complain that police mismanage the mentally ill in the field and make inappropriate referrals. Their perception is that police only want their help in crisis situations and do nothing to develop a working relationship.

The police, for their part, complain of admission procedures that are time-consuming, unclear, and inconsistent; of being patronized by mental health professionals; and of being relied on to provide physical security at the facility. Policies that lead to the person being quickly returned to the community are seen as making additional work for the police. Being turned away at the admitting room and not receiving information about final dispositions are also common complaints.

It is not surprising that many police officers develop a disdain for handling calls that involve mentally ill persons. Not being familiar with mental health treatment philosophies and services, officers are uncomfortable working in this setting. Responding to such calls is often considered not "real police work", and most law enforcement agencies provide few, if any, rewards or incentives for successfully handling these calls.

Current police procedures for managing the mentally ill lead to a number of problems that affect the police department as a whole:

- Duplication of effort by officers when the mentally ill are not initially recognized and require additional police action later.
- Escalation of encounters, including injuries, when improper techniques for interviewing and handling the mentally ill are used.
- The waste of officer resources when inappropriate dispositions are reached that must be corrected, e.g., mentally ill persons are taken

for psychological examinations when they do not meet the criteria for involuntary commitment.

- The waste of officer resources due to cumbersome legal and mental health commitment procedures.
- Loss of valuable information regarding the chronically mentally ill when law enforcement and mental health agencies do not work together.

Some police agencies have taken steps to improve their policy, procedures, and training for dealing with the mentally ill. Some have developed formal working relationships with mental health agencies for the joint management of the mentally ill. Many, however, have been faulted by mental health and legal groups for detaining persons who do not meet the criteria for commitment, for exacerbating the disorders affecting them, for inappropriately jailing them, and for failing to seek informal dispositions.

Community pressures have caused many agencies to develop new procedures without an understanding of the problem or of the elements necessary for improving the management of the mentally ill. Often the procedures are inadequate in that other community resources have not been included and specific guidance for the patrol officer does not include mental health and legal perspectives.

Successful management of the mentally ill is a goal that will be achieved only if community resources, in particular the law enforcement and mental health agencies, develop coordinated responses that meet the many needs of this population. Police agencies must first

look within themselves and examine the extent to which they need to improve their training, policies, and procedures in order to better prepare their officers for managing encounters with the mentally ill. They must also reach out to the mental health agencies in the community to coordinate procedures and develop lines of communication that will facilitate each other's efforts on behalf of the mentally ill.

\* \* \* \* \*

This monograph is the result of a year-long study into the ways in which the police and mental health agencies manage the mentally ill. Information for the study was drawn from literature reviews; surveys of law enforcement agencies' policies, procedures, and training; and interviews with police officers, managers, and chiefs, as well as mental health professionals and other researchers. On-site visits were made to five law enforcement agencies and included observations of police encounters with the mentally ill and the interactions among mental health staff, law enforcement officers, and the mentally ill. Agency and mental health records concerning police encounters with the mentally ill were also examined.

The remainder of this monograph is divided into two parts. Part One, which consists of Chapters II through IV, is largely descriptive. Chapter II provides the mental health context for subsequent discussions of improving the police response to the mentally ill. In

particular, the chapter examines the background of the deinstitutionalization movement and the network of community supports the movement envisioned, the legal criteria for involuntary commitments, the types of mentally ill persons found in the community, the particular plight of the homeless mentally ill, and whether the mentally ill are more crime prone than the general population.

Chapter III describes current practices in law enforcement agencies and the findings of other research into the police response to the mentally ill, including whether that response has led to the criminalization of mentally ill persons. Chapter IV describes how three communities have successfully developed joint law enforcement-mental health response systems.

Part Two, which consists of Chapters V and VI, is a guide to planning, developing, and implementing a response strategy that reflects the needs of the local community. Chapter V details, step by step, the process of working with mental health and other community resources to develop a coordinated response strategy. Chapter VI discusses the operational procedures that must be set in place to support implementation of the program. The chapter outlines procedures for managing encounters with the mentally ill from the time a request for service is received until a final disposition is reached. Particular attention is given to how police officers can recognize and handle different types of mental disorders. The appendixes provide supplementary materials to aid the process of developing a response strategy.

**PART ONE**

**DESCRIPTIVE ELEMENTS OF POLICE  
ENCOUNTERS WITH THE MENTALLY ILL**

## II

### INTRODUCTION TO THE PROBLEM

#### A. BACKGROUND OF MOVEMENT TO COMMUNITY-BASED CARE

Four factors were the major contributors to the movement to community-based, rather than institutionalized, care for the mentally ill:

- development of psychotropic medications,
- research that identified the benefits of community care,
- patients' rights litigation, and
- cost-saving incentives.

The development of psychotropic (mind-altering) medications was a primary facilitator of community treatment of the mentally ill. These drugs could effectively control, repress, mask, or reduce the dangerous and destructive impulses of the mentally ill without inducing any major side effects. In turn, with their erratic behavior under control, the mentally ill would be better able to function in the community. According to Lamb (1984:902), the new medications meant that the "great majority of the chronic psychotic population was left in a state hospital environment that was now clearly unnecessary and even inappropriate for them."

In 1961, the Joint Commission on Mental Illness and Health in the United States published a report entitled Action for Mental Health, which documented five years of research that showed that persons

suffering from mental illnesses were not being effectively treated within institutions. The report suggested that the learning of social adaptive skills was the treatment most needed by this population and that the setting most conducive to this process was the community in which the skills would be put to use. The report further suggested that every community should have a local emergency mental health program to aid in this process. Additionally, in 1963, President Kennedy called for mental health treatment in the least restrictive setting, increased research, and improvement in mental health facilities. These two calls for improvement led to the Mental Retardation Facilities and Mental Health Centers Construction Act of 1963, which began the process of making federal funds available for comprehensive mental health services through community mental health centers.

The third factor, patients' rights litigation, did not come into play until several years after the original push for deinstitutionalization in the mid-sixties, yet it has contributed significantly to perpetuating the movement to non-institutionalized mental health care. Specifically, three court decisions, Rouse v. Cameron (1966), Wyatt v. Stickney (1972), and O'Connor v. Donaldson (1975), held that a patient is entitled to release from a state hospital if the hospital fails to provide treatment. The Wyatt and O'Connor decisions held that nondangerous patients cannot be kept in an institution if they are not receiving treatment and if they can survive safely outside the hospital. In addition, O'Connor v. Donaldson, Rennie v. Klein

(1981), and Rogers v. Okin (1980) confirmed the right of the mentally ill to live within the community without treatment. By 1977, legislation had been passed in most states, beginning with California's Lanterman-Petris-Short Act in 1969, that imposed stringent criteria for involuntary commitment of the mentally ill, along with stringent time limitations on the duration of commitments. As a result of these changes in the law, many mentally ill persons have been released from mental health facilities while others who previously would have been institutionalized have been denied in-patient status. Moreover, many of the mentally ill who now reside in the community do so without seeking mental health assistance.

The federal and, especially, state governments were quick to see the economic benefits of community-based care and enthusiastically supported the movement for treatment in the least restrictive setting. The cutbacks in patients, staff, and services that followed deinstitutionalization (Teplin 1984: 28) and the closing of some mental hospitals relieved the federal and state governments of much of the staggering cost inherent in long-term hospitalization.

In 1963 the federal government made Aid to the Disabled (ATD) available to the mentally ill for the first time. Access to ATD funds made it possible for mentally ill persons to support themselves at home or in alternative living arrangements, such as board-and-care homes. (ATD has been replaced by Supplemental Security Income, which is administered by the Social Security Administration.) In addition, the

introduction of the Medicare and Medicaid programs made it easier for the mentally ill to afford care in nursing homes and group homes. These programs relieved state governments of much of the financial burden of caring for the mentally ill so long as they were not in state institutions. (For more information on the background of the community mental health movement see Lamb 1984, Kiesler 1982, Bachrach 1976, Stone 1975, Mechanic 1969.)

#### B. COMMUNITY-BASED MENTAL HEALTH SYSTEMS

The philosophy of community mental health is to provide quality, non-institutionalized, community-based services of prevention, referral, treatment, rehabilitation, and support for the mentally ill. Within this philosophy, community mental health stresses the intervention of community resources so that the behavior of the mentally ill person is changed, and the impressions, attitudes, behavior, and tolerance of the community are also influenced. The intent is to develop a network of community resources that actively participate in the provision of mental health services and social living skills to enable an individual who has a mental disorder to live in his or her community.

Over 800 community mental health centers in the United States provide a variety of services to the mentally ill. Some of the centers are located in hospitals; others operate as storefront centers; and

still others maintain a number of specialized units in different locations.

Many of the centers were started with seed money from the 1963 legislation that authorized \$150 million over three years for the construction of the centers. Many of the centers received additional federal support for operational costs between 1964 and 1981. Still others have developed and maintained services without federal assistance. In these instances, local and state, as well as private, funding have provided the necessary resources.

The services provided by the centers vary tremendously. This is due to state or local mental health priorities, funding, and the organization and administration of the facility. The following services are recognized as functions of community mental health care, although not all community mental health centers provide all these services:

- outpatient therapy
- emergency services
- residential treatment services
- referrals
- community education
- alcohol and drug counseling
- hospital screening
- court evaluations
- social support groups
- medication maintenance
- occupational skills and workshops
- telephone hotlines
- mental retardation services.

The concept of community-based treatment in lieu of institutionalization of the mentally ill has been criticized as ineffective social policy because the local support services originally envisioned for the mentally ill were never fully developed (Bachrach 1984, Lamb 1984, Teplin 1984). Community mental health centers were slow to develop and when they did they addressed only some of the complex needs of the mentally ill. The chronically mentally ill, those who were deinstitutionalized and who were to be treated in the community, were rarely provided the support services they were supposed to receive. As Teplin (1984: 18, 29) reports:

Our public health system is comprised of a rather fragmented assortment of components ... each sub-system designs its programs to fit a specific need ... the narrow parameters of each of the various sub-systems result in a number of persons who are unacceptable for treatment in any health care facility ... For example, persons thought to be "dangerous" ... or those with numerous previous hospitalizations ... are among the most unwanted clients of mental health agencies. Clearly, many persons fall into the "cracks" of the system.

Pepper and Ryglewicz (1983:389) point to another problem:

In the simplest terms, the patients from our state hospitals have been discharged into the community, but the dollars to support their care have not followed.

State mental health budgets, for example, have continued to allocate up to 80 percent of their mental health funds to institutional services

even though the large majority of clients are being served in the community (Jaskulski 1983).

Cesnick, Pierce, and Puls (1976:179-80) point to a number of shortcomings in the way mental health services are delivered.

- Some agencies provide services only during regular working hours.
- Hospital emergency rooms, usually the only source of 24-hour service, are often unwilling or unable to provide assistance, especially if the individual is uncooperative, angry, or threatening.
- Emergency room staff usually have only two options--hospitalize or release back into the community. They are unable to provide any kind of outpatient treatment or support.

Cesnick and Stevenson (1979:188) provide a wider perspective on the problem:

Working within the time restraints and the physical space of an emergency room, it is unlikely that hospital staff will develop a community treatment and support network that would make hospitalization unnecessary.

Snibbe (in Taft 1980:25) attributes some of the problem to the attitudes of his fellow professionals: "Mental-health professionals are unwilling to come out on the street and offer mental health services where they are needed the most."

Some communities have developed support services for the mentally ill, but to a degree inappropriate to the needs of the mentally ill in the community. Consequently, the services that exist have

been overtaxed and unable to provide an adequate level of care. Another problem regarding these services is that the mentally ill often have no desire to seek them out, because of bad experiences with mental health agencies in the past, because of their inability to work their way through the bureaucracies of a fragmented system, because their disorder leads them to deny their illness or their need for services, or because of a need for autonomy.

Other factors, such as reduced federal funding and involvement in mental health services since the mid-seventies, inadequate training for mental health professionals, and a lack of community education to enhance the acceptance of this population have contributed to a non-system of care. Consequently, those most in need are often left to fend for themselves without treatment, a support network, or social and vocational skills.

#### C. INVOLUNTARY COMMITMENT CRITERIA

Many of the problems that develop between law enforcement and mental health agencies concern the criteria for involuntary commitments. These criteria, for the most part, are subjective, inadequately defined in the laws, and therefore vulnerable to differing interpretations. (See Appendix A for a complete listing of the criteria in each state's involuntary commitment statutes.)

Involuntary commitment statutes in most of the states include four major criteria: mental illness, dangerousness, grave disablement, and the need for treatment. Each of the criteria is discussed briefly below.

Mental illness is the undisputed first criterion necessary for an involuntary commitment. This criterion, however, is often included in statutes without regard to the severity or degree of mental illness. Two states specify "serious mental illness" as the criterion but do not explain the difference between serious mental illness and non-serious mental illness. In fact, none of the statutes does much to define mental illness. Most of the definitions state that mental illness is an emotional or mental condition that impairs judgment, mental health, perceptions of reality, or daily functioning. Eight states go on to define mental illness as a condition requiring treatment or hospitalization and then include as a criterion for commitment, "in need of treatment or hospitalization."

Dangerousness is a legal standard that extends to oneself, others, and in three states, property. "Dangerous to self" and "to others" are often considered together, though they are quite different from the perspective of state interests. "Dangerous to self" invokes the state's parens patriae power as it allows the state to assume ultimate authority as guardian of the individual. "Dangerous to others" falls under the state's police power to protect members of

society from harm by another. Despite its importance as a social control instrument, there has been little examination of the meaning of dangerousness.

Dangerousness has two important aspects:

- What acts, whether they have been committed or threatened, constitute a danger?
- What are the chances that dangerous behavior will occur in the future and can this be predicted?

This first aspect, more so than the second, pertains to the law enforcement officer. The officer on the scene must interpret ill-defined laws and apply them to actual behaviors. In every state but two, dangerous behavior pertains to physical or bodily harm (Iowa's and Hawaii's statutes include emotional injury as well). Yet, the statutes do not define the types of acts or the degree of harm that constitutes dangerousness. Some states emphasize that the use of violence represents dangerous behavior but do not include aggressive, obnoxious, or risk-taking behavior.

Additionally, the interpretation of the officer on-scene might be quite different from that of a mental health worker or judge. Twenty-five of the statutes make this task easier by requiring a recent act or threat of an act of bodily harm as a commitment criterion. However, the other state statutes rely only on the predictions of mental health workers. Consequently, law enforcement officers must also predict or at least believe that dangerous behavior will occur. This brings into consideration the second aspect.

Dangerous behavior cannot be predicted (Steadman, Cocozza, and Melick 1978; Monahan 1973; Stone 1973; Whitmer 1980). While most lay persons associate dangerousness with mental illness, the American Psychiatric Association, and others, have shown that the mentally ill are no more dangerous than the general population (Stone, 1973). Some traditional psychiatric approaches have correlated dangerousness with a specific personality type or mental disability, but they have failed to address environmental factors that influence behavior. Thus, while a person may be dangerous or violent in one situation, other situations do not elicit this type of behavior. As a result, dangerousness cannot be generalized or predicted.

In need of treatment, as a criterion, is often as vague and ambiguous as the term mental illness. Usually it is included in statutes as an element of the definition for mental illness. Yet, there is a wide spectrum of mental illnesses, not all of which require hospitalization. Though most mental health workers speak of the benefit of care or treatment for a neurosis, for example, rarely is in-patient care or treatment needed. Though five states specify hospitalization or in-patient care as the appropriate treatment, the other 22 statutes only confuse the issue by failing to specify what type of treatment is needed for what type of mental illness.

Gravely disabled is perhaps the most specific and clearest criterion of all. It is individually listed in all but three state statutes, and those three include it in the definition of mental

illness. This criterion can be conceptualized in the same manner as the dangerous-to-self criterion--both rely on the parens patriae principle; individuals who cannot care for their basic needs (i.e. food, clothing, shelter) can be considered dangerous to their own welfare.

D. WHO AND WHERE ARE THE MENTALLY ILL?

Lamb (1984:902) reports that the number of mentally ill patients in state hospitals today has dropped from 559,000 in 1955 to approximately 132,000 in 1980-81. In New York State alone 35,000 patients were released from state psychiatric centers between April 1974 and March 1975 (Steadman, Cocozza, and Melick 1978:816). Added to the number of deinstitutionalized persons released to their communities are those who suffer from a major mental illness but have never been in a long-term psychiatric hospital due to non-institutionalization. This group of individuals has been affected by the corollaries of deinstitutionalization: 1) admission diversion or treatment in the least restrictive setting and 2) short-stay hospitalization, i.e., keeping persons in a hospital only as long as is essential to stabilize the disorder and remove the element of dangerousness (Pepper and Ryglewicz 1983). These two groups make up the majority of the severely mentally ill in local communities.

The lack of a comprehensive mental health data collection system makes it difficult to determine the number of mentally ill persons. Talbott (1980) and others have suggested that there are

between 1 and 4 million chronically mentally ill persons in this country, with chronic being defined as requiring hospitalization or the presence of a major psychosis for one or two years. Other figures indicate that approximately 1 out of 10 persons suffer from some type of mental illness. Many of these people have never been institutionalized and their disorders do not warrant in-patient care.

When the first wave of deinstitutionalization began in the mid-sixties, over 65 percent of the patients returned to their families; the remainder either lived alone or were referred to nursing or group homes. First to be released were the less severely disordered and those who possessed socialization skills. The second and third waves of discharged patients included individuals who had far fewer social skills, were more difficult to treat, and generally caused more problems than the first group. Consequently, many were not taken back by their families and had trouble living on their own or in group situations. In 1979, only 23 percent of the deinstitutionalized patients had returned to their families (Talbot 1980:45).

Today, the mentally ill live in a variety of settings, ranging from those still hospitalized to those who are homeless. They live with their families, by themselves in private residences, in bed-and-board homes, in jails and prisons, in halfway or group houses, in single-room occupancy hotels, or in nursing homes.

In many instances these types of living arrangements do not include adequate support mechanisms for meeting the basic needs of the

mentally ill. Most nursing homes, for example, are not designed to provide mental health services. Though private hospitalization is possible and the care provided is somewhat better, the cost of this treatment is often prohibitive. Many boarding homes and single-room occupancy hotels have severe fire and other safety hazards, provide limited supervision, and lack links to mental health or social service programs. Jails and prisons often lack the mental health services and facilities necessary to aid mentally ill inmates and their restrictive environment frequently contributes to mental disorders.

Some living arrangements, such as foster care, group homes, and halfway houses, provide at least adequate and often superior support services. Quite often the mentally ill receive supervision and companionship through the other members of the home. Outpatient services (such as medication and counselor visits), rehabilitation, and socialization skills training are provided, and the residents are encouraged to use social, recreational, and occupational resources.

The reasons for the inconsistency in the quality of living arrangements for the mentally ill are as numerous as the types of living arrangements available. Localized shortages of appropriate housing, prejudice against the mentally ill, inadequate funding, and a non-system of mental health care all contribute to the shortage of adequate living arrangements. Lacking in most communities is a continuum of living arrangements that includes hospitals, nursing homes, group homes, foster homes, shared apartments, and independent living.

Lacking in many communities, too, are programs that address other needs of the mentally ill: general psychiatric services (e.g., counseling and medication), round-the-clock crisis or emergency services, social and vocational training, and recreation.

#### E. THE SPECIAL PROBLEM OF THE HOMELESS MENTALLY ILL

The homeless mentally ill have arrived at their predicament for a variety of reasons. The recession, cutbacks in federal disability payments, and the lack of sufficient structured living arrangements and other means of support in the community have caused many mentally ill persons to become homeless. Some lack the social or financial resources to secure a permanent living arrangement. Others have been denied entrance or turned out of their living places, including family homes, because of their bizarre or frightening behavior. Still others prefer the street life to any form of structured living arrangement and are highly resistant to traditional modes of treatment (Bachrach 1984b). For many others homelessness comes first and mental illness second, often as a result of being homeless.

Just like other segments of the mentally ill population, the type and severity of mental disorders among the homeless mentally ill vary. Some are severely psychotic and others are only mildly disordered.

The transient lifestyle of the homeless mentally ill involves their claiming a doorway, park bench, heating grate, or floorspace of a public building as their home for a day, a night, and even weeks at a

time. Often they tend to congregate so they can look out for one another. Frequently, they are unsightly, they rummage through trash, and generally act bizarrely.

Not all homeless persons are mentally ill. Nevertheless, they often elicit a law enforcement response and usually, for the same reasons as the mentally ill, they frighten other people or make them uneasy.

The homeless (both those who are mentally ill and those who are not) are viewed by merchants as a threat to business and by residents as a threat to the security of their persons and their homes. Indeed, the closer they come to one's home or business, the greater the threat. For this reason, police officers are summoned to remove them and their belongings.

When the police are summoned they are expected to treat the incident as criminal in nature, yet being homeless is not a criminal act. Unless a crime has been committed or the person suffers from a serious mental disorder, there is little a police officer can do except persuade the person to "move along." The end result is simply a transfer of the problem from one location to another and, usually, another request for police action.

Referral to a shelter is possible but often not probable as the number of shelters in most communities fails to meet the needs of the homeless. Indeed, 5 of the nation's 10 largest cities provide no

public shelters. When shelters do exist they are often overcrowded, dirty, and more dangerous than living on the street. Lamb (1984:899-900) cautions that "for the chronically mentally ill, homelessness is a complex problem with multiple causative factors; in our analysis of this problem we need to guard against settling for simplistic explanations and solutions." In particular, he notes that the current emphasis on increasing the number of emergency shelters for the homeless, while "a necessary stopgap, symptomatic measure does not address the basic causes of homelessness ... and can only delay our coming to grips with the underlying problems."

#### F. ARE THE MENTALLY ILL CRIME PRONE?

Public concern about the presence of mentally ill persons in the community stems largely from the perception that the mentally ill are dangerous and prone to commit crime. Numerous studies have attempted to determine whether the public's perception is accurate or an unfair stereotype. Monahan and Steadman (1984) report that their review of the literature reveals that every study conducted before 1965 shows arrest rates among former mental patients to be lower than arrest rates among the general population but that more recent studies show them to be substantially higher (see also Teplin 1984). Steadman, Cocozza, and Mellick (1978) attributed this shift in arrest rates to the increase in the number of mental patients who had arrest records before they were hospitalized. Specifically, they found that only former

patients with two or more arrests prior to hospitalization had higher arrest rates than the general population subsequent to hospitalization. Monahan and Steadman's later research (1984) supported these findings and showed that when demographic characteristics are taken into account (i.e., age, race, sex, social class, prior criminality) crime rates among the mentally ill do not exceed that of the general population.

Teplin (1984) points out that most research into the relationship between crime and mental disorders is based on analysis of official arrest rates and as such is subject to three basic problems. First, arrest statistics do not account for criminal incidents that did not result in the police making an arrest. Second, the decision to arrest may be based on factors other than the commission of a crime. Third, the charge type does not always reflect the true nature of the incident that led to the arrest.

In order to overcome these potential biases, Teplin based her analysis on data gathered at the scene of police-citizen encounters. Excluding traffic violations 1,072 encounters involving 2,122 citizens were observed in a large northern city. The data revealed the following: very few (85 people or 4 percent of the sample) exhibited signs of serious mental disorder; the mentally ill were far less likely to be victims or complainants, but twice as likely as the non-mentally ill to be subjects of concern or objects of assistance, and somewhat more likely (35 percent versus 23 percent) to be suspects. The types

of violations involved did not differ significantly between the mentally ill and non-mentally ill subjects.

Teplin (1984:56) concluded from her analysis that "the stereotype of the mentally ill as dangerous is not substantiated by data from police-citizen encounters." She also noted that her data provide "indirect support" for the findings of Monahan and Steadman cited above.

#### G. CONCLUSION

During the past twenty years both the mentally ill and the treatment they receive have moved from long term hospitals and institutions into the community. This change in locus has also been accompanied by a change in just about every aspect associated with the treatment process. Quite often these changes have had a direct impact on the types and levels of police involvement with the mentally ill and the mental health system. In the next chapter, the ways in which these changes have affected police operations will be discussed.

### III

#### THE POLICE RESPONSE

This chapter discusses how the police respond to encounters with the mentally ill. Section A reports the results of a survey of the extent to which a national sample of law enforcement agencies prepare their officers to handle encounters with the mentally ill through specialized training courses and written policy and procedures. Section B draws on police and mental health literature and information gathered during visits to police agencies to document major aspects of the current police response to the mentally ill. These aspects include how the police become involved, the types of situations and subjects they encounter, officers' attitudes toward dealing with the mentally ill and the mental health agencies, and the factors that bear on the use of discretion and the determination of a final disposition. This chapter prepares the way for the first step in improving an agency's management of the mentally ill--identifying the scope of the problem in the local community and the strengths and weaknesses of the police response.

#### A. SURVEY OF POLICE PRACTICES

Police training curriculums, policies, and procedures were surveyed during mid-1983. Information on training practices was collected from 38 police academies serving 172 law enforcement

agencies. Eleven of the 38 academies provide training on a regional, county, or statewide basis, and the scope of the training provided reflected the desires of the agencies being served. Written information on police practices was obtained from 51 law enforcement agencies and telephone contacts were made with those agencies when further information was needed. The base number of agencies reported in the discussion of various aspects of the survey will vary because not all agencies responded to all parts of the survey.

Though not necessarily representative of all law enforcement agencies, the survey provides valuable information on how a variety of police agencies prepare their officers to deal with incidents involving the mentally ill. The 51 agencies surveyed were all under the leadership of Forum members, are located in 22 states and serve 13 percent of the U.S. population. Five agencies are located in the Northeast; 20 in the South; 11 in the North-Central states; and 15 in the West. Six agencies serve populations of fewer than 100,000; 19 serve between 100,000 and 250,000; 13 serve between 250,000 and 1 million; 4 serve between 1 million and 3 million; and 2 serve populations in excess of 7 million. The officers in these agencies account for 16 percent of total law enforcement personnel.

#### 1. Police Officer Training

Management of the mentally ill has always been more than just a minor, seldom-encountered experience for police officers. Bittner

(1967:282), for example, made the following observation almost two decades ago:

Indeed, officers of the uniformed patrol make [emergency apprehensions] about as often as they arrest persons for murder, all types of manslaughter, rape, robbery, aggravated assault, and grand theft, taken together.

Historically, training materials and police literature have included references to the handling of the mentally ill, but those references were usually lacking in substance. There was little explanation of the mental health system, the etiology of mental illness, the types of mental disorders, or techniques for effective interaction with the mentally ill. Several studies, dating back to 1958, have led to recommendations for systematic training for police in the types of mental illness, mental health philosophies, and techniques for identifying and handling the mentally ill (see Hollingshead and Redlich 1958; Matthews 1970; Patrick 1978; Janus, et al. 1979). Patrick (1978) found, for example, that officers who had received training in how to manage the mentally ill were more accepting of the tenets guiding mental health professionals. Janus, et al. (1979:28) found that 16 hours of instruction in abnormal psychology and psychiatric descriptions and syndromes improved the attitudes of officers toward the mentally ill and the mental health system. More importantly, officers were better able to perceive, understand, and report psychotic behavior which, in turn, improved their ability to make appropriate

referrals for treatment. In fact, an examination of police incident reports presented to psychiatrists indicated that referrals from officers with training were accepted 62 percent of the time in contrast with 14 percent for officers who had not received training.

Despite such evidence of the benefits of mental health training, the Forum's survey of training curriculums revealed that many police officers receive minimal training in basic mental health principles. The average length of time devoted to mental health training for recruits in the 38 police academies responding to the survey was 4.27 hours; the range was from a low of 90 minutes to a high of 22 hours. Two departments do not allot any time for training in this area, and eight departments allot between 14 and 22 hours.

For the purpose of the survey, mental health training was defined as instruction that specifically focuses on recognizing and managing the mentally ill. Included in this definition were the following topics:

- types of mental disorders (abnormal behavior) and disabilities
- types of mental illness
- recognizing the mentally ill
- handling the mentally ill
- exercise of discretion and determination of dispositions
- state and local laws
- involuntary commitment procedures
- departmental policy
- medications
- the local mental health system

- rights of the mentally ill
- suicidal behavior.

Although many academies provide instruction in basic human behavior and crisis intervention, those topics were not counted as mental health training unless there was specific reference to mental disorders.

Most of the above topics, with the exceptions of medications and rights of the mentally ill, were included in the surveyed curriculums, but the amount of time spent on each subject was minimal and the coverage cursory. Some of the more basic and important topic areas were not covered as much as might be expected. The most glaring omission was that the training programs for 17 of the 172 departments did not include instruction in the exercise of discretion and possible dispositions. Also, recruits from 17 of the 172 departments (not necessarily the same 17 departments) did not receive any instruction in the different types of mental illness.

Regarding development of the curriculums, 112 (65 percent) of the departments used professionals from local mental health agencies to assist in curriculum development. Mental health professionals also served as instructors for 119 (69 percent) of the departments.

Lecture was the predominant method of providing instruction. Role-play, audio-visual materials, and reading materials were also used by many of the academies.

## 2. Policy Directives

The written policies and procedures used by the surveyed departments varied in form and substance. Formal written directives were obtained from 43 law enforcement agencies; four other agencies indicated that they do not have any written directives concerning officer encounters with the mentally disordered. Those agencies without directives, however, are included in the base number (47) for all tabulations.

The directives were analyzed for coverage of the following 13 subject areas:

- policy statement on the mentally ill,
- recognizing the mentally ill,
- handling the mentally ill,
- relevant state law or commitment criteria,
- use of discretion,
- possible dispositions other than arrest or emergency detention,
- appropriate use of physical restraint or force,
- procedures for an emergency detention for examination,
- a list of mental health facilities in the community and which ones accept referrals,
- necessary forms for obtaining an emergency examination,
- procedures for reaching a disposition when the mental disorder is compounded by other problems (e.g., injury, sickness, hospital runaway, intoxication),

- legal rights of the mentally ill, and
- non-mental health social service referral agencies, (e.g., shelters, churches, crisis centers).

The subject covered most frequently was how to obtain an emergency detention for examination. Forty-two of the 47 agency directives (89 percent) provided instruction on procedures to be followed in effecting this disposition. Slightly fewer, i.e., 38 agency directives (80 percent), listed the state's criteria for initiating an emergency examination. The third most prevalent subject covered was the forms necessary for emergency detention; 37 agency directives (79 percent) listed or included examples of the necessary forms. Thirty-three (70 percent) of the directives listed local mental health facilities where an emergency examination could be conducted. The fifth most prevalent subject, which was included in 24 directives (51 percent), was procedures for reaching a disposition when the suspected mental disorder is compounded by other problems, such as intoxication. As noted in Chapter II, many mental health agencies will not accept persons exhibiting mixed symptoms of mental illness or whose disorder is complicated by substance abuse, physical ailments, or violent behavior.

The remaining eight subject areas, however, appeared in no more than 18 directives. The agency's policy on the mentally ill, dispositions other than arrest or emergency detention, use of

discretion, and use of physical restraint or force were covered in from 12 to 18 directives. Several important topics were seldom included. For example, how to recognize the mentally ill was treated in only 3 directives, the legal rights of the mentally ill in only 4, social service agencies (other than mental health) in 5, and how to handle the mentally ill in only 6.

Analysis of the written directives and information obtained during telephone interviews with agency personnel and on-site observations reveals that law enforcement agencies are concerned most with emergency detention for examination when dealing with the mentally ill. Often, encounters with the mentally ill are viewed in polar terms: emergency detention or arrest. Relatively scant attention is given to alternative dispositions that can be effected. It should not be surprising then, that, lacking clear and detailed procedural guidance, officers tend to arrest or seek emergency detention in inappropriate circumstances or to develop their own informal dispositions.

There exist several possible reasons why so much attention is paid to only two dispositions:

- 1) Conflict between the law enforcement and social service roles of the police precludes any acknowledgment of dispositions that do not involve arrest or commitment.
- 2) A lack of awareness on the part of patrol officers that alternative dispositions exist.

- 3) A lack of awareness as to which social services can aid in the determination of alternative dispositions.
- 4) The prevalence of a philosophy that states: when in doubt, detain for examination and let the mental health workers weed out inappropriate referrals.

(See Part Two, Chapter 5, for a discussion of how these obstacles can be overcome.)

### 3. Operational Procedures

The survey of operational procedures focused on how encounters with the mentally ill are managed and what attempts were being made (proactively and reactively) to improve the management of these encounters. Data were collected from 48 agencies, either through telephone contacts or written directives. The following five questions were posed:

- 1) Does the agency have a special unit or person(s) responsible for managing encounters with the mentally ill?
- 2) Does the agency require the presence of, or consultation with, a supervisor during the management of these encounters?
- 3) Does the agency have a designated individual who maintains liaison with local mental health agencies?
- 4) Does the agency have a separate system or make provisions for routing, reviewing, and maintaining records concerning encounters with the mentally ill?
- 5) Does the agency receive assistance from local mental health professionals in managing encounters with the mentally ill?

The results of this part of the survey are shown in Table III.1.

III.1. Results of Survey of Operational Procedures  
For Managing Mentally Ill  
(n=48)

| Question   | Yes |    | No |    |
|--|-----|----|----|----|
|  | N   | %  | N  | %  |
| 1. Special police unit or person?                  | 8   | 17 | 40 | 83 |
| 2. On-scene supervisory presence or consultation?  | 9   | 19 | 39 | 81 |
| 3. Designated liaison with mental health agencies? | 19  | 40 | 29 | 61 |
| 4. Separate record system?                         | 8   | 17 | 40 | 83 |
| 5. Mental health assistance:                       |     |    |    |    |
| Telephone consultation?                            | 22  | 46 | 26 | 54 |
| On-site assistance?                                | 15  | 31 | 33 | 69 |

An affirmative response to Question 1 indicates that the department has created a special unit or designated certain of its personnel to be responsible for managing encounters with the mentally ill. The individuals involved were always members of the department, either sworn or civilian, and not professionals from the local mental health services. Three types of special units were used. One type (used by four departments) responds on-scene to assist officers and assumes responsibility for the person, including initiating emergency detentions, when officers believe they cannot easily effect the appropriate disposition or when the disposition will require an extended amount of time. These special units are also responsible for picking up and transporting individuals being served with mental health

warrants. The special units, then, are intended to handle only difficult encounters. To avoid their being requested unnecessarily, patrol officers are provided with at least 15 hours of instruction on mental disorders and are guided by comprehensive policy and procedure, including use of the special unit.

The second type of special unit (used in two departments) is responsible for initiating emergency detention once an officer has determined that to be an appropriate disposition and has transported the individual to a mental health facility. The special unit usually meets the officer at the facility, collects all necessary data from the officer, and assumes responsibility for the individual, thus allowing the officer to return to patrol. As with the first type of special unit, responsibility for serving mental health warrants rests with these units.

The third type of special unit (two departments) uses the resources of the department's emergency service for incidents involving mentally ill individuals who are violent. The unit's purpose is only to restrain and subdue the person, at which point the responding officer assumes responsibility for initiating an emergency examination. Though these units are responsible for many functions other than encounters with the mentally ill and though they lack any special training for verbal interaction with the mentally ill, they are included here because they respond on a regular basis. In fact, in one department, the emergency service unit is dispatched whenever a patrol

unit is dispatched on a mental disorder call. In most cases, though, the responding officer, usually arriving on-scene first, indicates that their services are unnecessary and the unit is turned back before ever reaching the scene.

Information gathered from the responses to Question 2 indicates that supervisory direction occurs in one of two ways. In five of the nine departments that require consultation with a supervisor, the supervisor must go on-scene for every mental disorder call to assist in a disposition. The other four departments require an officer to consult with a supervisor, usually by telephone, before initiating an emergency detention.

Question 3 refers to a department's designation of one person who maintains liaison with local mental health agencies. Of the 19 departments that responded affirmatively to this question, 7 maintained regular contact (at least a monthly meeting or contact), and 3 maintain almost daily contact. The remaining 9 departments make contact as needed.

Eight departments maintain a separate record system (Question 4). Records of contacts with mentally ill persons that did not involve an arrest are maintained separately from arrest records.

Responses to question 5 indicate that 22 departments have arrangements with a mental health agency whereby officers can confer by telephone with mental health professionals concerning appropriate dis-

positions. Fifteen of those 22 departments can also request on-scene assistance from mental health professionals. As with special police units, the departments recommend use of these services in only difficult cases.

Comparing the information on operational procedures that was gathered during telephone interviews with the available written directives revealed, however, that the availability of mental health assistance was not reflected in over 40 percent of the directives. It may be that the survey question was inadequately worded and that more than 40 percent of the directives do make these services known. It may also be that a significant number of directives do not sufficiently detail the procedures to be followed by officers during encounters with the mentally ill.

#### B. MAJOR ELEMENTS OF ENCOUNTERS AND THE POLICE RESPONSE

Numerous specific factors determine how and why the police become involved with the mentally ill, how they manage such encounters, and what dispositions can be effected. This section, based on a review of the literature and information gathered during site visits, identifies these factors and how they interact. Teplin (1984:24), for example, concludes that police decision making in regard to the mentally ill is "based less on the degree of symptomatology per se, than on the exigencies and constraints pertinent to each situation."

1. Reasons for Involvement

One of the main reasons that police become involved with the mentally ill is that in most communities they usually have the only 24-hour, 7-day-a-week, mobile emergency community response capacity. Add to this the authority that police agencies have and the fact that they are a non-charging service and it becomes easy to understand the extent of their involvement in various community services. Without the existence of 24-hour emergency mental health services, the public has but one option: call the police. Yet, even in communities where such mental health services exist, the public may be wary of using them in many situations. Callers may fear that contacting a mental health emergency service may result in protracted discussions concerning the person's behavior, long waits until mental health professionals are available on-scene, and more involvement than the caller is willing to take on.

Although Liberman (1969) has shown that low-income citizens use the police as a means to obtain mental health treatment more so than higher income citizens, the entire community, regardless of individual socioeconomic status, views the police as the most accessible community resource. A history of calling the police and of getting a quick response is a reinforcing behavior. Another factor affecting the choice of police service over mental health service may be changes in the law in the direction of more stringent commitment criteria. Bonovitz and Bonovitz (1981), for example, have shown that a 1976

change in Pennsylvania state law regarding civil commitments and a subsequent change in Philadelphia Police Department policy were responsible for a 200 percent increase in the number of mental illness-related incidents handled by the police. Because the new criteria for commitment were restrictive and focused on dangerousness, the families of the mentally ill, unable to obtain help for the person through the mental health system, were forced to file a complaint with the police as a last resort.

Police also become involved with the mentally ill through requests by mental health agencies or through court orders. Requests from mental health agencies or professionals typically involve situations in which a police presence is required for security reasons. Though such cases do not involve police initiative nor police decisions as to appropriate dispositions, a police presence is often considered to be necessary for the successful accomplishment of the mental health intervention. As Bittner (1967:256) states:

The very fact that the person who made the decision solicited help is an indication that he could probably not have prevailed by himself or at least not on that occasion.

The reasons why police are called are varied. There is, however, one characteristic that ties all the reasons together. The police, when summoned, are the one community agency that cannot say no. Mental health and other social agencies often employ strict response or admission criteria. As Teplin (1984:4) observes, however, "police

have become the streetcorner psychiatrists; moreover, their 'office' never closes."

## 2. Characteristics of Encounters

The situational characteristics of police encounters were examined along four lines:

- the manner in which the encounter was initiated
- the location of the encounter
- the time of day the encounter took place
- the behaviors encountered.

a. Types of Behaviors Encountered. Police officers are faced with a variety of behaviors that must be assessed in determining an appropriate disposition. Some of these behaviors, such as an individual's failing to take proper care of himself or herself ("omission in care") and dangerous acts toward others, are specifically identified in state commitment laws as criteria for emergency detention (see Appendix A). Other behaviors are not so readily identified as symptoms of mental disorders and it remains the officer's responsibility to determine initially what the behavior means and whether it qualifies as a criterion for commitment.

Sheridan and Teplin (1981:143) found that bizarre behavior was the predominant reason for an individual's receiving police attention and being taken to a mental health facility. In their study of data from a mental health intake center, almost 27 percent of the individuals (n=838) were taken to the facility for exhibiting bizarre behavior. The second most prevalent behavior in their study was attempted suicide (12 percent of the cases). This was followed by cases involving destructive, assaultive, or violent behavior (11 percent) and disorderly behavior (6 percent).

In a sample of 90 officer reports on incidents in which the subject was taken to a New York City mental health intake center, 14 percent of the individuals were identified as violent. (The reports were made available for this study.) Additionally, Jacobson, Craven, and Kushner (1973:538) report that aggressive behavior was a factor in 42 percent of the 48 cases police brought to the psychiatric unit of a California hospital. Other behaviors exhibited included shouting obscenities or expressions reflecting paranoid thoughts (19 percent), indecent exposure (10 percent), attempted suicide (9 percent), and public nuisance behavior (8 percent).

Schag (1977) found that 65 percent of 196 police referrals to a county mental health center involved an overt act (i.e., act or threat against self or others or omission of care). Thus, the behavior encountered in a significant number of cases did not present clear-cut

evidence of dangerousness or mental disorder and officers relied on other indicators (frequently acting bizarrely or creating a public nuisance) in deciding to detain for examination. Table III.2 shows the frequency with which certain behaviors were mentioned by officers in the incident reports examined by Schag.

Table III.2. Types of Behavior Encountered by Police  
(n = 196 encounters)

| Category                | Frequency | Percentage |
|-------------------------|-----------|------------|
| Emotional state         | 78        | 39.8       |
| Bizarre behavior        | 75        | 38.3       |
| Public nuisance         | 72        | 36.7       |
| Acts against self       | 70        | 35.7       |
| Psychiatric history     | 66        | 33.7       |
| Confused behavior       | 55        | 28.0       |
| Uncooperative           | 48        | 24.5       |
| Acts against others     | 42        | 21.4       |
| Law violation           | 28        | 14.3       |
| Destruction of property | 23        | 11.7       |
| Omission in care        | 10        | 5.0        |

Source: D.S. Schag, Predicting Dangerousness - An Analysis of Procedures in a Medical Center and Two Police Agencies. Ann Arbor, Michigan: University Microfilms, 1977.

Similarly, Fox, Erickson, and Salutin (1972), in a one-year study of police referrals to three Toronto hospitals, examined officer reports to identify the reasons and behaviors that officers cited for bringing subjects in for examinations. Table III.3. presents their findings.

III.3 Behavioral Elements Attracting Police Attention  
(n = 337)

| Behavioral Element  | Frequency | Percentage |
|---|-----------|------------|
| 1. Prior mental illness   | 116       | 22.3       |
| 2. Aggressive behavior against others:<br>overt - actual or attempted                               | 50        | 9.6        |
| 3. Transportation under warrant or<br>committal papers already signed<br>by a doctor                | 38        | 7.3        |
| 4. Bizarre, extremely unusual behavior  | 38        | 7.3        |
| 5. Report of hallucinations and/or<br>delusions   | 34        | 6.5        |
| 6. Drug or alcohol intoxication - apparent<br>or reported   | 32        | 6.2        |
| 7. In an emotional state (hysterical,<br>incoherent, agitated)                                      | 31        | 6.0        |
| 8. Unusual active behavior (annoyance,<br>yelling, running around, bothering<br>people, disorderly) | 30        | 5.8        |
| 9. Unusual passive behavior (disoriented,<br>disheveled, vagueness, unable to<br>account for self)  | 27        | 5.2        |
| 10. Aggressive behavior against self -<br>overt - actual or attempted                               | 26        | 5.0        |
| 11. Aggressive behavior against self -<br>potential - verbal mention only                           | 25        | 4.8        |
| 12. Destruction or theft of property  | 23        | 4.4        |
| 13. Aggressive behavior against others -<br>potential - verbal mention only                         | 15        | 2.9        |
| 14. Voluntary request for hospitalization<br>or assistance by patient                               | 15        | 2.9        |
| 15. Other (any residual uncategorizable<br>information)   | 20        | 3.8        |
| <u>Totals</u>   | 520       | 100.0      |

Source: Richard G. Fox, Patricia G. Erickson, and Lorne M. Salutin.  
Apparently Suffering from Mental Disorder. Canada: University of  
Toronto, Centre of Criminology, 1972, p. 93.

b. Means of Initiation. Police encounters with the mentally ill can arise from several sources and in different ways. As noted earlier, the initiator can be a local mental health agency or a court or magistrate, although the incidence of such calls is relatively rare. Other calls for service come from the mentally ill themselves. Teplin (1984:52) found, for example, that the mentally ill person was the victim/complainant in 13 of 85 (15 percent) police encounters with the mentally ill. Often, however, calls from the mentally ill occur on a regular basis and involve little more than the officer's alleviating the irrational fears of the person. The following example (Gettinger 1977:30), though extreme from several perspectives, illustrates the point.

Then there's Mrs. W. She had little purple people from Mars. She'd call us six, eight times a night. They told us to do anything to stop her from calling. Finally a sergeant went out there. She told him the purple people from Mars had just landed. He asked where they were; she said in the garage. So he went back, stood in front of the garage and fired every bullet in his gun into the side of it. Shot it slap up. Then he went in and told her there would be somebody out the next day to pick up the bodies.

She didn't call us again for six months. But then she started up again. And when she did call, she asked for that sergeant by name.

In other encounters, the officer may be the initiator or the encounter may be the result of mutual agreement. When the officer is the initiator, it is because the person's behavior, be it bizarre or

illegal, attracts the officer's attention. Mutually initiated encounters are probably the rarest type and typically occur when the officer and individual maintain regular contact with each other.

A prevalent source of initiation is complaints from community members, family members, or friends about either illegal or bizarre behavior. Jacobson, Craven, and Kushner (1977:538-39) explain that the behavior exhibited by the subject is correlated to the initiator of the police encounter. For example, the public was most likely to call the police when the person was exhibiting confused behavior. Situations involving shouting behavior or a person having paranoid thoughts were also most frequently reported by citizens, in particular managers of businesses. Sixty-three percent of the cases involving aggressive behavior were initiated by a family member.

Sheridan and Teplin (1981:144) report that police officers are the single most prevalent initiator of encounters, although all other initiators accounted for the majority of requests for police service. The following tabulation summarizes their findings.

Initiator of Police Contact

|   | % of cases<br>(n=838) |
|---|-----------------------|
| Police  | 35.4                  |
| Self  | 15.4                  |
| Family  | 12.3                  |
| Mental health facility<br>(e.g., halfway house)                       | 9.1                   |
| Hospital without psychiatric<br>facility                              | 6.9                   |
| Non-psychiatric facilities<br>(e.g., Salvation Army,<br>nursing home) | 5.7                   |
| Friend, lover   | 2.5                   |
| Other   | 12.7                  |

A shortcoming of the Sheridan and Teplin data, as with most of the data presented in this section, is that they were collected at a mental health intake center and concern only cases in which a mental health disposition was attempted. There is no way of knowing who initiated encounters that resulted in other dispositions in these studies. (The exception is Teplin's data from on-scene observations of police-citizen encounters.)

Fox, Erickson, and Salutin (1972:106) report that while the police initiate a number of encounters, they clearly are not the major initiators. Table III.4 reports their findings on the initiation of 337 encounters. The encounters are broken down by the type of behavior or incident and whether initiation was proactive (the police) or reactive (all other sources). Incidents involving transportation only or a voluntary request for hospitalization have been omitted from the table. As can be seen from Table III.4, to the extent that police initiate encounters, they most often step in when "unusual", "aggressive", or "bizarre" behavior is present.

c. Location of Encounter. Where encounters occur is another variable that can affect the police response. First, locations can be classified as urban and non-urban. Just as more crime occurs in the cities, all police services will be utilized to a greater degree in urban areas that have high concentrations of people. In his study of

Table III.4. Initiators of Police Encounters  
With the Mentally Ill  
(n=337)

| Behavioral Element                       | Means of Initiation |               |              | Percentage<br>Base |
|--|---------------------|---------------|--------------|--------------------|
|  | Proactive<br>%      | Reactive<br>% | Unknown<br>% |                    |
| Unusual behavior                         |                     |               |              |                    |
| (a) passive                              | 18.5                | 59.3          | 22.2         | 27                 |
| (b) active                               | 20.0                | 60.0          | 20.0         | 30                 |
| Aggressive behavior<br>against self      |                     |               |              |                    |
| (a) overt                                | 15.4                | 61.5          | 23.1         | 26                 |
| (b) potential                            | 12.0                | 88.0          | -            | 25                 |
| Bizarre behavior                         | 13.2                | 73.7          | 13.2         | 38                 |
| Reports of hallucina-<br>tions/delusions | 11.8                | 79.4          | 8.8          | 34                 |
| In an emotional<br>state                 | 9.7                 | 74.2          | 16.2         | 31                 |
| Prior mental illness                     | 9.5                 | 78.4          | 12.1         | 116                |
| Intoxication drug/<br>alcohol            | 9.4                 | 65.6          | 25.0         | 32                 |
| Aggressive behavior<br>against others    |                     |               |              |                    |
| (a) overt                                | 8.0                 | 82.0          | 10.0         | 50                 |
| (b) potential                            | 6.7                 | 86.7          | 6.7          | 15                 |
| Property theft or<br>destruction         | 4.3                 | 73.9          | 21.7         | 22                 |
| Other                                    | 20.0                | 65.0          | 15.0         | 20                 |

Source: Richard G. Fox, Patricia G. Erickson, and Lorne M. Salutin. Apparently Suffering from Mental Disorder. Canada: University of Toronto, Centre of Criminology, 1972, p.106.

Note: "Proactive" = police initiation; "reactive" = all other initiators. Multiple elements were coded for some incidents

police referrals to a county mental health center, for example, Schag (1977) found that the police department of the major city within the county made 126 emergency apprehensions with a 25-officer force, while the county force of 63 officers made 85 emergency apprehensions.

The location of encounters can be broken down further into public and private sites. Sheridan and Tepfin (1981:144) report that nearly one-half of the police encounters they studied took place at the subject's residence (e.g., home, halfway house, Salvation Army lodge). They categorized the encounter locations as follows:

|                          | % of cases<br>(n=838) |
|--------------------------|-----------------------|
| Home                     | 30.4                  |
| Street                   | 23.6                  |
| Public place             | 12.4                  |
| Referral--other hospital | 11.1                  |
| Halfway house            | 9.2                   |
| Stationhouse             | 4.5                   |
| Salvation Army lodge     | 4.1                   |
| Other                    | 4.7                   |

Examination of 90 officer reports on subjects taken to a New York City mental health intake center provided additional evidence that the home is the predominant location of encounters. Of the 90 encounters, which occurred over a 10-day period, the location was unclear in six cases. Of the remaining 84 cases, the subject's home was the location in 37, or 44 percent, of the cases. In one case the encounter took place in the subject's nursing home. In seven other cases the person was remanded from the courts, but the original location of the encounter was not included in the reports. It is

possible that as many as 54 percent of the encounters took place in the subject's residence. Table III.5 shows the breakdown of locations.

Table III.5. Location of Encounters  
(n=90)

| Location                    | N  | %    |
|-----------------------------|----|------|
| Home                        | 37 | 44.0 |
| Street                      | 19 | 22.6 |
| Court remanded              | 7  | 8.3  |
| Referral--other<br>hospital | 5  | 5.9  |
| Nursing home                | 1  | 1.1  |
| Other*                      | 15 | 17.8 |
| Unknown                     | 6  | 7.1  |

\*Includes ledges, bridges, subways, colleges, churches, shelters, and stationhouses.

d. Time of Occurrence.

Little quantifiable information is available concerning the time that encounters take place. However, interviews with mental health professionals and police officers strongly suggest that the mentally ill are the most vulnerable in the evenings and during weekends and holidays, times when the individual's usual support systems are not likely to be available. Without someone or some service to turn to in times of stress, the mentally ill come to the attention of the police, either directly or through another initiator. An examination of the New York City officer reports referred to earlier

tends to support this theory. Of 79 cases in which the time of the arrival at the hospital was known, 48 (61 percent) of the arrivals were between the hours of 5:00 p.m. and 9:00 a.m. The breakdown is as follows:

|                        | <u>N</u> | <u>%</u> |
|------------------------|----------|----------|
| 9:00 a.m. - 4:59 p.m.  | 31       | 39.3     |
| 5:00 p.m. - 12:59 p.m. | 35       | 44.3     |
| 1:00 a.m. - 8:59 a.m.  | 13       | 16.4     |
|                        | 79       | 100.0    |

## 2. Characteristics of Subjects

Bittner (1967:288) has pointed out that most police encounters with the mentally ill involve individuals who are in relatively high states of agitation but with whom interaction is nonetheless possible. The agitation stems from the person's disorder. The inability to cope with stress or manage daily affairs, a dependency on others, and conflict in interpersonal relationships are just a few of the effects of a disorder that can contribute to easily attained and high levels of agitation.

As with characteristics of encounters, a handful of research studies have gathered information on the characteristics of the subjects of police encounters with the mentally ill. These studies have identified commonalities in persons suffering from a mental illness who have required police attention. As with the characteristics of encounters, the subjects' characteristics were gathered from written

reports of police contacts in which an emergency detention for examination was the officer's disposition. The studies do not address the characteristics of individuals suffering from a suspected mental disorder who were arrested or for whom an alternate disposition was effected.

Five studies cited earlier also present information on demographic characteristics. As for the sex of the subjects, males were detained for examination more frequently than females. The Fox, Erickson, and Salutin (1979) study found that males accounted for 62 percent of the group detained; Jacobson, Craven, and Kushner (1973) found the lowest proportion of males, 51 percent.

Looking at the subjects' ages, Schag (1977) found that the average age of all detainees was 35.7 years. In the New York City incident reports, the average age for males was 30.7; and for females, 36.0. Sheridan and Teplin (1981) found that over 68 percent of the detainees were between the ages of 15 and 34. Jacobson, Craven, and Kushner found 46 percent of the subjects to be between the ages of 20 and 29 and over 50 percent to be under the age of 30. All five studies indicated that only a small percentage of the detainees were more than 45 years old.

In the three studies that reported marital status (Sheridan and Teplin; Schag; and Jacobson, Craven, and Kushner), at least 47 percent of the subjects had never been married. Sheridan and Teplin

further indicated that their subjects were overrepresented as lacking social support systems, especially family.

Lieberman (1969) differentiated between persons who received mental health treatment by way of police intervention and those who received treatment without police intervention. His findings indicated that "police patients" were usually difficult persons to manage because of their inability to recognize both their disorder and their need for treatment. Lieberman characterized the two groups as follows:

Police Patients (n=17)

94% denied their mental illness  
17% realized their need for help  
58% diagnosed as schizophrenic

Medical Patients (n=35)

29% denied their mental illness  
80% realized their need for help  
26% diagnosed as schizophrenic  
28% diagnosed as neurotic  
23% diagnosed as depressed

The other studies cited also indicate that schizophrenia is a primary diagnosis. Sheridan and Teplin reported that 49 percent of the 838 subjects detained for examination were diagnosed as schizophrenic and over 62 percent were diagnosed as being psychotic. Fox, Erickson, and Salutin reported a psychotic diagnosis in 56 percent of the 679 cases, with schizophrenia being the major psychosis in 38 percent (259 cases). In both studies, neurosis, personality disorders,

and substance abuse (including alcoholism) were the next most frequent diagnoses, none of which accounted for more than 14 percent.

The subjects also tended to have a history of hospitalization. Jacobson, Craven, and Kushner reported that 75 percent of the 48 detainees studied had been hospitalized before, and Fox, Erickson, and Salutin found that over one-half of the 337 detainees had been hospitalized in the previous three years.

Based on the above studies, a description of the "typical" mentally ill person detained by police for examination would include the following characteristics:

- The person is young, usually around or below the age of 30.
- The person is unattached and lacking social support systems, particularly a spouse or family.
- The person is male.
- The person is diagnosed as psychotic and, more specifically, schizophrenic.
- The person is also difficult to manage. He has been in and out of hospitals, yet refuses to acknowledge his disorder.

The above information presents a profile of mentally ill persons encountered by the police. However, while certain tendencies do exist, it is important to remember that the population of persons suffering from mental illness is diverse, and will vary with each community.

### 3. Officer Attitudes

The police, no less than the general public, generally maintain a variety of attitudes toward the mentally ill. The most prevalent of these is that there is a correlation between mental illness and dangerous or violent behavior. Matthews (1970) found that police hold two major attitudes toward the mentally ill:

- 1) They are sick and should receive medical attention.
- 2) Mental illness involves violence or highly abnormal behavior.

Schag's (1977) analysis also supports this finding. Such attitudes point to an obvious shortcoming in the way police agencies prepare their officers to manage the mentally ill.

Police officers have repeatedly reported that they believe that their encounters with the mentally ill are an appropriate part of police work. Jacobson, Craven, and Kushner (1973:544) report that 75 percent of a sample of officers they interviewed hold this belief. Officers cited as reasons for their belief that it is their duty to protect people and property and to serve the public. A significant number also cited the reason: "no one else would do it." Interviews by this author with officers in several cities upheld this general finding. Bittner (1967:281) reported that while officers acknowledged that dealing with the mentally ill "is an integral part of their work, they hold that it is not a proper task for them." Officers also

maintain that encounters with the mentally ill are an undesirable aspect of police work. (See Bittner 1967; U.S. Riot Commission 1968; Jacobson, Craven, and Kushner 1973; Cesnick, Pierce, and Puls 1976; Schag 1977; Cesnick and Stevenson 1979; Fox, Erickson, and Salutin, 1979; Teplin 1984.) Reasons most often cited for this are as follows:

- Uncertainty on the part of officers concerning their role in civil or social service matters. It is often unclear where law enforcement work ends and social service tasks begin. Officers also question the appropriateness of their involvement in civil matters.
- A lack of training in techniques for dealing with this population. Traditional police techniques are not relevant to handling the mentally ill and often tend to exacerbate rather than alleviate the problem behavior. Thus, officers feel that they are responsible for situations in which they have no expertise and few, if any, fundamental techniques to use.
- A lack of written directives providing specific information for managing this population. This includes information on possible dispositions, mental health laws, and procedures for contacting mental health services.
- Inappropriate attitudes toward, and a misunderstanding of, mental health professionals and philosophies. Snibbe (1973:527) points out that some officers believe that mental health treatment is a wholly inadequate solution to the problem of the mentally ill. They wonder what goes on in mental health facilities when persons who were supposedly treated are involved in another incident within a few days. They are also bothered by the lack of security in mental health facilities.
- Lack of control over the situation and a feeling of futility. Officers see their authority diminished when all they can do is transport the subject to the hospital and request admission. They are also

frustrated when mental health facilities refuse to accept intoxicated, psychotic, and other difficult-to-handle subjects.

- Officers also have a difficult time separating personal from professional feelings when dealing with persons in social service encounters. They tend to feel too much sympathy for the person and his or her family.
- Managing the mentally ill takes away from "real" police work. Often, the amount of time an officer must devote to these encounters and dispositions is viewed as excessive. Moreover, handling the mentally ill is considered "not a good pinch." Departmental policies seldom offer incentives or rewards for successfully managing this population and officers seldom receive any feedback on the results of their efforts.

It appears that officers tend to make a distinction between the two dominant police roles often expressed in the motto "to protect and to serve." Encounters with the mentally ill are viewed as appropriate when public order is disrupted or when threats of, or actual, dangerous behavior has occurred. Officers have a dislike, however, for the social service role, in large part because they believe it is often extended beyond what it should include. Teplin (1984:8), for example, cites several studies that report that officers regard transporting the mentally ill as an inappropriate police function.

Officer attitudes toward mental health professionals and agencies are often born of misinformation. Considerable tension stems from a lack of awareness of the basic mental health philosophies, goals, and capabilities. While both groups are "helping" agencies, each takes a different approach to the fulfillment of this goal.

Police officers are concerned with the community first and the individual second. They are forced to make quick decisions and take action, possibly using force, without consideration of the environmental or historical factors involved. The officer must assume a take-charge approach to restoring order and coming to closure on an incident as quickly as possible. Mental health professionals, on the other hand, are first concerned with the individual. As such, they are unwilling to take a directive approach and make quick decisions. Rather, they must consider the causes and contributing factors in persuading or allowing the person time to reach a decision.

#### 4. Discretion and Dispositions

Reliance on informal guidelines and informal dispositions appears to be the hallmark of police decision making in managing encounters with the mentally ill (Bittner 1967; Schag 1977; Hanewicz, Fransway, and O'Neil 1982; Teplin 1984). Insufficient training and departmental guidance regarding alternative dispositions, the circumstances under which they should be invoked, and procedures for effecting them force officers to develop their own guidelines. Poorly defined legal criteria for emergency hospitalization and inconsistent and time-consuming procedures at hospitals and mental health facilities are also contributing factors. Reliance on informal guidelines, however, can result in inappropriate dispositions because officers will

tend to rely on those dispositions with which they are familiar and have had success in effecting in the past.

As seen in earlier sections of this chapter, the following factors influence an officer's decision regarding the appropriate disposition of encounters involving the mentally ill:

- the type of incident or behavior involved;
- the concerns of the complainant;
- characteristics of the subject, victims, complainant, and bystanders;
- the relationship between complainant and subject (e.g., family, friend, employer, stranger);
- whether there is evidence of a crime;
- legal criteria for emergency detention;
- police agency policy, organizational structure, and resources;
- awareness of community mental health and social service resources and their availability; and
- the officer's attitudes toward the mentally ill and this aspect of police work.

As Bittner (1967: 92) noted: "The external characteristics of cases are not irrelevant to the decisions, but their import is always mediated by practical considerations of what can and need be done alternatively." The discussion that follows provides insight into just how the many variables that are a part of police encounters with the mentally ill influence the disposition of the incident.

a. Informal Dispositions. Statistical evidence of the frequency and types of informal dispositions is not readily available, no doubt because police departments are not required to maintain records of incidents that do not evoke an official response. Indeed, "no paperwork" may be one of the attractions of informal dispositions.

Available evidence indicates that from two-fifths to three-fourths of police encounters with the mentally ill may be resolved informally (Teplin 1984; Hanewicz, Fransway, and O'Neil 1982; Rock 1960).

A range of actions fall within the category of informal dispositions:

- ignoring the incident
- warning the subject not to repeat the behavior
- returning the subject to his or her home
- listening and counseling
- contacting a responsible person
- referring or taking the subject to a helping agency.

Teplin (1984:21ff) describes three types of mentally ill persons who are likely to be handled in one of the above ways: 1) neighborhood characters, i.e., "mentals" who are not hospitalized because the police know them and how to "cool" the situation if an incident arises; 2) troublesome persons who may cause problems for the police but who are too difficult to handle to warrant bringing them into the station or hospital; and 3) unobtrusive mentals who are "more

disordered than disorderly." The latter often just need "someone to talk to."

Persons who are handled informally, thus, are frequently known to the police. They are often only mildly disordered and the police have become tolerant of a certain level of deviant behavior from them. So long as they do not exceed that level of tolerance, the police do not formally intervene in their behavior.

b. Emergency Detention. After informal dispositions, emergency detention for psychiatric examination is perhaps the next most frequent disposition of incidents involving the mentally ill. Bittner (1967) and Teplin (1984), however, have pointed out that police are nonetheless reluctant to initiate emergency detentions, and Teplin and others attribute that reluctance in large part to structural characteristics of community-based mental health services (Schag 1977; Lamb and Grant 1982; Cesnick, Pierce, and Puls 1976). In particular, they cite the following problems:

- reduced number of psychiatric placements available in hospitals and mental health facilities since the 1960s;
- bureaucratic procedures; and
- stringent admittance criteria that render inadmissible those who are dangerous, addicted to alcohol or drugs, physically disabled, or liable for criminal charges.

The more procedural steps between the street and the hospital, for example, the less likely that police will seek emergency

hospitalization (Rock 1960). Fox, Erickson, and Salutin (1976) confirmed this relationship with their finding that instituting a cooperative program between police and the local hospital increased police willingness to pursue this disposition.

Police reluctance to seek emergency hospitalization also stems in part from uncertainty about the types of mentally ill persons who will be accepted for emergency hospitalization. Suicidal and severely delusional persons will always be readily accepted (Teplin 1984). Beyond that, officers may be uncertain whether the behavior exhibited is indicative of mental illness, whether it is serious enough to warrant hospitalization, and whether the mental health staff will accept their assessment of the person's behavior and need for treatment. Clearly, officers' decision making will be influenced by their calculation of the time required to seek hospitalization and of the likelihood that the subject will be admitted.

Under what circumstances, then, do police seek to have mentally ill persons hospitalized? Sheridan and Teplin's (1981) analysis of 838 incidents in which the subject was referred by police for hospitalization revealed that those referred were a source of fear and anxiety in the community. Fifty percent of the referrals were for bizarre behavior (27 percent), attempted suicide (12 percent), and destructive, assaultive, and violent behavior (12 percent). In Jacobson, Craven, and Kushner's (1973) study of 48 cases of police referrals to a psychiatric unit, 20 (42 percent) were referred for

aggressive behavior and 15 (31 percent) for confused behavior. Four cases (9 percent) involved suicide attempts.

A history of treatment or hospitalization also leads police to seek emergency detention (Fox, Erickson, and Salutin 1972; Jacobson, Craven, and Kushner 1973; Sheridan and Teplin 1981). Schag (1977) suggests that knowing an individual has a psychiatric history leads to several perceptions that prompt a decision to hospitalize: 1) the person had a mental disturbance in the past and is still disturbed, 2) the basic problem is unresolved and likely to be manifested again in the future, and 3) other alternatives have been tried and have obviously failed.

As for the result of police referrals for hospitalization, the most comprehensive data are those of Schag (1977). Data were gathered from a community mental health center serving as a screening and in-patient facility for a county with a population of 160,686. Of 196 police referrals during a one-year period, 135 persons, or 69 percent, were involuntarily admitted to the in-patient facility. There were no significant demographic differences between those admitted and those released. There were, however, differences in the behavioral characteristics of the two groups. Positively related to involuntary admissions were confused thoughts and behavior, bizarre thoughts, and psychiatric history.

The strongest correlation existed between bizarre behavior and admission; 93 percent of those acting bizarrely were admitted.

Bizarre behavior was defined as highly unusual or idiosyncratic conduct and did not require an overt act, but was often associated with the individual's being labeled a public nuisance. If the behavior was so bizarre as to warrant police attention, it was often perceived by police and mental health workers as indications of both mental illness and dangerousness. Extremely bizarre behavior was perceived by mental health professionals as requiring in-patient care so that the problem-causing behavior could be treated.

The second strongest correlation was that of psychiatric history, particularly hospitalization, in combination with an overt act. Individuals who had a previous psychiatric history and who also committed or threatened an overt act against themselves or others, or who experienced a significant omission in care, usually were admitted. Those who committed or threatened overt acts but did not have a psychiatric history were usually released.

In the Jacobson, Craven, and Kushner (1973) study referred to above, all nude exposure and public nuisance cases resulted in the person's being hospitalized, as did 86 percent of the cases involving the shouting of obscenities and 63 percent of the cases involving confused behavior. Although no category of bizarre behavior was identified as such, the above behaviors can be considered bizarre. In cases involving aggressive behavior, 79 percent of the persons were hospitalized.

Monahan, Caldeira, and Friedlander (1979) found that 60 percent of police-referred hospitalizations were a result of dangerous behavior toward both others and self. Additionally, all hospitalized persons had threatened to or had committed a physically assaultive act to themselves or others within 24 hours and usually within one hour of coming to police attention.

Although dangerousness is an often-used criterion for hospitalization, in some mental health facilities dangerous behavior, as noted earlier, if it is perceived as too severe, is often a barrier even to an emergency examination. Mental health professionals in general hospitals prefer not, and often refuse, to examine police-referred subjects who are considered dangerous (Teplin 1984; Fox, Erickson, and Salutin 1972). The most often-cited reason was a lack of security measures in the mental health facility.

c. Arrest. Arrest appears to be the least frequent resolution of incidents involving the mentally ill. Teplin (1984), for example, reports that 14 (16.5 percent) of 85 encounters with mentally ill persons ended in arrest. Thirty-four (8 percent) of 380 persons handled by Galveston County's Mental Health Deputies Unit between September 1975 and August 1977 (Gulf Coast Regional MH/MR Center, undated) were arrested. (See Chapter IV for a description of the Galveston program.) Similarly, about 163 subjects (10 percent) out of the 1,639 processed by a Los Angeles County police hospital squad in 1961-62 were arrested (Rock, Jacobson, and Janepaul 1968). Also, during 1976-1982, New York

City Police arrested 504 (.8%) persons out of 66,039 encounters (New York City Police Department statistical summaries, 1983).

A major concern of law enforcement and mental health agencies alike is whether arrest, no matter how infrequently invoked, is still over-used as a means of managing the mentally ill. Evidence in the literature of the "criminalization" of the mentally ill is inconclusive, however.

Lamb and Grant (1982:21), drawing on their own findings and those of Abramson (1972), Sosowsky (1978), and Steadman, Vanderwyst, and Ribner (1978), conclude that it "seems possible that mental status as such is causally related" to higher arrest rates among the mentally ill than among the general population. Bonovitz and Bonovitz's (1981) examination of police handling of 248 incidents involving the mentally ill in a Pennsylvania community, however, did not support the criminalization hypothesis. In 1979, Monahan, Caldeira, and Friedlander interviewed 50 police officers who had just sought involuntary civil commitments and 50 police officers who had just made an arrest. The conclusion of their study was that mentally ill persons were not being criminalized by placement in jail rather than a hospital and that serious lawbreakers were not being placed in hospitals rather than in jail. In 30 percent of the commitment cases, for example, police could have made a legal arrest but chose to commit instead.

Teplin (1984:30) cautions that much of the research to date "is so fraught with methodological problems as to preclude definitive conclusions regarding the criminalization thesis." Her own study of 844 police-citizen encounters involving 1,798 citizens provided what she calls "preliminary evidence that the mentally ill are being criminalized." In the 844 encounters studied, 506 suspects were identified, 30 of whom were also identified as being mentally ill. Fourteen of the 30 mentally ill suspects (46.7 percent) were arrested, compared with 133 (27.9 percent) of the 476 suspects who were not mentally ill. In other words, the probability of arrest was 20 percent higher for the mentally ill suspects. Because the data did not permit comparisons over time of relative arrest rates for mentally ill and non-mentally ill suspects, Teplin cautions that her findings "cannot be interpreted as being indicative of an overall trend toward criminalization" (p. 40).

While research results regarding the criminalization theory may be contradictory or inconclusive, such is not the case regarding the reasons why police arrest mentally ill persons. The numerous studies cited throughout this discussion of final dispositions are in agreement as to the factors that lead to arrest of the mentally ill when the seriousness of the incident, citizen demands, prevailing statutes, or police policy do not dictate an arrest. Several of the reasons listed below are corollaries of the reasons why police are reluctant to seek emergency detention of the mentally ill:

- Arrest may be the officer's only alternative in situations in which the person is unlikely to be accepted by the hospital or mental health facility but is too disturbed to be ignored.
  - The conflict between mental health professionals and police regarding the suitability of the person for admission (e.g., intoxicated, too dangerous) may lead officers to use arrest as a means to commitment. If the court orders a civil commitment, the charges are then dropped.
  - Teplin (1984:16, 37) found that officers would obtain a signed complaint when on-scene so that it would be available should hospitalization be denied.
- Arrest may be the quicker and more familiar disposition when judicial or mental health procedures for involuntary commitment are cumbersome and time-consuming. In these situations, too, the court is left to determine whether institutionalization by jailing or by hospitalizing is the appropriate response.
- The lack of mental health alternatives to emergency detention may force officers to arrest when they recognize the individual is not seriously enough disturbed to be involuntarily committed but cannot be left alone.
  - According to a recent task force report issued by the Virginia Corrections Department and the Mental Health and Mental Retardation Department, "at least 12,000 mentally ill Virginians are jailed annually--many for such minor offenses as trespassing--because of inadequate community services for the people who have been released from institutions (Washington Post, 1985)."
- Officers may also arrest the mentally ill because they fail to recognize the signs of mental disorder. The person may appear, for example, to be intoxicated or under the influence of drugs. Lamb and Grant (1982:20) offer two additional explanations:

-- Signs of mental illness may go unnoticed during a difficult encounter. One policeman was quoted as saying: "He didn't look anymore mentally disturbed than any other criminal."

- Officer attitudes may also influence the decision to arrest.

-- Teplin (1984:36) posits that mentally ill persons may respond to officers in ways that are seen as disrespectful and that this causes punitive action by the officer.

-- Lamb and Grant (1982:21) remind us that police see their primary responsibility as protecting society. One policeman told the authors: "He seemed crazy, but he knew right from wrong in regard to this offense and we felt he should go to jail."

### C. CONCLUSION

This chapter has presented a variety of information on the police response to the mentally ill. The results of a national survey have given an indication of what departments are doing, administratively and operationally, to manage the mentally ill. A review of previous research and other literature, as well as the results of firsthand observations, have identified a variety of characteristics of police encounters with the mentally ill and components of the mental health treatment system. The typical police response has been identified. In the next chapter, three exemplary police responses will be discussed.

IV  
MODEL PROGRAMS

Because a response strategy must be consistent with the needs and resources of the local community, the types of programs possible are as numerous and varied as the communities they serve. This chapter describes three community programs, each of which uses a different approach to responding to the needs of the mentally ill. The three communities are Madison, Wisconsin; Galveston County, Texas; and Birmingham, Alabama.

The intent of this chapter is not to provide law enforcement agencies with programs to be emulated exactly. Rather, the intent is to provide models, key elements of which may be readily transferable to the development of a response strategy appropriate to the needs and resources of other communities.

Though each agency's response strategy, to some extent, will vary from any other agency's, response systems can be classified into four general categories. The first model program discussed, that of Madison, Wisconsin, uses the "generalist" approach, i.e., all police officers are responsible for calls involving the mentally ill. Galveston County, Texas, uses an "officer specialist" approach to the problem, and Birmingham, Alabama, uses a "civilian specialist" approach. The fourth category would be special units that comprise

civilians and officers. No one approach is recommended over the other; each can fulfill the needs, and operate within the resources, of the community it serves.

For reasons of space, only three programs are described here.\* The three chosen have been formally or informally recognized by professional groups or peers as successful. The inclusion of these programs, however, should not be construed as an invalidation of the success of other programs.

#### A. MADISON, WISCONSIN

A comprehensive network of social service agencies supports the Madison Police Department in its efforts to effectively handle encounters with the mentally ill. The crucial component of this network is a 24-hour Crisis Intervention Service (CIS), which has the capacity to respond anywhere in Dane County to assist officers in determining an appropriate disposition. When encountering a person who is actively psychotic, in some type of crisis, or otherwise in need of the services of mental health professionals, Madison Police Department officers, all of whom handle such calls, can confer over the telephone with CIS staff or request on-scene assistance. The department's Social Services Coordinator is responsible for maintaining close and constant contact with the community's mental health agencies.

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\*The program descriptions are based on on-site observations and written materials provided by the respective police departments.

Located on the outskirts of Madison is Mendota State Hospital, which at one time housed over 1,000 mentally disordered persons. With the onset of the deinstitutionalization movement, Madison became the community of residence for many of the chronically mentally ill persons who had been released from the state hospital. The strain that these persons placed on the community was felt most strongly by the police.

Over the next six years (1975-80), the Dane County Mental Health Center (DCMHC) developed one of the most comprehensive and innovative mental health programs in the country. The program has three basic components:

- Clinical Services - provides outpatient services, such as counseling, education, transitional skills development, support networks, medication maintenance, skill training, and treatment plans.
- Emergency Services - provides 24-hour emergency phone service, emergency counseling and referral for walk-in clients, and 24-hour mobile crisis intervention services.
- Mobile Community Treatment - provides a support system to help clients learn and maintain skills for community living and to reduce the frequency and duration of psychiatric hospitalizations.

Through these primary services, as well as numerous other programs, the non-profit, county-contracted center is able to provide mental health services for almost all of the chronically mentally ill in Madison.

The DCMHC has had great success with its program because it took the steps necessary to guarantee its acceptance by the community it serves. Social and public service organizations and the business and professional communities were involved at the planning stages so that potential problems could be identified and resolved prior to the initiation of services. This process improved the community's support for the program, because the community was made to feel that it was an essential element of success. A major benefit of developing a community approach has been that all elements of the program have gained an understanding of the mental health system and its capabilities.

The police department was no exception to this process, particularly in regard to emergency services. Because police officers spend a considerable amount of time handling social and personal crisis situations, they are in a key case-finder role. They often have the initial contact with the mentally ill and are in a position to identify those persons and make appropriate referrals or take other actions necessary to reach a disposition in the best interests of the client and community. In order to utilize the police as a resource for client identification and to foster positive relationships between the two professions, the DCMHC extensively involved the Madison Police Department in the planning process and paid close attention to the viewpoints of patrol officers. Conversely, the police department has

incorporated into its response the resources and expertise of the Mental Health Center.

The Crisis Intervention Service, which came into being in May 1975, focuses primarily on suicide attempts and threats, potential involuntary hospitalizations, family crisis situations, psychotic persons, and survivors of suicide victims. The service provides intervention, assessment, treatment plan formulation and implementation, limited-term treatment in emergency situations, and referral and follow-up for long-term treatment, when necessary. Since its inception the program has received an average of 150 referrals a month, one-third of which originate with law enforcement agencies.

The process of developing the law enforcement-crisis service relationship was recognized as necessary by both professional groups and began early in the process. The mental health center, through its other programs, was aware of the importance of establishing a cooperative working relationship with various community groups. Whereas the Mobile Community Treatment Program, for example, established a relationship with the landlords of buildings in which the mentally disordered lived, the Crisis Intervention Service worked closely with the police. This relationship, however, was not one-way. Rather, both systems realized that the development of this type of program would make the tasks of each system more manageable. The CIS would be better able to identify and locate clients in need of its help. The police, in turn, would receive help in determining an appropriate disposition,

would come to understand the plight of the mentally ill, and would eventually be able to manage that population with greater ease.

The police department showed a keen interest in making this joint program work, not only because of the benefits to be gained but also because of its priorities. The department, under Chief Couper, has made human and social services a priority. Numerous relationships with social service agencies have been developed, related recruit and in-service training has been increased greatly, and the position of Social Services Coordinator was established. Because the department was interested in this crisis service-law enforcement relationship, it committed the resources necessary for success.

The early planning processes focused on fostering positive attitudes between the two groups, especially those of the police toward the mental health center. Prior frustrations experienced by officers in attempting to determine an appropriate disposition for the mentally ill had to be overcome. The CIS had to show that this program would be different from the former system, which often left the officers to travel from hospital to hospital searching for an examination and a bed for the subject. Under the new program, all police referrals would be accepted until such time that officers could become familiar with appropriate referrals.

The planning process also revealed that appropriate responsiveness on the part of the CIS staff would require five elements:

- ready and continual availability,
- quick and in-person response on the scene, when requested,
- acceptance or sharing of responsibility for the disturbed person,
- formulation and initiation of alternative dispositions, and
- provision of feedback to the officers involved.

These five elements, as well as the above-mentioned initial acceptance of any police referrals, were reflected in CIS policy and quickly became the foundation of the program.

The next major step in the process involved teaching the CIS staff how to make on-scene responses. Officers with extensive crisis intervention experience served as instructors. The initial training experience involved CIS staff riding along with patrol officers. As with many elements of the program, this experience resulted in mutual benefits. Crisis staff were introduced to the rigors of patrol work, as well as the attitudes and perspectives of the officers. The officers, in turn, were able to get to know the crisis staff as fellow professionals attempting to do a job.

The crisis intervention training provided by the department focused on encounters involving the introduction of a third party into potentially volatile situations. Specifically, the training covered familiarization with and respect for firearms, procedures for avoiding violence, entering the homes of subjects, appropriate use of police in

life-threatening situations, and first aid. In addition, SWAT and other special-unit personnel discussed tactics and the role of CIS staff in dealing with person-with-a-gun situations.

Training for the officers at this stage of the program involved in-service instruction and exposure to the newly developed written policy that explained the purpose of the program in detail. The priorities, limitations, and procedures of the program were fully detailed and officers were strongly encouraged to use the resources of the CIS.

When first implemented, the program was often misused and inappropriate referrals were made frequently. With perseverance on the part of both groups, however, the problems lessened. Officers became more aware of the types of problems that could be encountered and which ones should be referred to CIS staff. As recruits came through the academy, they were given approximately 20 hours of in-depth training in mental health resources, the causes of encounters with the mentally ill, response strategies, and particularly, the procedures used in working with the CIS. This training is presented by the Social Services Coordinator and professionals from the CIS and the Mobile Community Treatment Program.

The CIS role in training and informing officers continues beyond the academy. Patrol officers are given profiles of mentally ill persons in their area, including information on behavior patterns,

dangerousness, and medications. This information enables the officers to recognize and respond quickly to situations involving these persons.

One of the most important factors in the success of this joint effort is the position of Social Services Coordinator. A sworn officer fills this position and is responsible for maintaining liaison with the DCMHC (and all other social service agencies), reviewing officer reports of encounters with the mentally ill and submitting selected ones to the DCMHC, assisting officers on-scene, if necessary, and acting as a buffer between CIS staff and officers in the event of a misunderstanding. Because he is an officer, the coordinator is fully aware of the concerns and needs of fellow officers and can induce officers to relate their true feelings about the program, whereas they might be reluctant to do so with a CIS staff member. He can, in turn, couch criticisms by the CIS staff in such a manner that officers accept the comments more readily than they would if made directly by a non-officer.

The Social Services Coordinator's importance cannot be overestimated, but the department's contribution to the program's success also includes the clear and concise policy that guides officers. Guidelines have been developed for approaching and communicating with the subject. Possible dispositions are outlined and the means to effect them are discussed. Officers are encouraged to reach a disposition by themselves, but they can easily consult a mental health

professional if necessary. (The directive is included in Appendix E.)

When on-scene, the officer tries to obtain as much information as possible to aid in a final disposition. The written directive of the department lists five basic dispositions that range in degree of restrictiveness according to the nature and severity of the incident:

- release and referral,
- release to family or friends and referral,
- voluntary examination,
- involuntary examination, and
- arrest.

With the first two dispositions, the officer usually reaches a decision without consultation with CIS staff. According to the directive, these dispositions are appropriate only if the officer believes that the person's aberrations are not incapacitating and a recurrence is unlikely. If the officer believes release and referral are not appropriate, he or she should consult with the CIS staff. Initial consultation is usually done by phone and is sometimes followed by further consultation on-scene, at the Mental Health Center, or at one of the local hospitals. If an examination is necessary, a voluntary examination is always preferred over an involuntary one.

The department's written directive also details the circumstances under which arrest is an appropriate disposition:

- if a felony has been committed,

- if abnormal behavior is involved but it is minor in nature or unrelated to the incident (misdemeanor arrest), and
- if the person exhibits behavior indicative of a mental disorder but does not meet the criteria for emergency temporary detention for examination and will not voluntarily admit himself to a facility for psychiatric examination.

In situations involving arrest, a statutory rather than ordinance violation is cited because the former allows for court-ordered treatment and the latter does not.

If the officer believes that emergency temporary detention is the appropriate disposition, the officer must obtain a Police Officer's Affidavit for Temporary Custody in accordance with his statutory authority. This initiates a process that may result in the involuntary commitment of the detained person. Madison's statutory requirements for such a process are as follows:

- 1) The officer shall have observed or have learned from a reliable source of specific violent or dangerous acts, or attempts or threats to perform specific violent, dangerous acts by the individual.
- 2) The officer shall have reason to believe, based on ... observations or on information provided by the mental health professional, that the behavior was the result of some mental abnormality.
- 3) The person's conduct constitutes imminent danger of substantial physical harm to himself/herself or others.

State law allows the officer to commence procedures for temporary detention without consulting with or even against the advice of a CIS staff member. As a matter of policy, however, officers do consult with CIS staff and in practically every circumstance heed the advice of the mental health professional when deciding if temporary detention for examination is appropriate.

If a mental health professional concurs with the officer, the temporary detention is maintained for up to 72 hours at the Mendota State Hospital in Madison. At that point a probable cause hearing is held and evidence must be presented to convince the court of the need for a 14-day hold at the institution. During this stay, the subject is examined by two psychiatrists; medications can be administered if the subject consents or if specifically ordered by the court. If, at the end of this period, a community facility has not been identified that can treat the person, or the medications have not facilitated a recovery, or if both doctors find evidence of dangerousness, a commitment trial is held.

Indicative of the cooperative relationship between the police department and the DCMHC is the review and follow-up of officers' reports. Whenever an officer encounters a mentally ill person, he completes an incident report, a copy of which is forwarded to the Social Services Coordinator. The coordinator then reviews the report for adherence to the department's policy and procedure. Because of the coordinator's familiarity with the mental health center and individual

clients, he can also examine the report from a mental health perspective to identify problem areas. Selected reports are then forwarded to the DCMHC for review. If an individual is identified as having numerous or severe encounters with law enforcement personnel, a change in the client's treatment plan is considered to prevent further encounters. Also, in the case of referrals, the CIS staff can contact the social service agency and the client to determine if contact between the two was made.

Feedback from the DCMHC is given to the referring officer and his immediate supervisor on all referrals, mostly through brief letters. This procedure is of tremendous value in that it advises the officer of the result of his intervention and the immediate treatment plan for the client. It also recognizes the officer for providing a needed service to the client. On occasions when the officer extends himself to a degree that exceeds the usual demands of service, letters of commendation are sent to both the officer and his or her superiors.

Like the police-CIS relationship, the overall criminal justice and mental health systems in Madison are characterized by coordinated and uniform procedures. In the district attorney's office, for example, four full-time attorneys are responsible for probable cause hearings and commitment trials. The Dane County jail has two full-time mental health professionals on staff to screen and counsel inmates.

The Madison Police Department and the Dane County Mental Health Center have developed, implemented, and maintained a successful program for handling the mentally disordered. The interaction of the two agencies has enabled the police to improve their management of this population. Officers know how to identify and interact with the mentally disordered and how to seek emergency detentions; they have also become familiar with the mental health center, its philosophies, and referral agencies. The mental health center, for its part, has achieved its goal of being able to identify, locate, and monitor the mentally disordered. Between them, the two agencies have also reduced inappropriate hospitalizations and incarcerations.

B. GALVESTON COUNTY, TEXAS

In contrast to Madison's generalist approach, Galveston County uses law enforcement specialists in its response strategy. Five deputy sheriffs certified as Texas peace officers, emergency medical technicians, and mental health specialists staff the Mental Health Deputies Unit, a 24-hour response program for managing law enforcement encounters with the mentally ill. The deputies are law enforcement officers first, but as mental health paraprofessionals, their goal is to intervene in crisis situations and determine the appropriate preliminary disposition. A major concern is to avoid inappropriate institutionalization or incarceration.

Galveston's program became operational on September 1, 1975, under the auspices of the County Commissioner's Court, the Galveston County Sheriff's Department, and the Gulf Coast Regional Mental Health/Mental Retardation (MH/MR) Center. Two factors provided the major impetus for developing the mental health deputy program. First, during the late 1960s and early 1970s, there was a substantial and consistent increase in the number of mentally ill persons entering the criminal justice system and being housed in the county jail. The management of this population within the jail had become a major problem for the sheriff and his deputies. As in many other institutions across the nation, suicides by the mentally ill in the jail were a clear indication of the management problem.

Second, the sheriff's deputies assigned to patrol duties were also experiencing problems with this population and in implementing the Texas Mental Health Code. According to the code, if an officer learns from a credible source that an individual is believed to be mentally ill and likely to harm himself or others, the officer must obtain a warrant from a magistrate, take the person into custody, and transport him to a psychiatric facility for evaluation. Because this was a time-consuming task, and because they were unfamiliar with the mentally ill and the mental health system, officers were reluctant to become involved in such cases.

As a first step in alleviating the problem, the sheriff's department initiated a series of discussions with the MH/MR Center to

determine ways to improve the management of the mentally ill. The initial exchanges quickly grew into a total community effort to address needs, resources, possible solutions, goals, objectives, and procedures. The County Commissioner's Court, particularly the committing judges, and the senior county psychiatrist were also concerned about needless incarcerations and quickly involved themselves in developing the solution. The University of Texas Medical Branch and the Moody Foundation, both in Galveston County, as well as numerous social service agencies also became involved. The interaction among these groups and their commitment of the resources at their disposal contributed to a solution with clearly defined goals, objectives, and procedures.

The first goal of the new program was to improve communication among the various professions involved. The second was to establish a special operations unit to deal with the mentally ill through crisis intervention, special screening, and diversion recommendations, all in compliance with state law and while also protecting the rights of the mentally ill and the community. The third goal of the program was to reduce the incarceration and institutionalization of the mentally ill and provide alternative dispositions. As will be seen below, the goals and objectives of the program have been achieved with great success.

Galveston County's Mental Health Deputies Unit is a diverse group of carefully screened and highly trained law enforcement

officers. The unit began operating in September 1975 with two deputies. Today the unit has five deputies, including one woman and a member of each of the major ethnic groups in Galveston County. Twenty-four hour coverage is provided through eight-hour, split-shift tours. Between 8:00 a.m. and 8:00 p.m. at least two officers are on tour, and one officer is available between 8:00 p.m. and 8:00 a.m. Each officer puts in an average of 70 hours a week (some of this time is on-call duty). The unit handles, on average, between 12 and 20 calls in a 24-hour period. Not all of these calls require a strict mental health response; some involve family or spousal disturbances and other problems of a social service nature.

The unit works out of the administrative offices of the Gulf Coast Regional MH/MR Center. All officers work in plainclothes and are provided radio-equipped, unmarked cars. The unit's duties also include investigating suicides and suicide attempts, intervening in domestic disturbances, and handling situations involving barricaded or hostage-holding individuals. The officers are empowered to function as an investigatory arm of the probate court and to determine which individuals need psychiatric evaluation. They are also responsible for carrying out all probate court orders requiring investigation of candidates for civil commitment.

Prior to achieving mental health deputy status, all officers are required to complete a demanding and multi-faceted training program. Recruits must first be certified as Texas Law Enforcement

Officers by completing the Galveston County Sheriff's Department requirement of 420 hours of training, an amount that exceeds the Texas P.O.S.T. requirement by 60 hours. Of this total, 16 hours are devoted to the management of the mentally ill. The officers are then assigned to patrol duties for at least the six-month probationary period. It is after these requirements have been met that officers are recruited to be mental health deputies.

Potential mental health deputies are selected by the unit's director. Numerous factors come into play during the screening process, but the primary determinants are an individual's past experience and education in a mental health or social service capacity, favorable or non-cynical attitudes toward law enforcement roles and mental health philosophies and practices, and an ability to work in accordance with the goals and resources of not only the unit but also the network of community diversion services.

After being selected as candidates for the unit, officers begin their training as emergency medical technicians. This training, which requires 300 hours, qualifies them to provide emergency medical care in the event of an on-scene injury. This training also aids in the identification of medical problems that could cause a person to exhibit behavior similar to that of one who is mentally ill. In this way, the appropriate treatment can be obtained without undue delay.

Upon successful completion of the medical training program, the officers then begin a nine-month mental health paraprofessional training program. While intensive, the program is highly flexible so as to meet the needs of each officer, depending on past work experiences and education. In this way a candidate's strengths are reinforced while deficiencies are overcome. The bulk of the program consists of on-the-job training with the mental health deputies and mental health professionals at the MH/MR Center and the University of Texas Medical Branch. Because the unit deals with psychological emergencies, training is concentrated on the emergency aspects of identification, screening, and stabilization rather than the clinical aspect of treatment. Thus, when a deputy is called to the scene of a disturbance, he or she can screen the subject and determine a preliminary disposition appropriate for the subject and community.

Between 60 and 70 percent of the calls the unit receives come from either patrol deputies or, on occasion, from the sheriff's dispatch center. The remainder of the calls for service come from the Probate Court, family or friends, emergency medical services, and outpatient resident programs. In some instances a mental health deputy goes to the scene of the disturbance; in other situations, usually those involving patrol officer contacts, the subject is taken to a centralized location for screening by a deputy. Calls from patrol deputies and other patrol officers involve cases in which the deputy is unsure of an appropriate disposition or cases which will require an

extended period of time. In cases in which an emergency examination is necessary, the mental health deputy assumes responsibility for the individual.

After a mental health deputy has screened an individual brought to his or her attention, the deputy has two options. If there is no urgent need for a mental health evaluation, the deputy can arrange for outpatient services, elective hospitalization, assistance from other human services agencies, or take no further action. If a mental health examination is indicated, the deputy must obtain a magistrate's warrant to transport the individual to an approved facility for an emergency psychiatric evaluation.

In about 50 percent of the cases the deputies request psychiatric evaluation. Of those examined, about half are hospitalized. Hospitalization is usually voluntary, short-term, and done locally at the University of Texas Medical Branch facility. When the client is released from the hospital, the MH/MR Center helps him or her make use of community support programs.

In the event of an involuntary hospitalization, all civil commitment hearings are conducted by a designated, full-time Probate Court judge. Duties of commitment for involuntary hospitalization rest with the district attorney's office. Three assistant district attorneys handle this procedure on a month-long rotation schedule.

This ensures that channels of communication are always open and that the roles of each component are clearly established.

The unit maintains an active record of each contact it makes for six months. After that, the records are maintained in the inactive files for five years. All mental health unit files are maintained separately from other law enforcement files to protect their confidentiality and to avoid confusion with arrest records.

Along with responding to calls in the community, the deputies screen jail inmates who have been identified by correctional deputies as possibly needing mental health attention. These are inmates who did not exhibit any mental disorder when admitted but appear to have developed problems in confinement. The inmates are then further screened for psychiatric examinations by psychiatrists from the University of Texas Medical Branch. A one-hour clinic is held in the jail twice weekly, at which time the screened individuals are examined. These examinations are therapeutic evaluations, not forensic evaluations to determine competence to stand trial. If the evaluation indicates a need for therapy, a decision is reached as to the most appropriate treatment and the facility best suited to provide the treatment. The cost of the jail clinic, which is independent of the number of patients seen, is borne by the MH/MR Center.

The Galveston County Mental Health Deputies Unit has had an extraordinary impact on the law enforcement, mental health, and

judicial communities. Since 1975, jail admissions of mentally ill persons have been reduced by 99 percent. Countless hours and dollars have been saved because patrol officers can remain on the street, relieved of responsibility for dealing with unfamiliar mental health agencies. The careful monitoring of persons in the mental health and legal systems and the network of available services have reduced the involuntary hospitalization rate such that this area has the lowest rate in the State of Texas and one of the lowest in the nation. In 1980, the American Psychiatric Association presented its Gold Award to the center for its innovative work in establishing a network of services for the mentally ill.

C. BIRMINGHAM, ALABAMA

Professional social workers, working side-by-side with the Birmingham Police Department, have relieved police officers of the need to respond to repeat social service calls or calls in which police action is not necessary. Birmingham's Community Service Officers (CSOs), working out of a central location, are called to the scene of an incident to assist and often relieve an officer in determining an appropriate disposition. The large majority of their responsibilities involve mental health emergencies that include suicide attempts, although they are also trained to manage family disturbance, spousal abuse, and homeless calls. Acting as liaison between the police department and the subject, as well as between the subject and social

service agencies, a CSO is often able to determine and implement a disposition with less difficulty than an officer would face. Because the CSO is recognized by mental health and social service professionals as a peer, he or she can more easily gain access to the necessary services.

The CSOs are civilian social workers who have received extensive training in crisis intervention and community referral procedures. Once an officer has arrived at the scene of a disturbance and has assessed the incident as being within the CSO's responsibilities, the officer can call a CSO for assistance and relief. These are cases of a social service nature that require contacts with local social service and mental health agencies or cases that require extended amounts of time to resolve. The immediate role of the CSO is one of mediator, counselor, and screener. Once the immediate crisis has been calmed and the presence of a sworn officer is no longer necessary, the officer can leave the scene and return to patrol. The CSO then determines the most appropriate disposition for the subject. The CSOs, because they are not police officers and do not come with the trappings of that authority, can often gain the confidence of the subject with less difficulty than an officer would face.

Since its inception, the Community Service Officers program has been subject to numerous political and economic pressures. Nonetheless, the unit has been able to persevere and make a significant contribution to the management of the mentally ill. Birmingham is

included here as a community with a model program because of its unique approach and also because of the obstacles it has had to overcome. Both Madison and Galveston County have had strong support from community agencies and much of their success can be attributed to this. Birmingham, however, does not have the comprehensive mental health services often found in other communities, yet it has developed a system for improving police management of the mentally ill.

The idea of the police-social worker team in Birmingham had its origins in the Master of Social Work program at the University of Alabama. In 1976, several social work graduate students were assigned to the east precinct, one of four in the city. The students rode with patrol officers and assisted them on-scene with calls of a psycho-social nature. In this early arrangement, the students never accepted total responsibility but rather offered advice as to an appropriate disposition. The initial results were quite positive. Not only was the need for their services demonstrated by the number and types of calls in which they were able to provide assistance, but the officers expressed a strong acceptance of the program and the students. Within a year the program had been extended to the three other precincts. Amid all of the success there existed one crucial problem, however. A student's tour lasted only one semester. Thus, every four months the officers would have to break-in a new group of social work students. The trust and cooperation needed for the program to work also had to be reestablished with each new group of students.

In the fall of 1977, the university and the city finance department were able to secure eight full-time CSO positions through the federally funded Comprehensive Employment Training Act (CETA) Title II Program. Each precinct was assigned two CSOs, who between them provided coverage seven days a week from 1:00 p.m. to 11:00 p.m. Each day a CSO held roll-call to discuss cases, social services within the city, and ways to improve the delivery of services. Once a week a psychiatrist from one of the three community mental health centers attended the roll-call in an advisory capacity. During this phase of the program, the CSOs would respond to calls at the request of an officer. Once on-scene, the CSO would either assist the officer or relieve him of responsibility, especially if there was no threat of violence or no further need for law enforcement authority.

In 1979, the program underwent a major change. A civilian CSO was assigned to each precinct and worked a 7:00 a.m. to 3:00 p.m. day shift, responding to calls on request. At 3:00 p.m. each precinct was then staffed by a two-member crisis management team, which worked until 11:00 p.m. Each precinct's team had a different combination of civilian CSO, sworn CSO, or patrol officer, but each team had at least one sworn member. The intent was to determine the most effective staffing so that it would serve as the prototype for permanent crisis management teams. This scheme, however, did not work. The first problem was the inappropriate use of the team. The team's car soon became the utility car for the precinct and the team answered many

calls that were unrelated to its mission. Second, the CETA funds were cut repeatedly and with each reduction in funding a CSO position was eliminated.

Recognizing the strong need by both the public and the police for this service, the Birmingham City Council unanimously voted to fund six permanent CSO positions in July 1979. The program, however, soon suffered another setback. To meet the expiration dates of a Law Enforcement Assistance program that required the city to provide two social workers for the jail, the city was forced to transfer two civilian CSOs to the jail or lose funding. By October 1979, the program reverted to its original civilian structure following the transfer of two civilian CSOs and reassignment of sworn CSOs back to patrol duty. At this point the remaining CSOs were brought under central administrative control to better serve the city as a whole. Their schedules were staggered so that 12-hour coverage, from 6:00 a.m. to 6:00 p.m., would be possible.

Currently, two CSOs provide coverage from 8:00 a.m. to 6:00 p.m., five days a week. In addition, two social workers are assigned full time to the jail. The demands that a city of 300,000 people place on the two CSOs can be overwhelming. Consequently, through an informal agreement patrol officers usually request the services of a CSO only when the situation involves a mentally ill person.

For the police, much of the problem of managing the mentally ill stems from a local mental health system that is ill-prepared to deal with psychiatric emergencies. Though the city has over 80 boarding homes for the mentally ill, three regional mental health centers, and three hospitals willing to provide their facilities for involuntary examinations, these mental health components have not been able to develop a coordinated system of emergency services. The procedures for emergency evaluations are lengthy and cumbersome and generally discourage officers from seeking aid for the mentally ill. Basically, when an officer seeks an emergency evaluation he must go to one of three hospitals, two of which do not have psychiatric professionals in-house for examinations and must "borrow" a psychiatrist from the third hospital. Arrival at the hospital is followed by a medical admission, a record check, a medical examination, officer consultation with the psychiatrist, the psychiatrist's review of records, and finally the psychiatric examination. Even if the psychiatrist determines that a temporary emergency admission is warranted, the subject's financial status must also be evaluated. If the subject is indigent, he is unlikely to be admitted. Along with this financial constraint, the university hospital receives city, county, and state funding to maintain only five beds for the entire Jefferson County area.

From a law enforcement perspective, the success of the CSO program rests in its ability to free patrol officers from having to seek emergency examinations, a process that can take anywhere from two

to eight hours. Once at the hospital the CSO contacts the various parties necessary to the process. The CSO, being familiar with the hospital's staff and procedures, is able to facilitate the examination. In addition, the CSO is able to recount the incident, behavior of the subject, and other influential factors in the terminology of mental health professionals, which further facilitates the process. In situations in which all beds for the indigent are filled and an indigent person requires hospitalization, the CSO, often familiar with the person and his or her medical history, is able to work with the Probate Court and mental health services to obtain a temporary holding order pending transfer to a state or other hospital. Similarly, in situations in which the person has a family, the CSO can work with the family, the mental health services, and the Probate Court to reach an appropriate disposition.

The CSOs, due to their experience and liaison with the three systems--police, mental health, and legal--are often the decisive element in securing the necessary services for the mentally ill. In addition, the CSOs also reduce the number of repeat calls for police service that this population generates. The savings in money and officer time, as well as the improvement in officer's attitudes, are additional benefits of this program.

The CSO program has proven to be a valuable resource for the Birmingham Police Department and the entire community. The program has overcome many of the barriers associated with civilian personnel

working with sworn officers, especially those providing social service assistance. The officers have come to appreciate the program for the valuable assistance it provides them, yet there is a clear understanding of the limitations of the program. Because the CSOs are understaffed and kept constantly busy with mental health emergency calls, the patrol officers have maintained responsibility for other social service calls. Both components bring qualities to this team that the other is lacking. The patrol officers contribute their criminal justice knowledge, experience, and most importantly their authority. The CSOs bring their clinical skills and knowledge of local social service resources. Together, the two groups have developed a relationship that has improved the community's ability to care for the mentally ill.

#### D. CONCLUSION

The three programs just described vary in their organization and responsibility, due in large part to the composition of locally available resources. Regardless of the type of program, law enforcement officers in the three communities have a better understanding of the mentally ill and greater acceptance of mental health workers and procedures. This enables them to interact with the mentally ill in a confident and professional manner and to make informed on-scene decisions as to proper disposition. Countless dollars and officer hours have been saved either through the use of special units or the fielding

of well-informed and prepared patrol officers. Repeat calls involving mentally ill persons have been reduced. Job satisfaction regarding this often frustrating and unfamiliar police function has also been improved.

Relationships between police and mental health professionals in the three communities can now be characterized as amicable rather than antagonistic. Local jails, to a great extent, have been relieved of serious management problems through the elimination of unnecessary incarcerations. The mentally ill have benefited by not being subject to unnecessary incarcerations and hospitalizations, and they have also benefited from more humane and appropriate treatment by police officers. Mental health agencies have been better able to identify persons in need of treatment and reduce many repeat calls for police service. Additionally, these agencies have been relieved of many inappropriate referrals and dissatisfaction on the part of police officers and other community groups.

**PART TWO**

**A PLANNING GUIDE FOR  
POLICE MANAGERS**

## DEVELOPING A RESPONSE STRATEGY

The aim of this chapter is to help the police manager develop and put into action a strategy for responding to encounters with the mentally ill. The intent is not to specify what such a program should look like but instead to discuss the process by which improved police services for the mentally ill can be devised and brought into action.

The bulk of the discussion deals with the various preparations involved: getting the planning process under way, identifying those features of the current response system (not limited to the police) that require reform, plotting the dimensions of that new program, specifying existing as well as additional resources that will be required to carry out the new program, devising the organizational arrangements and role definitions by which to successfully manage the program's operation, and so forth. Also examined are the processes involved in getting the new program started, i.e., the processes that bridge the planning and implementation phases. And, lastly, the discussion turns to implementation, that is, the carrying forward into full operation the preparations undertaken during planning and start-up.

Two caveats. First, the discussion that follows presumes a sequence of events or stages. This presumption helps to organize the material and facilitate its communication. In real life, however, no

such orderliness can be expected. The process of program building is inherently dynamic as well as complex, its various components interacting in complicated, often surprising ways. The challenge for the manager of such a process is to be aware of the major issues involved, of the options for dealing with them that are likely, in one form or another, to be available, and of the stages in the process at which those issues most probably will be among the prevailing concerns.

Second, although this chapter is designed to help the police manager meet this challenge, the guidance offered is neither definitive nor grounded in substantial experience. The reason is three-fold. First, the police have been actively involved in setting up new ways of handling the mentally ill in only a handful of communities. Second, even if one were prepared to broaden the base of relevant experience to include other examples of police leadership in devising innovative ways of coping with problem populations, one would still be hard pressed to find useful examples. By and large, law enforcement has relied on traditional police methods, or variations thereon, to meet social problems. It has not, for the most part, sought to develop new approaches either on its own or in cooperation with other community institutions. Thus, the base of experience from which to draw lessons that police agencies can follow in constructing new strategies for their community's mentally ill is narrow.

And third, the problem of how to enable the mentally ill to live in the community under circumstances that take into account both

their rights and interests as well as those of society is dauntingly difficult. This is the message of the first three chapters. It is repeated here to point out that it is unrealistic, in light of the already substantial investment of resources both private and public and at every level of government, to expect an authoritative directive for a police-led campaign to reform the handling of the mentally ill in the community.

The suggestions that follow, then, should be viewed as a guide to meeting the challenge of creating a better police response to the mentally ill. They are not a blueprint to be followed mechanically.

#### A. PLANNING

##### 1. Organizing the Planning Process: Pre-planning

Some managers, particularly those who prize improvisation and an intuitive approach to administration, may be inclined to postpone or even omit what sometimes is referred to as pre-planning. Nonetheless, there is merit in giving preliminary attention to the issues likely to be encountered once the process of designing an improved response to the mentally ill is under way.

One place to start is with a review of your understanding of the problem. Do you have a full grasp of the significance of the obstacles to be overcome or do you need other information? Is the

problem posed by the mentally ill, for example, part of a larger issue, such as an overcrowded jail, inflamed race relations, or excessive numbers of citizen-police assaults? Is it a chronic condition, one that has gone on for perhaps some time, gradually worsening, as might be the case in complaints about the residents of a group home? Or, has a particular incident precipitated a crisis of some kind, such as an accidental homicide while a deranged suspect was being taken into custody? And if so, does that incident point to a previously unrecognized problem, such as unclear policy or procedure, inadequate training, or the absence of specialized back-up services? Does the information presently available tend more to obscure than to clarify the real issue? For example, have the news media distorted the public's perception of the "menace" presented by the mentally ill? Are the circumstances such that "something" must be done quickly or is there time to act with relative deliberation to effect basic improvements in the agency's response?

Mulling over questions like these can be helpful in opening up the range of issues to be dealt with, the limitations of your knowledge and information, and the complications to be faced in devising and implementing corrective action. Sometimes referred to as "scanning", this kind of review may suggest that additional information, although still preliminary, is needed before going further with the planning process. For example, you may wish to review your agency's policy regarding emergency detention for clarity, completeness, and currency

in light of recent changes in the law. Your agency's own personnel, particularly those with first-hand experience in coping with the mentally ill and the community's mental health services, may be helpful not only in what they report but also in how they report it. A quick conversation with several officers who have handled emergency detentions, for example, may reveal some confusion as to how departmental procedures are to be applied, frustration at the large amount of "downtime" required to process a mentally ill person through the mental health center, or perhaps irritation at the interruption in their "real" police work caused by having to deal with "mentals". Although fragmentary, such opinions will increase one's awareness of the problem's dimensions.

Other valuable sources of background information will be found outside the agency. There may be, for example, an advocacy organization that represents the mentally ill population, or some segment of it, that can be tapped for its perception of the problem. Initiating contact with the group's leadership may generate useful information and recommendations while also establishing the potential for a working relationship in the future.

A major aspect of the new response strategy will be coordinated with the mental health agencies within the community. It is important, therefore, to learn how they are structured, who their key officials are, and the differences between their various services and goals. If no one within the department has this kind of information,

it may be possible to obtain it through an informed intermediary. This may be a government official, for example the city manager, or a knowledgeable and trusted acquaintance, such as a physician. The head of the state or local chapter of the American Psychological Association also would be able to provide this information as well as insights into who in the community were particularly concerned about the problems of the mentally ill.

A potentially valuable source of ready advice and insight on how to get started are those law enforcement agencies whose model programs were described in Chapter IV. A telephone conversation with the officer in charge could elicit additional details on the program. Assuming that such an individual had participated in the program's genesis, he or she would be uniquely suited to describing the developmental process and how best to handle it. Also worth exploring is the existence of other programs, particularly those in areas close enough to be visited. And finally, of course, you may wish to supplement the information contained in this manual with other readings. A starting point would be the publications cited in the appended bibliography.

Two additional threshold preparations remain to be accomplished. One is to enlist those officials and other individuals whose active cooperation will be needed if the envisioned reforms are to be successfully planned and implemented. An integral element of this process will be the creation of a structure by which their participation can be effectively organized and directed. The other preparatory

step will be to mobilize the resources within your own agency that will be needed during planning and to begin the process of building an agency-wide acceptance of the need for improvement in the police response to the mentally ill. These two preparations may be made more or less simultaneously or in sequence. For the purposes of this discussion, the solicitation of other agencies' cooperation is considered first.

In considering the strategy to follow in approaching other agencies, keep in mind that gaining the collaboration of the mental health services will be an important element. Moreover, these services that are community-based almost certainly will be the most critical. In many large-and medium-sized cities, for example, there are a variety of noninstitutional services, each addressing a different aspect of assimilating the mentally ill into the community. They could include outpatient psychotherapy, information and referral, administration of medication, mobile community treatment, housing locator services, and emergency services. Some variation in emergency services can be expected, but in some communities they will include 24-hour telephone service, walk-in services, and 24-hour crisis intervention services that dispatch mental health professionals to the scene of mental health emergencies. From a law enforcement point of view, particularly the social service and order-maintenance functions of policing, emergency services are the most important element of community care. Not only

because these services can assist law enforcement in managing the mentally ill but because they are a successful means of initiating treatment services for this population. (See Chapter II for a discussion of community-based mental health care.)

Assuming that your earlier scanning has disclosed that the director of the community mental health center is likely to be receptive to law enforcement overtures, a direct approach may be the most sensible one to take. That is, you would meet with this official to explain what you have in mind, to offer your agency's resources in support of the effort, and to solicit a similar commitment on the part of the mental health center and its staff. Assuming this initial session goes well, other meetings should be arranged at which mid-management and operations staff of the two agencies can become familiar with one another's perceptions of the problem, gain a better understanding of their respective philosophies, and begin to establish a working relationship. Quite often communication can be enhanced through the distribution of written materials describing each agency's operations, as well as the relevant law, current policy statements, procedural directives, and similar documents of mutual interest.

It is not intended to suggest that these sessions be pursued to the point that a complete program is developed and then presented to other community groups. Rather, these first few meetings should be devoted to gaining an understanding of the two systems so that the fundamentals of a joint program can be discussed and their feasibility

determined. In the process, moreover, a foundation of common concern and commitment will be established upon which a larger coalition of other agencies may be built to the extent required.

These early meetings may be useful in other ways. For example, preliminary agreement can be reached as to which other agencies should be asked to participate and how the participation of all should be structured. With respect to the latter issue, several possibilities exist.

One planning-group arrangement, particularly useful when the number of participants threatens to become unwieldy, is to establish both a membership committee and a smaller executive committee, each of which comprises the top officials in the participating organizations. Most of the work is done by the executive committee members (with the assistance of their respective agency's staff), but the commitment of the general membership is maintained by giving it ultimate decision-making powers. Another arrangement is to provide the membership group with a staff composed of mid-level personnel temporarily detailed (either on a part-time or full-time basis) from some or all of the participating agencies. In this case the entire consortium exercises both policy-making and executive functions.

A slightly different arrangement is to create two distinct organizations, one composed of agency heads or their personal representatives, and the other made up of mid-management personnel. The

former group establishes policy and exercises overall executive direction while the latter performs the necessary staff services.

The preliminary meetings of law enforcement and community mental health personnel can be used to review these and other organizational arrangements. An additional function will be to identify other agencies to be invited to participate in the planning process. The possible array of organizations whose operations impact the mentally ill and who, therefore, might be considered for inclusion in the coalition is large. In addition to mental health services and law enforcement, in most communities it includes the following:

- the courts, civil as well as criminal
- the prosecutor's office
- the public defender's office
- the jail
- hospital emergency services
- public welfare
- private community services agencies (or an umbrella organization, such as United Way)
- the city or county planning office
- services for the elderly
- private groups serving as advocates for the mentally ill or their families (e.g., the National Alliance for the Mentally Ill and the Association for Retarded Citizens)
- local colleges or universities, particularly any that have teaching hospitals or programs in the mental health field
- the news media.

In selecting participants, you may wish to tap the growing awareness within private industry of the importance of involving line personnel in decisions which affect their jobs and working conditions. As applied here, this would consist of including lower level staff, such as patrol officers, mental health counselors, and their counterparts from other service agencies, in policy-making and staff-support groups, together with representatives of top- and mid-management.

In many communities the potential list of participants will be enlarged because the target area in which the new program is to be established consists of contiguous jurisdictions (thereby requiring, for example, the participation of both city and county agencies) or by an overlay of state services in addition to locally provided aid. Although it is desirable, even essential, to include agencies whose ultimate participation in carrying out the new program can be foreseen, there are off-setting considerations: too large a group erodes the participants' sense of involvement and thus becomes self-defeating; and larger groups tend to be more difficult to manage than do smaller ones, other factors being equal.

The question of coalition size may not arise as a practical matter. It will be recalled, for example, that the three model programs discussed in Chapter IV each involved only a small number of agencies other than law enforcement. However, it is conceivable that

other officials or organizations (a city council member, for example, or an advocacy group for the mentally ill) may seek to address issues that include, but go well beyond, the police response. A more comprehensive program of this sort would call for the inclusion of a greater portion of the full spectrum of organizations concerned with the mentally ill. In this event, you may well be compelled to confront the possibility of an unmanageably large planning consortium.

One organizational structure that is relatively well-suited to larger groups uses a building-block approach to the problem. Under this approach the problem is first broken down into its component elements, which are then dealt with one after another. Only those agencies whose participation is required to deal with that phase of the overall problem being addressed at any given time are actually involved. Thus, for example, police membership in the planning group would terminate when preparations for the new police response had been concluded. Similarly, other organizations would be involved only to the extent that their participation was vitally needed.

The other matter of major importance to be considered during the pre-planning phase is the organization of the agency's own resources. Obviously, the chief executive's active participation and support are essential. In addition, however, research suggests that the involvement of middle management personnel in the planning of change contributes importantly both to the quality of the planning process and to the successful implementation of the new program.

O'Neill (1982) has shown, for example, that an officer's decision to take advantage of a mobile crisis unit is greatly affected by the support a supervisor shows for the unit. In the majority of cases, the officers' first contact with the unit was prompted by a supervisor's suggestion. In some agencies managers go still further to involve selected line personnel not only in the staff work required to develop the information upon which new policy is founded but, as has been mentioned, also in the making of that policy. As with middle-manager involvement, this approach can bring into play perceptions, insights, and information that otherwise might be overlooked. It also helps to give line staff a stake in the new program, thereby encouraging commitment to its success.

## 2. Problem Definition and Analysis

Once the preliminary preparations have been concluded, the actual planning process can get under way. The membership and organizational structure of the planning group will have been decided at this point and the first meeting will have been commenced.

One of the first activities of the planning group will be to achieve a thorough understanding of the nature of the problem posed by the mentally ill in the community and how the major involved agencies currently respond to that problem. This component of the planning process will determine the response strategy to be implemented.

Each of the major involved agencies should be directed to identify the specific dimensions of the problem from their perspective and to document their current response, including the laws and agency policies that underlie that response. This information should be presented to the planning group, both orally and in writing, for their review and analysis. It may be well to ask the participating agencies to undertake this study prior to the first meeting of the planning group so that the group does not have to lose any time in getting down to business once it begins to meet.

Outlined below is a problem-oriented approach to identifying the problem from the perspective of the law enforcement agency. This approach was used by Madison, Wisconsin, and Galveston County, Texas, in setting up their programs (see Chapter IV), though in somewhat different forms. The approach outlined here and the specific questions to be answered, as contained in Appendix D, were taken from the works of Goldstein and Susmilch (1981), which were instrumental in the development of Madison's program.

a. Identifying the Problem. The earlier "scanning" of the problem was aimed at obtaining a general understanding of the problems and the issues involved. This examination of the problem seeks specific answers to questions about how the police become involved with the mentally ill, the frequency of such encounters, the characteristics of the individuals and the incidents, how the police handle the

incidents, and why they respond in the manner they do. The answers to these questions will be found in departmental records, police reports, and officers' verbal accounts of their encounters with the mentally ill.

Appendix D contains a list of detailed questions that will guide the department in its examination of the problem. The first group of questions is aimed at quantifying various aspects of the problem and identifying the characteristics of the encounters: What percentage of police business involves dealing with the mentally ill? How many calls for assistance are received from the mentally ill themselves? From third parties? What type of behavior is involved? Where do the incidents occur?

The second group of questions in Appendix D focuses attention on the basis of police authority in dealing with the mentally ill. These questions prompt a review of the laws and statutes that provide the foundation for police decisions to arrest, detain for examination, or otherwise handle a mentally ill person who is the subject of police assistance.

b. Assess the Current Response. The third group of questions in Appendix D leads to a thorough assessment of the current police response. In developing solutions to a problem, a natural tendency is to forget the current response and to develop a new one. The current response should be examined for two reasons, however. First, certain

elements of the current response may be both effective and appropriate and should be retained. Second, those elements that have been inappropriate can be identified so that they are not included in the new response. Moreover, the identification and documentation of inappropriate responses will prove helpful in convincing both the community and the department's officers of the need for an improved response. Examining the current response will enable the department to accomplish the following:

- Establish more precisely the relationship between what the police are doing and the substantive problem that triggers a police response (e.g., ignoring cases leads to repeat calls).
- Identify factors that limit the effectiveness of the current response (e.g., incomplete procedures).
- Detect any negative or unanticipated consequences of the current response (e.g., response by uniformed personnel elicits violence).
- Discover responses that are effective (e.g., Officer Smith's nondirective approach).
- Identify activities that are useless (e.g., sending a SWAT team on every call involving a mentally ill person).
- Provide a basis for evaluating police and community policies (e.g., identify shortcomings).

Assessing the current response requires moving away from the details of individual incidents, which is the focus of the first group of questions, and focusing instead on the broad, general, and abstract nature of both the problem and the response. Look at the reasons for

the problem response from the police perspective. Such factors as a lack of community care or a lack of shelters for the homeless may dictate certain aspects of the police response. Another reason may be that the police have the community's only 24-hour response capability. Examining the broad and general nature of the response helps to surface deficiencies which otherwise might not be spotted. Such a review, for example, might reveal that although police services are generally satisfactory, nothing is being done to educate retail businessmen in areas frequented by the mentally ill about alternatives to calling the police when they need assistance.

The examination of the current response should also include an assessment of the costs of that response. Determining the costs of police operations in managing the mentally ill may be one of the most influential factors in gaining public and governmental support for an improved response system. Costs are most often described as financial, and this is the type of cost that many communities are most concerned with. Galveston County and Birmingham (see Chapter IV) for example, have carefully documented the savings realized through their new response systems. Yet, the expenditure of tax dollars is only one cost to be considered. Costs incurred by the mentally ill, such as denial of treatment, stigmatization, and in some cases death or attempted suicide due to improper management, are difficult to quantify but must be considered. So, too, should the nonfinancial costs to the department and its officers, such as the frustration and waste of time

resulting when an entire shift is spent trying to locate a service agency willing to assist, and the dissatisfaction that results from rarely receiving feedback regarding a final disposition. When taken together, the various types of costs, though sometimes minor by themselves, can demonstrate the need for and even the design of, a new system for managing the mentally ill.

The fourth group of questions in Appendix D will also help to identify shortcomings in the current response and possible remedial actions. From this analysis, you can begin to devise alternative strategies for handling the mentally ill that can be presented to the planning group for consideration.

A final word of caution. Use all relevant sources of information in examining the police response. This will not only provide a comprehensive understanding of the response but will also eliminate the tendency to place too much emphasis on one source. In reviewing officer reports, for example, remember that the reports are used for a number of reasons and may not accurately reflect the actual management of the incident. Written procedures and training materials reflect official guidance, but official procedures are often circumvented by unofficial actions. Thus, sources of information should be augmented by interviewing officers and by on-scene observations, if possible. Observations and interviews will yield information on the variety of responses possible at the incident level. The ways in which officers handle situations can be as numerous as the number of officers

involved. Conversely, responses can often become highly routinized regardless of the specific factors attending each incident.

Whether the police response is uniform or varied, it is also helpful to identify the factors that influence the response. These factors might include pressures from superiors, misconceptions about how to treat the mentally ill, red tape or delays at a hospital emergency room, a lack of recognition--officially and unofficially--for effectively handling this population, and poor working relationships with the examining doctors and mental health professionals.

### 3. Explore and Choose Alternatives

If the previous steps in this process have been carried out thoroughly and imaginatively, selecting the appropriate response strategy could be a relatively easy matter. Gaining an understanding of other community agencies, examining programs at work in other communities, identifying the problem, and assessing the current response from community-wide perspectives should have identified the major components necessary to the solution. The process of developing a new response system, then, would entail systematically arranging previously identified components into alternative configurations and evaluating the results.

Once possible solutions have been identified, criteria for choosing the most efficient and effective one must be delineated.

Agreement on the criteria is necessary as is their clear articulation. These criteria will vary with the community and the nature of the problem it faces and, as a result, there is no single formula for choosing a solution. A successful effort at making a choice, however, requires that all involved parties have a clear understanding of why one solution is chosen over another. Answering the following questions should prove helpful in determining the relative priorities to be given to possible solutions:

- What impact will the new response have on reducing injury or death (e.g., eliminating injuries due to improper handling)?
- What potential does the response have for reducing the total problem (e.g. reducing inappropriate incarcerations, hospitalizations, and repeat calls; increasing use of informal dispositions; increasing support services)?
- What potential does the response have for improving the handling of incidents (e.g., removing the person from the scene without attracting a large crowd)?
- To what extent will community concerns about the mentally ill be reduced?
- To what extent is the program preventive in nature (e.g., identifying a person with two or three recent police contacts so that appropriate action can prevent the need for further contacts)?
- What effect will the response have on individual freedom (e.g., bizarre behavior alone does not require incarceration or hospitalization)?
- What will be the financial cost of the response (e.g., sending three cars and a SWAT truck would not save money)?
- To what extent are the police provided both the authority and resources necessary for full implementation (e.g.,

identifying situations in which temporary detention for examination is allowable)?

- With what ease can the solution be implemented?

The last question seeks to determine whether the response system can accomplish its goals. The following factors are involved:

- the people who must implement the system (e.g., their support and appropriate use);
- the level of impact or change the system requires (e.g., changes in law, involvement of community resources, length of time to implement); and
- the physical or technical nature of the system (e.g., access to facilities, transportation, new forms).

Of these factors, perhaps the one that deserves the most attention is the people throughout the community who must implement the system. Without their support, the system can easily fail through inappropriate use or lack of use. This potential problem, however, can be averted by including representatives of the major involved agencies in the planning phase.

The second factor that contributes to the ease of implementation and that might also cause the planning group to alter aspects of the new system is the level of impact. An overly ambitious solution might prove too difficult to implement either because it requires radical changes in the operations of community agencies or because it would require years for full implementation to be achieved. In this

instance, it may be necessary to phase in the new response system, beginning with those components that address the most critical needs.

The third factor, physical and technical changes, must also be considered. A new system might, on paper, appear quite effective. Yet, in reality, officers might quickly become upset with the system because it requires transporting a subject to a distant facility or an extensive amount of paperwork.

#### 4. Resource Mobilization

Having chosen the new response strategy, the planning group must next mobilize the resources needed to implement that strategy. Each of the involved agencies will have to evaluate what resources at its disposal can be used to support its part of the program, what, if any, additional resources will be required, and what other resources it can contribute to the overall program. If the new program requires only that the agency develop or improve policy, procedures, and training, the agency can likely do so within the context of its regular department budget. The establishment of a 10-officer special unit, however, would require the allocation of significant additional resources for salaries, training, and physical facilities. Between these two extremes there may well exist a number of options, at least some of which can be implemented through the reassignment of existing resources.

Coordinated actions by the involved agencies should lead to more effective use of existing resources, for example, than if the various groups operate separately. Streamlining the procedures in a psychiatric emergency room will save time for both the hospital staff and officers who bring in subjects for an examination. Even if new money is necessary, the savings accrued through increased efficiency can help to offset those costs.

If additional funding will be required to implement the new program, the planning group may want to submit a coordinated budget to the local funding authority (a city council, for example) rather than seek piecemeal funding through individual agency appropriations. Presenting a comprehensive plan and budget to the funding authority will enhance that body's understanding of how the individual agency requests fit into the overall plan.

#### B. START-UP

The last step before the new program can be implemented is to set in place the policy and procedures that will guide the operation of the program and to train the involved staff in their use. Much of the start-up preparation will have to be done individually by each of the agencies directly involved in the new response system, but the planning group should be kept advised of progress in this regard and should be given the opportunity to review each agency's policy statements and

procedural directives. The planning group will also be instrumental in arranging for a sharing of interagency training resources.

This section describes how the police department should approach transforming the conceptualization of the new response strategy into written policy and procedures and a training plan. Chapter VI suggests what the content of the procedural directives should be and Appendix E contains several sample directives on procedures for handling the mentally ill. The discussion in Chapter VI can also be used to guide the development of a training curriculum.

#### 1. Preparation of Policy and Procedures

Reducing policy and procedures to writing is more of a mechanical than an abstract process. If the problem has been identified and broken down into its basic elements and a solution has been developed, policies will be natural outcomes of those processes. What remains for the law enforcement agency is the process of articulating this information in a manner that is easily comprehended.

Depending on the scope of the new police response, policy may have to be written for both patrol personnel and for personnel within a special unit. In any event, the policy must be explicit and practical and the process of its development must be flexible.

Written policy statements direct agency personnel toward uniform goals and objectives. They must be clear, must accurately

present the agency's position in a positive manner, and must reflect the agency's commitment to the program. Yet, the agency must ensure that the policy does not overly restrict an officer's discretion in reaching a disposition. Policy is different from procedure in that it should be a broad, general statement of the values and principles that guide officers toward the achievement of agency objectives.

Policy statements are beneficial not only because they guide officers, but also because they aid in the supervision and evaluation of officers and serve as training aids for instructors. In some agencies, policy statements have been compiled into a single document. In others, policy statements are included with written procedures, usually in one of two ways. First, a clear and concise policy statement can be a preamble to the procedure, providing the context within which the officer is to follow the procedure. Second, the intent of the policy can be incorporated into the procedures. If the policy is to be included with procedural directives, it should be clearly set apart so there is no room for misinterpretation.

Written procedure should provide officers with specific guidance for dealing with mentally ill persons and mental health agencies. The directives should not prescribe strict, unalterable procedures that do not allow for generalization in different types of encounters. Rather, because each encounter is different, the directives should provide officers with enough information and guidance to determine an appropriate disposition. Thus, careful attention should

be paid to allowing officers the opportunity to exercise discretion. This discretion, however, must remain in a context appropriate for incidents involving the mentally ill. In other words, officers should be provided a number of dispositions, all of which are deemed appropriate for encounters with the mentally ill in general. The officer then has the responsibility for determining a disposition appropriate to the specific incident. For example, the following alternatives are possible:

- counsel, release, and refer the client;
- counsel, release to family, friends, or community house, and refer;
- consult with a mental health professional;
- obtain agreement to voluntary examination;
- detain for involuntary examination; and
- arrest.

Along with listing appropriate dispositions, the directives must also explain the circumstances that determine whether a particular disposition is appropriate. For instance, a person who is exhibiting minor aberrations and who is under the care of a doctor or specific treatment program is not a candidate for an involuntary examination. Similarly, an extremely excited and agitated person who has just committed a felony and who does not meet the criteria for an emergency temporary detention should be arrested. (See Chapter VI for a further discussion of dispositions.)

To further assist officers, procedures should include criteria for emergency detention (as contained in state statutes) and

an explanation of the criteria. The telephone numbers, addresses, and hours of operation of mental health centers and other social service agencies should also be included, along with the names of contact persons within each agency, if appropriate. Additionally, any procedures requiring uniform or specific steps, such as obtaining mental health warrants, should be clearly outlined.

Misinterpreted or ignored directives are often worse than no directives at all. Hence, in developing policy and procedure, three guidelines should be kept in mind:

- Include the perspectives of persons outside the control of the agency that impact on the management of the mentally ill (e.g., the legislature, the courts, mental health agencies).
- Include the perspectives of agency personnel who are familiar with or who must manage the mentally ill (e.g., middle management, patrol officers, and special operations team personnel).
- Include illustrative situations, solutions, contingencies, and information related to the management of the mentally ill (e.g., use of force, crisis-unit procedures, social service referral agencies, and procedures for transporting subjects).

Following these three guidelines will greatly facilitate the implementation of the new directives. The first guideline is important in that outside actors greatly influence what an agency can do. State law regarding commitment procedures and the officer's role in this process must be clearly understood and should be included in the procedures. The court and the prosecutor's office can provide

assistance in interpreting new or unfamiliar laws. Through either a formal or informal process, any community agency that was directly involved in developing the response strategy should review and comment on written directives. Ultimate responsibility for drafting police directives rests with the chief executive. These groups, however, can be helpful in providing the agency with guidance in areas in which they have more expertise. Mental health professionals, for example, could review the procedures to ensure their completeness and suitability for the type of incident at hand. Also, the department's legal advisor should review all drafts of policy.

Although the actual drafting should be done by the department's planning officer or other specialist, it is recommended that the input of mid-management and line personnel also be obtained. Agency personnel in middle management and supervisory positions will greatly influence whether the new system will be successfully implemented. Including them in the directive-development process will increase the chances that they will support the implementation of the program. Patrol and other personnel who must carry out the program and who are experienced in managing the mentally ill should also be included in the review process. Their knowledge regarding on-scene management of encounters involving the mentally ill can be helpful in eliminating any impractical procedures that might otherwise go undetected.

## 2. Training

Training the individuals responsible for implementing the new response system is the next step. As with policy and procedure, the

types of training programs to be developed will be determined by the scope of the new system. In any event, the agency should first examine existing recruit and in-service training curriculums to determine where changes are needed. More specific and intensive training programs may have to be developed for an officer filling the position of mental health liaison and for officers in a specialized response unit.

Along with improving its own training program, the law enforcement agency should be prepared to provide orientation training for mental health staff who will work with the police department. Both agencies should devote a portion of their training to the philosophies and procedures of the other agency, and the two professions should combine and share resources in this regard.

Cross-training sessions between law enforcement and mental health personnel often provide a basis for forming positive working relationships. It is important that the persons who will be most involved in the response system are also involved in the training. This could include mental health crisis staff, the officer responsible for mental health liaison, and the officer who will command a special unit. Cross-training gives each agency the opportunity to receive information consistent with the policy and procedures to be implemented and to become familiar with the expectations of the individuals responsible for the other agency's involvement. This reduces the chances of officers'

hearing one thing in the classroom and another in the field. Another benefit of this method is that it facilitates the development of amicable relationships among personnel from each agency. For example, other factors being equal, a patrol officer is likely to be more willing to contact a crisis unit if he knows the individual who will respond.

The value of recruit, in-service, and cross-training experiences in mental health matters cannot be overestimated. Numerous studies, especially those of Patrick (1978), Levinson and Distefano (1979), Janus, Bess, Cadden, and Greenwald (1979), and Teese and Van Wormer (1975), have demonstrated the positive effects of mental health training for police officers. Teese and Van Wormer found, for example, that officers, after mental health training, view the mental health system and its professionals in a more positive light. The mental health system came to be seen as a resource capable of assisting in the management of the mentally ill. Additionally, the officers were far less suspicious of mental health professionals and were willing to consult with them. Janus, et al. (1979), also found that police officers developed respect for mental health professionals and felt less apprehensive about expressing themselves when discussing mental health issues. Perhaps most importantly, officers' attitudes toward the mentally ill themselves were changed. Prejudice toward the mentally ill, born of fear and ignorance, was minimized. Anxiety in dealing with mental health problems was reduced and officers proved to be quite empathetic about the problems of the mentally ill.

As seen above, the attitudes and behaviors of officers can be changed when they are provided with a comprehensive program of instruction. Obviously, attitudes of officers will also be influenced by departmental policy and the effectiveness of the new response system. But the first step must be made in training. The department must convey to officers that calls involving the mentally ill, though often difficult to manage, are not a nuisance or an exercise in futility. Officers must realize that the department is committed to managing this population in the most effective manner possible. Information presented must be relevant to the problems officers encounter and must be presented in a clear and interesting way. Squeezing a curriculum of this type into a half-day session will not suffice. For officers to receive adequate instruction in this area, a minimum of 16, or more, probably 20 hours, will be necessary.

Training curriculums for recruit and in-service classes should cover several important, diverse, yet closely related topic areas. Listed below is a basic outline that includes topic areas most beneficial to improving an officer's response to the mentally ill.

I. Nature of the Problem

- A. Types of calls being handled by police
- B. Citizen attitudes toward mentally ill

II. Understanding the Mental Health System

- A. Current perspectives on treating the mentally ill
- B. Community care

- C. Services of local community mental health center and other agencies and institutions that deal with mentally ill
- III. Understanding Mental Disorders
- A. Differences between mental illness and other aberrant behavior, including causes
  - B. Types of mental illnesses, particularly those likely to come to the attention of the police
  - C. Effects of medications and illegal drugs
  - D. Reasons why the mentally ill attract police attention
- IV. Legal Implications
- A. Legal definitions of mental disorders
  - B. Criteria for temporary detentions and civil commitments
  - C. Procedures for initiating temporary detentions and civil commitments
- V. Procedures for Officers
- A. Departmental policy and procedures
  - B. How to recognize and handle the mentally ill
  - C. Homicidal and suicidal risk assessment
  - D. Use of discretion
  - E. Reports
  - F. Follow-up
- VI. Referral Agencies
- A. Mental health agencies
    - 1. services provided
    - 2. hours of operation
    - 3. staff to contact
    - 4. procedures to assist officers
  - B. Social Agencies
    - 1. services provided
    - 2. hours of operation
    - 3. staff to contact
    - 4. procedures to assist officers

Within this outline, there are numerous possibilities for varying the way the information is presented. For some topics, methods other than lecture are often better suited to conveying information. Instructors can use videotapes or movies, reading materials, role-plays, guest lecturers, panel discussions, and site visits. As noted above, the use of mental health professionals and the department's liaison officer or specialized-unit commander is essential. Some of the classes should be held in the community mental health center, if possible. This would enable the officers to become familiar with the physical setting and to observe the center's operations. For a detailed listing of recommended readings and audio-visual resources, see Appendix G.

Officers should finish the training sessions with an increased grasp of the nature of the problem, legal concerns, types of mental disorders, ways of recognizing and handling the mentally ill, and procedures for interacting with mental health professionals. The intent should not be to turn patrol officers into mental health paraprofessionals, but rather to provide them with knowledge and skills for managing the mentally ill in a manner beneficial for the subject, the complainant, the officer, and the mental health agency. As such, the officer must have a clear understanding of the following principles:

- Mental illness is not a crime.
- The police department is an essential component in the network of community services for the mentally ill.

- The manner in which officers deal with the mentally ill will impact the condition of the subject and the department's future involvement with mentally ill persons.

Training for the agency's liaison officer, in addition to the topic areas outlined above, should address the tasks specific to liaison. Specifically, this individual must have a thorough knowledge of the operations of the mental health agency. In some instances this would include knowledge of the case histories of individuals who have had repeated contacts with law enforcement officers. This will enable the liaison officer to review reports of later incidents in the light of earlier decisions as to appropriate treatment for the individual.

The liaison officer must also have an awareness of how to mediate potential disputes between officers and mental health workers. The liaison officer must be able to comprehend and present the perspectives of mental health professionals as well as those of police officers. While some formal training will help to prepare the officer for this role, the majority of the required skills are best obtained through hands-on training. Spending time at the mental health agency, going on mental health crisis calls, sitting in on interviews, and becoming familiar with case management skills will all contribute to the liaison officer's understanding of the mental health system.

Training for a special law enforcement unit must be commensurate with the duties of that unit. If the unit is to assume formal mental health tasks, then the training should be of a more

formal nature than that provided to the liaison officer. Tasks such as intake evaluations, residential visits in a mental health rather than a law enforcement capacity, counseling, and diagnosis will require extensive training in a mental health setting. Before a department undertakes such a project, it should be certain that the local mental health system is committed to providing this training.

Training for mental health professionals by the police department is also recommended. If mental health staff are to work with officers and appreciate the concerns and pressures that guide officers' actions, they must have first-hand knowledge of police work. Ride-alongs would enable them to learn about the duties and perspectives of patrol officers. Crisis staff should also be instructed in how to intervene in dangerous situations. This training will facilitate understanding by mental health staff and also help to clarify their role and responsibilities when they are on-scene with police officers.

#### C. IMPLEMENTATION

The required staff and other resources should now be in place, and the new program can be implemented. Depending on the scope of the program and the availability of some of the required resources, the implementation may be phased or full scale. As the program moves into full operation, attention to several considerations will help to keep it on track.

## 1. Tolerance

An important element that can contribute to the success of a new program in which several groups are combining resources to address a problem is tolerance. One aspect of tolerance is attitudinal-- realizing that kinks in the system will be inevitable during the initial stages. A second aspect is procedural. For example, the police department should realize that feedback to officers regarding a final disposition might take longer than originally anticipated. Also, the mental health agency must realize that officers will probably make some inappropriate referrals during the initial stages of implementation. Other areas that might initially require high tolerance levels include the following:

- response time by mental health crisis staff to the scene;
- waiting periods in the mental health center;
- encounters in which on-scene assistance is requested but just not possible; and
- situations in which the mental health agency just does not have an answer.

An initial period of high tolerance, however, should not become an excuse for unresponsiveness. When mistakes happen or problems arise, remedial action should be taken immediately.

## 2. Monitor Program

Although mistakes are inevitable, especially at the beginning, they should not be permitted to go undetected or uncorrected. For this

reason it is recommended that all contacts between police and the mentally ill as well as contacts between the police and mental health agencies be monitored. In the police agency, this will require that a designated individual review and maintain records regarding officer contacts with the mentally ill. The mental health liaison officer or the head of a specialized unit is a logical choice. In an agency using the generalist approach, as in Madison, all patrol officer contacts with the mentally ill should be recorded on an incident report and forwarded to the liaison officer. Reviewing and cataloging these incident records will enable the liaison officer to monitor the types of incidents encountered, the ways in which officers respond, and any deficiencies in the training program or written directives. In addition it will enable the liaison officer to identify persons who have had repeated contacts with the police. The liaison officer or head of the specialized unit can then work with the mental health staff to devise a strategy for obtaining proper treatment for those individuals. The police agency should maintain a copy of these reports for its own files and forward copies to the mental health center, as appropriate, for inclusion in the subject's file.

Each of the agencies involved in the program (e.g., police, mental health, prosecutor, and courts) should take steps to ensure the confidentiality of the subject's records. With community-based treatment, many agencies are involved in providing the services previously

provided by a single institution. Often the provision of services requires access to case histories, but the histories are not always available because the confidentiality rules of one agency prohibit dissemination to another agency. In the interest of community treatment, the relevant community agencies should develop procedures to guide the dissemination of personal records.

### 3. Liaison, Feedback, and Recognition

The establishment and continuation of various liaison efforts will be essential to the success of the program. Within this broad term, four specific tasks are required:

- at least monthly meetings of the planning group;
- frequent, informal, yet substantive contacts between the liaison officer and mental health professionals regarding case management;
- feedback to patrol officers about the final disposition of encounters they handle; and
- recognition and reward for officers who exceed the expectations of the program and provide the mentally ill exemplary care.

While the program is in the early implementation stages, the planning group should meet regularly to discuss policy concerns. These meetings should be a forum in which persistent problems involving agency interactions can be addressed. They should also be used as a mechanism for evaluation and change, if necessary. These meetings will enable each group to remain aware of the concerns of the other agencies

and of the course on which the program is headed. When problems are identified, however, it is best that they be resolved on the operational level. If this is not feasible, then changes on the policy level might be necessary.

Frequent, usually daily, contacts between the liaison officer and mental health professionals will enhance efforts to maintain a positive relationship. Contacts such as these would usually center on encounters between the police and the mentally ill and interactions between the police and the mental health staff. This will enable liaison personnel to discuss procedures, individual subjects, and the performance of mental health staff and police officers. The necessary alterations can then be made to keep the program running smoothly.

A system of feedback for patrol officers, and their immediate supervisors, who refer subjects to or request assistance from mental health staff must not be overlooked. Within 72 hours of the referral or request for assistance, the officer should be informed of the final disposition or treatment plan for the subject. This is a valuable reinforcement mechanism for officers, who, as a result of their actions, have aided a subject. It also enables the officer to understand the reasons for the way the case was handled, especially in situations in which the officer re-encounters the subject. Not knowing why the subject is being re-encountered can cause the officer to conclude that his or her previous efforts were futile. Knowing why the subject was

released and what is being done to avoid future encounters, on the other hand, will help the officer to deal with the subject in a positive manner. Feedback is best accomplished through brief letters or memorandums that can be given to officers by the liaison officer.

Finally, an official system of recognition and reward for officers who handle clients with skill and sensitivity is also recommended. There exists a variety of means for accomplishing this, such as the following:

- letters to superiors commending officers,
- letters of commendation for inclusion in the officer's personnel file,
- selection of these officers for specialized training in this area,
- publicizing the officer's efforts through news-letters,
- presentation of an annual award for the officer making the greatest contribution to the management of the mentally ill.

Few police agencies have a reward system for officers who provide exemplary service to citizens. A system of this type would alleviate this discrepancy and also articulate the agency's commitment to managing the mentally ill in an effective manner.

#### D. CONCLUSION

This chapter has discussed mechanisms by which a law enforcement agency can change the community's management of the mentally ill. In most communities, this will require the re-channeling of existing resources or possibly the expenditure of new resources. The benefits of this effort will be shortly realized if the agency's approach to change has encompassed the steps outlined in this chapter.

It is important that the police and the community as a whole recognize that the problem of managing the mentally ill is a continuing one. Police initiative in this regard can only prove beneficial. First, the agency will benefit by having a clear policy, training programs that will increase officers' understanding of the problem, and explicit procedures that will contribute to effective management and the prevention of encounters that get out of control. Second, police initiative will show the agency's service area that it is committed to improving the community's response to social problems. The example the agency sets can spur other community groups to assist in the management of the mentally ill.

VI  
OPERATIONAL PROCEDURES

Managing an encounter with a mentally disabled person can be a frustrating, unfamiliar, and sometimes frightening experience for a police officer. Attempting to communicate with a person exhibiting bizarre behavior and reaching an appropriate disposition can be a difficult task. One or two bad experiences with deranged individuals or a mental health agency can cause officers to develop negative attitudes toward the mentally ill and mental health professionals. Additionally, officers may develop a disdain for this type of call, which in turn, can contribute to the improper management of these encounters. An inadequate response by officers, such as displacing the problem, ignoring the incident, or effecting an easy but inappropriate disposition can only worsen the problem for the complainant, the subject, and the department. Repeated calls for assistance involving the same subject are often the result. Insufficient training and procedural guidance will force officers to devise their own ways of handling encounters. The resulting response will be inappropriate, at worst, and inconsistent, at best.

This chapter describes procedures to be used by police officers in handling an encounter with the mentally ill. The purpose of the chapter is twofold: First, the information provided will guide the development of the policy and procedure that must be set in place before a new response strategy can be implemented. By addressing each

of the topics included in this chapter when developing written directives, a department will be taking a major step in ensuring the successful implementation of its response strategy. Second, the chapter provides a guide to the types of information that should be included in recruit and in-service training programs to prepare officers for executing departmental procedures. (See Appendix E for exemplary directives prepared by the Omaha, Nebraska, Police Division; the Madison, Wisconsin, Police Department; and the Fairfax County, Virginia, Police Department.)

The discussion of procedures has been divided into two aspects: the intervention process and disposition process. The intervention process begins with dispatch procedures and ends with techniques for handling the mentally ill. The disposition process focuses on how an officer, either alone or with the assistance of superiors or mental health professionals, can arrive at an appropriate disposition.

#### A. THE INTERVENTION PROCESS

##### 1. Receiving and Dispatching the Call

Police operators receive a variety of calls concerning the mentally ill, and each type of call can require its own response. In many instances, the caller, whether it is a complainant or a person in need of mental health care, is only trying to locate an agency that can provide non-emergency services. In other instances, the caller is requesting a police response because an individual is acting bizarrely,

disturbing public order, or committing a crime. The caller may or may not know whether the individual involved has a mental disorder. Still other calls might involve a mentally ill person who is filing a complaint about a problem that, in reality, does not exist. To the mentally ill complainant, however, the problem is quite real--often frightening--and should be treated accordingly. For example, a call from a woman who complains of laser rays from outer space or from a man who insists that he is being followed by an assassin with a gun should not be ignored.

Departments should make certain that written guidelines are available to aid police telephone operators in handling calls involving the mentally ill. In general an operator has four options:

- handle the problem over the phone
- make a referral
- forward for routine dispatch
- forward for priority response.

In cases involving hallucinating callers, the operator may be able to alleviate the problem over the phone, especially if the complainant is a chronic caller. Remaining aware of the frightening event that the caller is experiencing, the operator should not deny the problem but rather concentrate on downplaying its frightening aspects. If this approach is not quickly successful, then a patrol unit should be dispatched if the complainant requests one. In any situation involving violence, threats of violence, threats of suicide, or weapons, a patrol response is necessary.

If it is obvious that the caller's needs do not require an on-scene police response and can be handled by available mental health or social services, then the appropriate referral should be made. To aid operators in this effort, an up-to-date list of referral agencies, crisis hotlines, and suicide prevention services should be readily available and should include such information as contact persons, addresses, telephone numbers, hours of operation, services offered, and who is eligible for assistance.

To assist operators in determining if a police response to a call is necessary, an assessment instrument should also be available. The sample questionnaire included as Appendix F is a good starting point for developing an assessment instrument that reflects the local problem and local statutes regarding treatment of the mentally ill. A professional from a local mental health center could be asked to review the questionnaire for completeness. Remember that the longer the questionnaire is, the less likely that it will be an effective tool.

The dispatcher, upon receiving the necessary information from the operator, should either dispatch the call or assign it a priority for dispatch. In situations involving violence, the threat of violence, the threat of weapons use, or the threat of suicide, a high priority should be assigned to the call.

Departments should consider the extent to which information to guide operators and dispatchers can be computerized. Contact

information for making referrals to community agencies could easily be maintained on a computer system, as could records of all calls involving mentally ill persons. Profiles of mentally ill persons who have come to police attention or whose disorders are of the type that may lead them to come to police attention could also be maintained on-line. The profiles, developed in conjunction with mental health professionals, should include a description of the person's disorders, contacts with police or mental health agencies, treatment history, and recommendations as to how the person should be handled.

## 2. Officer Receipt of the Call

When an officer receives a call from an official source (dispatcher or a court order to pick up or transport), when a citizen alerts an officer's attention to a potential problem, or when the officer notices an individual behaving in an unusual way, the officer should evaluate the situation before taking action. The dispatcher should provide the officer with all available information. Because many calls involving the mentally ill are repeat calls, the officer may be familiar with the individual and may be able to incorporate experiences from previous encounters into the current response. The more information an officer has, the more appropriate the response will be. The officer should also consider his or her basic goals in managing the encounter and how the specifics of the incident will influence the attainment of those goals.

Written procedures should detail the officer's responsibilities in handling an encounter with the mentally ill. Basic responsibilities are as follows:

- Determine whether the person is mentally ill or dangerous.
- Determine if a violation of the law has occurred.
- Determine the appropriate disposition in accordance with the specifics of the incident.
- Initiate action to effect the disposition.
- Accomplish the above tasks while ensuring that no harm comes to the subject, any bystanders, or the officer.

### 3. Arrival at the Scene

When traveling to the scene, an officer should not use emergency lights and siren unless there is an indication that a weapon or violence is involved. To avoid exacerbating what could be a highly charged incident with numerous bystanders, the officer should turn off lights and siren, if used, within a block of the incident. If, on arrival, it is apparent that violence or a weapon is involved, the officer should request a backup. If the incident involves a hostage, a barricade situation, a potential suicide, or other situation with which the officer is not equipped to deal, the officer should contact the appropriate superior or special unit and wait for assistance, if possible. In suicide-threatening situations, however, the officer

should establish and maintain communication until additional resources arrive.

While on-scene, the officer should present a calm, take-charge image. The person who summoned the police may be panicky or distraught. The fact that he or she requested a police officer indicates an inability to deal with the situation.

Before trying to assist the mentally ill person, the officer must bring other people on-scene under control to keep the encounter manageable. Any bystanders who are not witnesses, including disruptive family members, should be asked to leave the scene; they can only contribute to a deterioration of the incident. Provocations from bystanders might only encourage the person to do something dangerous. It is important that these and any other measures that will calm the person and keep the incident discreet and absent of attention be employed. This will enable the officer to keep the incident as manageable as possible and reduce the opportunity for onlookers to stigmatize the mentally ill person. Witnesses and helpful family members, however, should be identified and advised to remain close by. This is especially true when the situation involves a potential suicide.

The first concern of the officer should be the halting of or the prevention of a crime. Once this is accomplished the officer can then begin to sort out the factors on-scene that may influence the disposition. The officer should observe the scene for indications of

bizarre behavior or for results of bizarre behavior. For example, a collection of personal belongings piled in a driveway may have come from an open window. Not only will this observation alert the officer to potential danger but it may also help the officer gain a better understanding of the person and the incident. Family members or witnesses should be interviewed to obtain pertinent information. The officer should also determine if a crime has already been committed as this will affect the range of possible dispositions. If the person is exhibiting bizarre behavior, the officer should try to get specific details concerning the behavior, its causes, and its effects.

The procedures developed for officers to follow on-scene should include the use of a checklist like the one recommended for police telephone operators (see sample in Appendix F). Circumstances may not always permit actual use of the questionnaire, but the officer should be aware of the types of questions to ask witnesses, family members, and the mentally ill person.

The information collected by an officer on-scene will also be beneficial to obtaining a psychiatric examination for the subject, if needed. Quite often the individual's behavior on-scene meets the criteria for an involuntary examination, yet, once at the examination facility the individual is calm and the officer's concern appears unfounded. The use of an assessment instrument can help an officer present valid evidence of the need for an examination.

#### 4. Recognizing Mental Disorders

From the officer's perspective, it is not essential that he or she be able to identify specific types of mental disorders. Rather, the officer must be able to recognize general indicators of mental illness so that appropriate preliminary action can be taken. Depending on the severity of the disorder, the mentally ill can be difficult to distinguish from persons not having a mental disorder. Mental illness is not a form of mental retardation, although a number of persons are affected by both mental illness and mental retardation. Hence, the mentally ill can be intelligent, perceptive, and articulate. They can be employed and maintain familial relationships. With the onset of their disorder, however, they become unable to deal realistically with the world. Their thoughts and actions are not based on reality, and their ability to think clearly is impaired. This level of impairment can vary tremendously not only from person to person but also over time with each person. For this reason, the officer should carefully record any signs of mental illness. As noted, this will be quite helpful in reporting symptoms of mental illness in a person who has since stabilized and now appears "normal."

Three general characteristics are symptomatic of a mental disorder:

- The behavior and mood of the person are inappropriate to the setting.
- The behavior of the person tends to be inflexible.
- The behavior of the person tends to be impulsive.

Within these three general characteristics fall numerous specific symptoms of mental illness.

As noted above, the officer on-scene is not expected to be a diagnostician. Rather, he or she is expected to be able to assess the situation and make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder. Written procedures should remind officers of the more common signs of mental disorders. Recruit and in-service training programs should have provided the context for interpreting these signs by instructing officers in the types and symptoms of mental disorders.

Written procedures should instruct officers to look for the following types of indicators of mental illness when assessing the scene and interviewing the subject, family members, or witnesses:

- Sudden changes in lifestyle
  - can be both a cause and indicator of mental disorder
  - involves an inability or unwillingness to fulfill one's expected role and responsibilities
- Major changes in behavior
  - behavior may have undergone sudden and drastic change
  - behavior may be marked by exaggerated mood swings
  - person may show lack of judgment regarding family, job, money, or property
  - person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic, or fright
  - anxiety is intense and unfounded
  - person is in a state of panic or fright
  - person may be hallucinating or in a state of delusion (see below)
  - person may have trembling hands, dry mouth, or sweaty palms
- Believes others are plotting against him
  - person has an unreal fear of being watched, talked about, followed, persecuted, or harmed
  - person cannot separate reality and imagination
- Hallucinations
  - person experiences events that have no objective source but that are nonetheless real to him or her
  - can involve any of the senses but most common experiences are seeing or hearing things
  - can also be induced by drug or alcohol abuse
- Delusions
  - personal beliefs that are not based on reality
  - can cause person to view the world from unique or peculiar perspective
  - often focus on persecution or grandeur
- Depression
  - accompanies many mental disorders in varying degrees
  - often characterized by a persistent, general malaise
  - serious depression can involve withdrawal from family, job, and social involvement

- Obsessions

- recurrent thoughts, ideas, or images that person cannot dismiss from mind

- usually involve behavior that person finds unacceptable

- can cause tension and high level of anxiety

- Unexplained losses of memory

- person cannot remember the day, year, where he is, etc.

- not to be confused with loss of memory that often accompanies aging

- Confusion

- inability to focus on particular topic or interactions

- might be an indication that person has an obsession

- also caused by stroke, diabetic coma, intoxication, senility.

Persons who are mentally ill must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are often uncomfortable or annoying. Unlike hallucinations, these are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize anything is happening. As with other symptoms, the side effects are not exclusive to medication for the mentally ill and a determination of mental illness should not be made solely on the basis of their existence. Some of the major, noticeable side effects are listed below:

- minor stiffness; a rigid, shuffling gait;
- an at rest, hand jerk;
- acute muscle spasms, tilted head;
- a constant, fine, fast tremor;

- blurry vision;
- a rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or--in severe cases--facial distortion.

(The material in this section was drawn from Matthews and Roland [1979: 3-7] and Russell and Biegel [1976: 59-65]. See Appendix B for a more clinical description of major mental disorders and Appendix C for a discussion of four conditions that can accompany or be confused with mental illness--personality disorders, crises behavior, suicidal tendencies, and mental retardation.)

#### 5. Handling the Mentally Ill

Though for the purposes of this chapter procedures for recognizing and handling the mentally ill are discussed separately, in reality the two efforts are often intertwined. In order to determine whether a person is mentally ill, the officer will usually have to interact with the person. This is especially true in situations in which others are not available to provide information about the subject.

Training in various techniques for communicating with and handling the mentally ill will put the officer in the best position to manage the situation successfully. As noted above, the officer should

follow these guidelines before interacting with the person on-scene.

- Gather as much information as possible before arriving on-scene.
- Be discreet and avoid attracting attention.
- Be calm, avoid excitement, and portray a take-charge attitude.
- Remove as many distractions or upsetting influences from the scene as possible--this includes bystanders and disruptive friends or family members.
- Gather as much information as possible from helpful witnesses, family members, and friends.

By first getting the situation under control, the officer will be in a position to interact with the person and effect a disposition with a minimum of distractions.

When first approaching the person, the officer should be aware of the potential for violence. Though involvement with a mentally ill person is not usually dangerous and the likelihood of violence is no greater than with anyone else, the officer must remain aware of the potential. Accordingly, the officer should position himself in relation to the person so that the possibility of being struck or hit by flying objects is minimized. He should not rush or attempt to overpower the person unless someone's safety is being threatened. If the person is acting dangerously, but not directly threatening any other person or himself, the person should be given time to calm down. Time is the officer's ally. Violent outbursts are usually of short

duration. It is better that the officer spend 15 or 20 minutes waiting and talking than to spend 5 minutes struggling to subdue the person. Communication, rather than intimidation or force, is the most effective tool.

While, or immediately after positioning himself, the officer should begin the process of interaction. Reliance on the technique of firm gentleness is recommended. Though seemingly a paradox, this technique is quite effective. The person should be treated gently and with care. Firmness consists of assuming a take-charge and insistent attitude, but without intimidation.

The next step should be for the officer to introduce himself and the reason for his presence. For example, the officer should tell the person that he is there to determine what the problem is and how it can be solved without harming or inconveniencing anyone. It is essential that a tone of helping be established if the officer is to handle the situation effectively. Taking a tough guy or adversarial approach will only exacerbate the situation, as will threatening or abusing, either physically or verbally. Tough methods will usually frighten the person and cause him or her to react in a defensive and possibly violent manner. Himmelsbach (in Goldstein 1979:70-71) makes a useful analogy between a mentally ill person and a frightened animal in need of help. "You would not attempt to rush in and grab the animal while yelling and screaming at it. Instead, you would make slow cautious

moves, talking to the animal in a quiet, calming voice, all the while easily approaching it."

Once initial communication has been established, the officer should build on this helping and non-threatening foundation. If the person is in an open public space or other area where attention is easily attracted, the officer should try and relocate both the person and himself to an area more conducive to calm conversation. Avoiding excitement and attention will often help the person to relax and will ease the process of determining a disposition. If the person is reluctant to move elsewhere, the officer should not rush him. Rather, the officer should talk about the idea some more and remember that giving the person a little time can often allow him to change his mind. If the officer does approach the person, he or she should remember to maintain a comfortable personal space. As with aggressive or threatening tactics, crowding the individual's personal space may cause fright and provoke a defensive reaction. Also, the officer should be aware that the trappings of his uniform--gun, handcuffs, and nightstick--may frighten the person. The officer should explain that they are necessary to his job and are not intended to hurt the person. Indeed, explaining how these instruments will keep away the person's enemies may neutralize their otherwise intimidating nature.

The subject should not be cross-examined with a flurry of close-ended questions (i.e., "yes" and "no" questions). Instead, the person should be asked questions that allow him to explain the problems

that are bothering him. For example, it is better to ask: "What types of fears do you have?" and "What is causing those fears?" rather than: "Do you have any fears?" A sincere and open-ended approach will often help the person to relax and provide specific information that will assist the officer in reaching a disposition.

When the person talks about specific problems or complaints that concern him, the officer should listen attentively but avoid commenting on them. Instead, he should concentrate on identifying the person's underlying problem. For example, the person may claim that the waitress serving him is poisoning his food and that the vendor outside is waiting to kill him. The officer should not dispute these complaints but should offer a comment such as: "You believe that other people are trying to kill you." This approach avoids debates and arguments about the possibility of these events and shows the person that the officer understands the problem he is experiencing. Disputing the person's claims is fruitless. Often, these complaints are a result of delusions or hallucinations, although to the mentally ill person the problem is real. Thus, any attempts to invalidate or offer advice will not benefit the officer in attempting to reach a disposition. By conveying to the person his impression of the person's feelings, the officer does not agree or disagree with any statements but only legitimizes the person's feelings. This is the best approach to communicating with the mentally ill.

Occasionally, an exception to this approach may be warranted, but the exception should only involve situations in which the mentally ill person is the complainant. For example, the chronic caller who complains about death rays from another planet may best be handled by pretending to make an interplanetary communication over the cruiser radio. Generally speaking though, it is best to avoid specific statements and focus on general problems.

The thrust of the discussion above can be summarized into seven basic guidelines. If these are adhered to, the likelihood of successful interaction between the individual and the officer will be greatly enhanced. And if communication is possible, the chances of inappropriate action can be reduced. Thus, the officer should always try to interact with the person while keeping the following in mind:

- Avoid excitement, confusion, or upsetting circumstances. These may frighten the person, inhibit communication, and increase the risk of physical injury to the subject and other persons at the scene. This includes abstaining from using words such as "psycho" or "nut house."
- Do not abuse, belittle, or threaten. Such actions may cause the person to become alarmed and distrustful. A firm, all-business approach is best.
- Do not lie or deceive the person. This can also cause the person to be distrustful. It may also limit any chances for successful treatment and make any future management of the person by officers more difficult.

- Do not rush the person or crowd his personal space. Any attempt to force an issue may quickly backfire in the form of violence.
- Do not let the person upset you or trick you into an argument. Ignore any attacks on your character, physical appearance, or profession as these will undermine your ability to communicate and will also provide the person with ammunition for future attacks.
- Remember the principle of firm gentleness. With a take-charge attitude and an insistence on your orders being followed, gently indicate that your only intention is to help the person.
- Remain professional in your contacts. You can empathize and lend an ear without becoming too familiar with the person. (See Matthews and Roland 1979:8-11 and Himmelsbach, in Goldstein 1979:72-73.)

The guidelines above embody one common element: communication. Communication allows the officer to gain valuable information regarding the problem. It also enables the officer and the subject to understand each other and, in turn, reduces the tension that accompanies these encounters. If there is any "key" to working with mentally disordered persons, it is being able to listen to their complaints and their frequent tirades without becoming defensive and threatened. Allowing the subject to get his message across to another person who then says, "I understand", is the vehicle that allows the mentally disturbed person to be helped (Himmelsbach, in Goldstein 1979:73).

In addition to providing general guidelines, written procedures should include specific ways for handling situations officers are likely to encounter. Himmelsbach has identified six situations

that are most often encountered by police and the best way for addressing them. The following situations have been excerpted from his work in Goldstein (1979:73-77).

- Subject is Compulsive Talker - Persons engaged in compulsive talking produce a stream of sometimes meaningless chatter at a rapid, almost non-stop rate. These are understandable communications, but bear little or no relation to the problem at hand. This behavior indicates high levels of anxiety. If your requests to slow down are not effective, you can interrupt the compulsive speech pattern by asking the individual specific concrete questions. For example, ask his birth date or address; ask him to give the full name of his children or his parents; or ask him where he works or goes to school. Your goal is to interrupt the speech in order to break its pattern and bring it somewhat under control.
- Delusional Statements - Delusions are unique ways of viewing the world, and delusional statements frequently come into conflict with the views of others. There are three possible responses to delusions:

- agree with them
- dispute them
- defer the issue.

If you agree with the mentally disturbed person's delusion, you put yourself in a position of being ineffective in your attempts to provide the person with help. The individual could legitimately ask, "Why do you want me to go to the hospital, since you agree that what I say is true?" Such agreement can also have the effect of increasing the subject's upset state, since the delusion is only a means for him to reduce his anxiety. To have others begin to believe in "his world" may be more frightening than helpful.

The next option, disputing the delusions, is equally ineffective. A direct confrontation with the subject over his disordered thinking may well result in his withdrawing from the person making the attack. He will become inaccessible, or arguments may ensue. This might result in the individual's acting out aggressively due to the threat he experiences.

This leaves the third option, deferring the issue. In this response, you do not agree with or dispute the person's statement; rather, you acknowledge the person's view of the world, indicate that it is not your own, and follow with a statement of how you understand the person's feelings. An example of this type of response would be:

Subject: There are many people who want me dead.  
There is an organization on T.V. which  
had my name on T.V.

Officer: I can see you're worried about someone  
harming you. I don't know of anyone who  
wants to hurt you, but I really would like  
to assist you in any way I can to help you  
feel safer.

By this response, you neither confirm nor dispute the person's view of the world. Rather, you give the person a message of the availability of help.

- Subject exhibits paranoid tendencies - Paranoia often involves very severe delusions. You must be very sensitive (both verbally and physically) when you respond to such individuals. Paranoid persons are marked by their extreme suspiciousness and tension. They can appear to be very frightening to others.

You must be acutely aware of any indications that the paranoid person is feeling threatened by you. If you detect this fear, you should become as non-threatening as possible, giving the person a feeling that he is in control of the situation. You should neither pick up on any verbal challenge, nor agree that you know anything more about the subject than he tells you. Many paranoid people may say things like, "You know what has been happening to me." Or, "You're a police officer, you have those secret records on me." You must not confirm that you have any special knowledge about the person.

When you're moving into or around a room in which a paranoid person is present, it is good practice to announce your actions before initiating them. Telling the subject that you are moving across the room to sit in a chair reduces the probability that he will think you are about to attack him. This telegraphing of your actions assumes that your goal is not to subdue the individual physically. Except in situations in which the person must be physically detained, avoid any physical contact with the person.

- Subject is conscious but non-responsive - This happens in cases in which the person may be catatonic or severely depressed. You should never assume that because a person is not responding to your statement, he is not hearing what you say. In these situations, there is the temptation to begin acting and talking as if the subject were not present. This is a mistake. Mental illness does not render a person deaf. Therefore, you should make every effort to obtain a response from the individual. This can be done by quietly asking questions and being sensitive to any types of reply, such as a head nod.

If this is not successful, you should attempt to understand the person's thoughts or feelings and communicate that understanding to him. These "guesses" can be based on the information which you acquire at the scene, as well as on the body posture and emotion the individual may be displaying. By making this effort, you communicate to the subject that you wish to understand his situation. The subject may then feel less threatened about discussing his difficulties with you.

- Subject is hallucinatory - Hallucinations are very frightening for the person who is experiencing them. Difficulties emerge when the person is actively hallucinating in the presence of the officer. The first response you must give is to validate the hallucinatory experience for the individual, but, at the same time, indicate that the hallucination does not (objectively) exist. If an individual is seeing or hearing things, you must indicate that you understand that those experiences are real and frightening for the subject, but that they do not exist in reality. Second, you must firmly and empathetically indicate that those sensations are due to the extreme emotional stress that the person is experiencing, and that once the stress is lessened, the hallucinations will disappear. You may have to repeat this reassuring message many times before the individual can begin to respond to it.
- Subject is psychotic and aggressive - This is probably the most troublesome situation for any police officer to respond to effectively. If the subject is in the act of attacking you or another individual, there is no question that you should respond with your police control skills. However, in many instances, the subject will not be acting out, but will be threatening someone. He may be waving his fists, or a knife, or yelling. If the situation is secure, and if no one can be accidentally harmed by the individual, you should

adopt a non-threatening, non-confrontative stance with the subject. You may point out that you do not like to get injured or beaten up, that there is no need for the individual to threaten you because you are going to "listen" to him, that getting into a pitched battle with you may cause more problems than it will solve.

You should then begin talking to the subject as outlined earlier, allowing the individual to vent some of his hostility. You can also indicate this low-threat, low-offensive style by sitting down, removing your hat, or otherwise trying to put the person at ease. Sit a comfortable distance from the subject, move the chair so that its back faces the subject, and straddle it. This permits you to use it as a protective block if the person suddenly charges you, it's essential that you appear relaxed and non-threatening, but you must also be on your guard.

#### 6. Physical Force

In situations in which physical restraint or force is needed, the officer should not hesitate to take the necessary action. As noted above, however, excessively emotional or even violent outbursts by the mentally ill are often of short duration. It is better to let the outburst dissipate rather than wrestle with a person who is under extreme emotional stress. Bizarre behavior alone is not reason for physical force.

Only when the person is so dangerous or violent that himself or another is likely to be harmed should force be used. As in all situations, using the least amount of force necessary to accomplish the task is the prescribed method for stopping the outburst. Stories about the mentally ill having super-human strength may sometimes be overly

dramatized, but in most cases, they are not far from the truth. Increased adrenalin and an insensitivity to pain often create a situation in which at least two officers are needed to restrain the person. The presence of several officers might also alleviate the need for physical restraint. Quite often, a show of force will allow the person a face-saving way out of physical restraint.

If, however, the officers do have to restrain the person it should be accomplished quickly. The officers should first attempt to maneuver the person into a spot where he can be overpowered with the least risk of injury to anyone. They should be wary of any objects the person could use as weapons. The person should be restrained by grabbing him by the arms and wrapping him in a blanket, sheet, or coat. If these methods do not work, only then should handcuffs be used. Insensitivity to pain can cause the person to cut or bruise his wrists or to fall and injure himself. Handcuffs, if used, should be double locked to lessen the chance of wrist injuries.

Several types of gadgets or devices are designed to immobilize or incapacitate enraged persons. Some of these are quite elaborate and produce electrical charges, spray water or mace, or hurl missiles or beanbags at the person. Others are much simpler and include nets, long poles, and lassos. These instruments can serve a useful purpose in extreme situations and have probably prevented injury or death on occasion. However, they should be reserved for only the most extreme encounters. What works best and what is most beneficial

to the well being of the disturbed person and the image of the department is patience and communication, neither of which these devices encourage.

#### B. THE DISPOSITION PROCESS

The officer should constantly evaluate the behavior of mentally disordered persons, their background, their support network within the community, their possible involvement in a crime, and the seriousness of the crime, refraining from making a disposition until as much information as possible can be gathered through the preliminary investigation. If the law enforcement agency has developed a relationship with a local mental health agency whereby joint efforts are used to determine a disposition, the officer's job can be considerably easier. If such a relationship does not exist, the officer on-scene, perhaps under the direction of a supervisor, will have full responsibility for reaching the appropriate initial disposition.

An officer's disposition for any situation involving the mentally disabled will depend on two factors:

- the nature of the situation, and
- the behavioral aberration of the individual involved in the situation.

Within these two factors, the officer must choose among six possible dispositions.

- 1) counsel, release, and refer the individual to a mental health center;

- 2) counsel, release to family, friends, or some other support network, and refer;
- 3) consult with a mental health professional;
- 4) obtain the person's agreement to seek voluntary examination;
- 5) detain for involuntary examination; and
- 6) arrest.

As with situations involving persons who are not mentally ill, the officer must exercise his or her discretion in accordance with local statutes and departmental policy. These should be identified and included in the department's procedural directives.

1. Counsel, Release and Refer

If the incident is of a minor nature, the person's mental disorder does not appear incapacitating, and the person does not meet the legal definition of dangerousness, "counsel, release, and refer" is usually an appropriate response. The officer should explain to the person why he or she attracted the attention of the law enforcement agency, whether the attention was warranted, and ways in which the problem can be avoided in the future. For example, the officer can tell the person that his conversation with the alien upsets people and causes them to call the police to investigate. Though no violation has been committed (except perhaps loitering) other people do not

understand why the person talks to aliens and the person should try to keep his conversations low-key.

Before releasing the individual, the officer should be reasonably certain the situation will not recur and that the person can be left on his or her own. If the person is extremely excited, he or she should not be released. If circumstances permit, the officer may want to transport the person away from the scene if the person agrees. Before releasing the person, the officer should also refer the person to an appropriate social or mental health agency. The officer should tell the person that he will be giving the referral agency the person's name, phone number, and address, and that a contact by the agency should be expected within a day or two (if an arrangement such as this exists with the mental health agency).

## 2. Counsel, Release to Family, and Refer

If the incident is minor and the person is not severely disordered, but releasing the person on his or her own would be unsafe, the officer should release the person to family, friends, or a support network, such as a group home. This action is also appropriate if the incident that required police attention is likely to recur if the person is left on his or her own. The officer should recount the incident to the caretaker, make an appropriate referral and, in turn, contact the referral agency. Releasing the person to a caretaker may require the officer to transport the subject. Other means include

sending the person in a cab or having the caretaker meet the officer at the scene or a half-way point for pick up.

### 3. Consult with a Mental Health Professional

Being able to consult a mental health professional in determining a disposition will make the officer's job much easier through the sharing of responsibility and the insight gained through such interactions. Consultation with a mental health professional is often necessary when dealing with the mentally ill, particularly while officers become familiar with managing this population. Because many encounters with the mentally ill fall into the vast gray areas between release and refer and arrest or involuntary examination, professional assistance is needed. This assistance can take one of three forms:

- telephone consultation
- on-scene consultation
- consultation at a central location.

Consultation will enable the officer to receive advice on a disposition and may even result in a disposition. For example, the mental health professional has the expertise and resources to relieve the officer of his responsibility for reaching a final disposition while usually guaranteeing that the incident will not immediately recur once the officer leaves the scene. It must be stressed, however, that simply dropping off a person at the local mental health center,

hospital, or other central location does not qualify as consultation nor as a final disposition.

#### 4. Voluntary Examination

In situations in which the person is mentally ill to a degree that the officer believes the person is incapable of caring for himself and has no one who can provide that care, voluntary examination is an appropriate disposition. The officer should make every attempt to convince the person that an examination is in his or her best interest. A voluntary examination can be effected even when the person does not meet the criteria for involuntary examination but is seriously mentally ill. Moreover, even if the criteria for involuntary examination do exist, the officer should still try to convince the person of the benefit of a voluntary rather than an involuntary examination.

Some persons realize their illness and understand the need for an examination. If they do not, the use of coercion can often work to the officer's advantage. This does not include deception or intimidation but the presentation of the facts of the matter. For example, the officer can offer arrest as an alternative to a voluntary examination if the person has violated the law. Also, refusal of a voluntary examination could quickly result in an involuntary examination brought on by a distraught family member or neighbor. The officer can also explain to the person that a voluntary examination is not an admission of mental illness and does not necessarily result in hospitalization.

By keeping it voluntary, the person maintains more control over the final outcome than if it is involuntary.

#### 5. Involuntary Examination

An involuntary examination is appropriate when the person is suffering from a serious mental illness, is dangerous to self or others, is unable to care for his or her basic physical needs, or is so impaired that he or she does not understand the need for treatment. This is merely a general categorization; specific criteria must be determined from state law. It is imperative that officers know the criteria for involuntary examination and are given sufficient guidance in interpreting their authority. The statutory requirements for involuntary examinations are analagous to probable cause for arrest without a warrant and as such the procedure should not be initiated if the requirements are not present. Though an involuntary examination is not the same as involuntary hospitalization or commitment, it is the first step in those processes and holds serious consequences for the mentally ill person. The department should be certain that all officers are aware of the rights of the detained mentally ill and that officers advise the person of those rights.

This disposition is certainly an appropriate one in many cases. The law enforcement agency, however, should take all precautions to guard against the liberal application of the criteria. The argument has been made that when in doubt the officer should seek

involuntary hospitalization. The logic accompanying this argument is that mental health professionals will weed out anyone who does not need hospitalization. To some degree, this is true. Yet, the possible stigmatization and mistreatment of the individual and the potential waste of agency and mental health resources are only two of the reasons why this argument must be tempered by careful assessment of the situation.

Before proceeding to the intake facility, the officer should contact the facility, if circumstances permit, so it can prepare for the arrival of the officer and subject. In this way, too, the facility can alert the officer if it has no one on duty who can examine the person or if it has no more beds available, and an alternative disposition can be discussed.

#### 6. Arrest

Arrest is always appropriate when a felony has been committed. Arrest is also appropriate in cases in which the officer would normally make an arrest if the person were not mentally ill, and if the current signs of mental illness are minor or not related to the violation. Arrest may be appropriate, too, if there was a minor violation of a statute yet 1) the officer is not comfortable about releasing the person on his or her own; 2) the officer cannot locate a caretaker; 3) the person will not agree to a voluntary examination; and 4) the person does not meet the criteria for an involuntary examination. As a last resort, arrest for a minor infraction is appropriate if the arrest will

provide the person with basic physical needs that would not otherwise be fulfilled. This is only appropriate if a violation has occurred and is inappropriate if the person is mentally ill but has not committed a violation.

It should also be noted that arrest is sometimes recommended by mental health professionals when it would be beneficial to the subject's treatment plan. In others words, making the subject more accountable for his actions can be accomplished through arrest and confinement. However, this action requires careful monitoring by a mental health professional and should not be attempted without such guidance. On the other hand, arrest should not be effected merely to take a "problem" client off the hands of the mental health professionals.

When arresting the person, the officer should advise the person of his or her rights. In addition, before the officer proceeds to frisk the subject, he should make his intentions known.

The officer should also advise custodial personnel at the jail or detention center of any indications of mental disorder regardless of whether they are still evident. Mental health professionals should then be notified. The officer should also record these signs on the incident report as they may bear on issues of competency, insanity, and future dispositions. Finally, the officer should make known to the prosecutor and the court any signs of mental illness.

All reports concerning an officer's interaction with the mentally disordered person should be forwarded to the agency's designee for liaison with mental health services. Both arrest and incident reports, as well as any other routine agency reports, should be included in this category. The liaison individual should then review these reports from three perspectives. First, from a law enforcement perspective to ascertain whether policy and procedure were adhered to and whether the disposition effected was appropriate. Second, from a mental health perspective in that an individual having several contacts with the police within a short time period should be called to the attention of a mental health agency as possibly being in need of treatment or care. Third, the individual should examine the reports from a liaison perspective. This involves review of the manner in which the officer and mental health professionals interacted. As above, the purpose is to identify problem areas so they can be corrected. The liaison person should maintain a copy of the reports for the agency's mental health files and, as appropriate, forward a copy to the mental health agency.



APPENDIX A  
STATES' INVOLUNTARY COMMITMENT CRITERIA

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COMMITMENT CRITERIA

| STATE                | MENTALLY ILL | DANGER TO OTHERS BY RECENT ACT | DANGER TO SELF BY RECENT ACT | THREAT OF DANGER TO OTHERS | THREAT OF DANGER TO SELF | GRAVELY DISABLED | IN NEED OF TREATMENT | REFUSED VOLUNTARY TREATMENT | DANGER TO PROPERTY | THREAT OF EMOTIONAL INJURY TO OTHERS | HOSPITAL IS BEST RESPECTIVE ALTERNATIVE | PERSON WOULD READILY BENEFIT FROM TREATMENT |
|----------------------|--------------|--------------------------------|------------------------------|----------------------------|--------------------------|------------------|----------------------|-----------------------------|--------------------|--------------------------------------|---|---|
| ALABAMA              | YES          | YES                            | YES                          | *                          | *                        |                  |                      |                             |                    |                                      |   |   |
| ALASKA               | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |
| ARIZONA              | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| ARKANSAS             | YES          | YES                            | YES                          | *                          | YES                      | YES              |                      |                             |                    |                                      |   |   |
| CALIFORNIA           | YES          | YES                            | YES                          | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| COLORADO             | YES          |                                |                              | YES                        | YES                      | YES              | YES+                 |                             |                    |                                      |   |   |
| CONNECTICUT          | YES          |                                |                              | YES                        | YES                      | YES              | YES+                 |                             |                    |                                      |   |   |
| DELAWARE             | YES          |                                |                              | YES                        | YES                      |                  | YES+-                |                             | YES                |                                      |   |   |
| DISTRICT OF COLUMBIA | YES          |                                |                              | YES                        | YES                      |                  |                      |                             |                    |                                      |   |   |
| FLORIDA              | YES          | YES                            | YES                          | *                          | *                        | YES              | YES                  | YES                         |                    |                                      |   |   |
| GEORGIA              | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             |                    |                                      |   |   |
| HAWAII               | YES          | YES                            | YES                          | *                          | *                        |                  | YES                  |                             | YES                | YES                                  | YES                                     |   |
| IDAHO                | YES          | YES                            | YES                          | *                          | *                        | YES              | YES+                 |                             |                    |                                      |   |   |
| ILLINOIS             | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| INDIANA              | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |
| IOWA                 | YES          |                                |                              | YES                        | YES                      | YES              | YES+                 |                             |                    | YES                                  |   |   |
| KANSAS               | YES          |                                |                              | YES                        | YES                      | YES              | YES+                 |                             | YES                |                                      |   |   |
| KENTUCKY             | YES          |                                |                              | YES                        | YES                      |                  |                      |                             |                    |                                      |   | YES   |
| LOUISIANA            | YES          |                                |                              | YES                        | YES                      | YES              | YES+                 |                             |                    |                                      |   |   |
| MAINE                | YES          | YES                            | YES                          | *                          | *                        |                  |                      |                             |                    |                                      | YES                                     |   |
| MARYLAND             | YES          |                                |                              | YES                        | YES                      |                  | YES+                 |                             |                    |                                      |   |   |
| MASSACHUSETTS        | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             |                    |                                      |   |   |
| MICHIGAN             | YES          | YES                            | YES                          | *                          | *                        | YES              | YES+                 |                             |                    |                                      |   |   |
| MINNESOTA            | YES          | YES                            | YES                          | *                          | *                        | YES+             |                      |                             |                    |                                      |   |   |
| MISSISSIPPI          | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| MISSOURI             | YES          |                                |                              | YES                        | YES                      |                  |                      |                             |                    |                                      |   |   |
| MONTANA              | YES          | YES                            | YES                          | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| NEBRASKA             | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             |                    |                                      |   |   |
| NEVADA               | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| NEW HAMPSHIRE        | YES          |                                |                              | YES                        | YES                      |                  |                      |                             |                    |                                      |   |   |
| NEW JERSEY           | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |
| NEW MEXICO           | YES          | YES                            | YES                          | *                          | *                        | YES+             | YES                  |                             |                    |                                      | YES                                     |   |
| NEW YORK             | YES          | YES                            | YES                          | *                          | *                        | YES              | YES-                 |                             |                    |                                      |   |   |
| NORTH CAROLINA       | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             |                    |                                      |   |   |
| NORTH DAKOTA         | YES          | YES                            | YES                          | *                          | *                        | YES+             | YES                  |                             |                    |                                      |   |   |
| OHIO                 | YES          | YES                            | YES                          | *                          | *                        | YES              | YES-                 |                             |                    |                                      |   |   |
| OKLAHOMA             | YES          | YES                            | YES                          | *                          | *                        | YES              | YES-                 |                             |                    |                                      |   |   |
| OREGON               | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| PENNSYLVANIA         | YES          | YES                            | YES                          | *                          | *                        | YES              | YES                  |                             |                    |                                      |   |   |
| RHODE ISLAND         | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |
| SOUTH CAROLINA       | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |
| SOUTH DAKOTA         | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      |   |   |
| TENNESSEE            | YES          | YES                            | YES                          | *                          | *                        | YES              | YES                  |                             |                    |                                      |   |   |
| TEXAS                | YES          |                                |                              | YES                        | YES                      | YES              | YES-                 |                             |                    |                                      |   |   |
| UTAH                 | YES          |                                |                              | YES                        | YES                      | YES              |                      |                             |                    |                                      | YES                                     |   |
| VERMONT              | YES          | YES                            | YES                          | *                          | *                        | YES              | YES                  |                             |                    |                                      |   |   |
| VIRGINIA             | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      | YES                                     |   |
| WASHINGTON           | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             | YES+               |                                      |   |   |
| WEST VIRGINIA        | YES          | YES                            | YES                          | *                          | *                        | YES              |                      |                             |                    |                                      |   |   |
| WISCONSIN            | YES          | YES                            | YES                          | *                          | *                        | YES              | YES                  |                             |                    |                                      | YES                                     |   |
| WYOMING              | YES          |                                |                              | YES                        | YES                      | YES              | YES                  |                             |                    |                                      |   |   |

1 Adapted from Edward D. Bois, "Involuntary Civil Commitment Statutes," *Mental Disability Law Reporter*, 7(July-August, 1981): 350-69.

\* A threat of danger as a criterion is not specifically listed but is implied by a recent act of dangerousness.

+ The criterion is not listed separately but is included in the definition of mental illness.

- Specifies hospitalization as the treatment necessary.

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APPENDIX B  
UNDERSTANDING MENTAL DISABILITIES

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## UNDERSTANDING MENTAL DISABILITIES

Police encounters with the mentally disabled can take many forms and can occur in a variety of settings. Handling these individuals is often a difficult task due to the nature of their disability. Working with mental health agencies is often a frustrating and possibly intimidating experience for the uninitiated. Clearly, these factors often cause officers to avoid calls involving the mentally disabled or to handle the calls in an inappropriate manner. By gaining an understanding of mental illness and retardation, an agency and individual officers are in a better position to improve the management of this population.

This appendix provides information that can be used in training classes that prepare officers to manage encounters with persons who are suspected of being or are known to be mentally ill or mentally retarded. The intent of this appendix is not to provide law enforcement officers with diagnostic skills, but rather to help them identify indicators of mental illness and mental retardation and to provide a basis for understanding those disabilities.

### A. MENTAL ILLNESS

Mental illness is in most cases a temporary disorder during which an individual has difficulty coping with life's stresses and

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problems. The disorders can fluctuate in seriousness, can usually be reversed or alleviated, and can strike a person at any time. The etiology, or causes, of mental illnesses are often unknown, and different persons suffering from the same mental illness can often show different symptoms and be affected in different ways.

Perhaps the best way to describe mental illnesses is to focus on their erratic and confusing nature. In fact, many individuals and organizations believe the term mental illness is misleading in that it implies a similarity to physical illness and the correspondent roles of patient and physician. (See Shah 1976, Hoff 1984, and American Psychiatric Association 1980.) Szasz (1984: ix) in his book, The Myth of Mental Illness, states the following:

Stricly speaking, then, disease or illness can affect only the body. Hence there can be no such thing as mental illness. The term "mental illness" is a metaphor.

Whereas physical illnesses are characterized by specific symptoms that follow a clearly defined progression, specific causes that can be identified, and a reasonably certain outcome, the identification and treatment of mental illness, in comparison, are characterized by uncertainty and ambiguity. In any particular mental illness, there can exist any number of varying symptoms, so that persons suffering from the same mental illness can exhibit different symptoms and persons suffering from different illnesses can exhibit the same symptoms. Also, the symptoms do not progress in a clearly defined

manner, nor is their presence constant. For example, a person may be irrational, violent, and suffering from hallucinations, but within an hour may appear totally unaffected.

As with symptoms, the causes of mental illness are not specific and uniform. The general causes may include the person's environment, such as family and upbringing, and adaptability to stress, or the illness may be the result of a chemical imbalance within the person. Because the causes and symptoms of mental illness are rarely specific and not easily identified, the outcome of the disorder is often uncertain. Though, as noted, mental illness is in most cases a temporary condition, there is no time limit to the definition of temporary. The disorder may last for a few days or it may last for years. Also, the disorder may be of a recurring nature in that the person may be quite well for months at a time and then the disorder emerges again.

Mental illness may be understood best by viewing it in the context of mental health. In dealing with the stresses, and uncertainties of life, each person develops mechanisms that enable him or her to function effectively despite those distractions. The pressures caused by these distractions are released through a variety of behaviors or are rechanneled so that they are used in a positive manner. At times, the pressures may impair one's ability to fulfill his or her responsibilities and to function in an ineffective manner. This condition is usually dealt with quickly by the person so that effectiveness is soon restored. It is when the person's mechanisms for

dealing with these pressures fail that one begins to experience a disorder in functioning. The person's perception of reality becomes distorted and his or her ability to understand, accept, and deal with reality is impaired. The ability to tolerate these pressures differs with each person so that identical pressures may cause one person to experience a disorder while another person remains unaffected. Also, the types and levels of disorders are such that the person's grasp of reality may be only slightly impaired or it may be extremely impaired.

Basically, there are two broad categories of mental illnesses: neuroses and psychoses.

#### 1. Neuroses

A neurosis is a mental disorder that is caused by an event or thought so painful that it permanently scars the person's personality and acts as a hidden cause of the disorder. In an attempt to alleviate the pain of the event or thought, the person develops a defense mechanism that could be considered extreme or overreactive. When an event similar to the original one occurs, the person employs this defense mechanism. Though it helps the person deal with the anxiety of the event, the defense mechanism, because it is extreme, also causes the person to behave in a manner that others consider odd. Therapy, which usually does not include hospitalization, is quite effective in reducing the recurrent nature of neuroses.

Neurotic disorders are neither accompanied by gross distortion of reality nor severe personality disorganization. Although normal functioning is impaired, the neurotic person recognizes a discrepancy between his feelings and behavior and those considered appropriate to the circumstances. He is aware of his peculiar behavior, expresses discomfort about it, but disavows the ability to change the distressing state of affairs. Under the broad term of neuroses there are six specific categories.

- Anxiety neurosis - This is characterized by chronic and diffuse anxiety not restricted to particular objects or situations. During stressful situations, the person displays a level of anxiety that is constant and out of proportion to the importance of the situation. The person is often irritable and may experience nausea, insomnia, loss of appetite, increased heartbeat, and sweating.
- Phobic neurosis - This is an unreasonable fear of a specific object or situation that the person consciously acknowledges as presenting no serious danger (e.g., fear of heights, of being in closed or narrow spaces, etc).
- Dissociative neurosis - This type of neurosis includes multiple personalities, amnesia, and fugue. All three are characteristic of alterations in consciousness or identity. Multiple personalities involve the existence of two or more personalities, which are often discrepant, and each of which is dominant at a particular time.

Transition from one personality to another is sudden and associated with psycho-social stress. Amnesia caused by neurosis is not the same as amnesia due to an organic cause. Nonetheless, the essential feature is an inability to recall important personal information. The amnesia begins suddenly and usually follows a threat of physical injury or severe stress. Fugue is characterized by sudden, unexpected, though purposeful, travel away from home or customary work locale with the assumption of a new identity and an inability to recall one's previous identity. (American Psychological Association 1980: 9-11.)

- Depressive neurosis - The person suffering from this experiences chronic sadness or apathy that is not justified by the circumstances. Usual activities and pastimes no longer are of interest or pleasurable to the person. Depressive neurosis is quite like a major or psychotic depressive episode (see pp. B-10 and B-11) with the exception that it lacks the severity, duration, delusions, and hallucinations that accompany the latter.
- Obsessive-compulsive neurosis - An obsession is a constant and repeated set of unwelcome thoughts, ideas, images, or impulses that are experienced as senseless, inconvenient, or repugnant. For example, a person who is obsessed with sexual behavior may believe that every individual encountered is attempting to seduce him or her. Compulsions are repetitive and seemingly purposeful acts that

are performed according to certain rules. The act is not pleasure-able although it may serve to relieve tension. For example, washing one's hand after every handshake is compulsive behavior.

- Conversion neurosis - This type of neurosis involves an involuntary loss or alteration of physical functioning that suggests a physical disorder but is actually an expression of a psychological conflict or need. The symptom usually develops in a setting of extreme stress, appears suddenly, and is usually of short duration. Examples include blindness, paralysis, seizures, and vomiting.

Although neuroses may appear quite serious and frightening, they are considered serious mental illnesses only in extreme cases or when compounded by other mental disorders. This is true from both a mental health and legal perspective. Rarely will an officer encounter a person suffering from a neurosis who is in need of hospitalization. There are occasions though, when an emergency examination is necessary because the person is so overcome by anxiety that he meets the legal criteria for an emergency evaluation. In most situations involving persons suffering from a neurosis, the application of criteria for an emergency examination will not be applicable, and the most an officer can do is try and calm the situation and make a referral.

## 2. Psychoses

A psychosis is a severe emotional disorder in which the affected person suffers a significant loss of contact with reality.

Psychotic behavior has also been classified as socially deviant because interpersonal behavior and social propriety do not meet minimum levels of acceptance. Illogical thought processes, incoherent speech, social withdrawal, neglect of familial and occupational obligations, and hallucinations or delusions cause the person to be labeled deviant and, in turn, causes others to request police assistance. A third characteristic of a psychosis is that the behavior of the person appears to be beyond his or her control. From a law enforcement perspective, this characteristic is perhaps the most important of the three.

The first two characteristics--loss of contact with reality and deviance--are usually quite obvious and require wariness on the part of the officer when dealing with the person. A psychotic person may manifest an almost infinite combination of the above-mentioned deviant-type behaviors. These behaviors often prevent the person from maintaining a harmonious existence with his environment either because the person is perceived as being, or is actually, dangerous to himself or others is unable to care for himself or is incapable of functioning within the limited tolerated by society. His behavior constitutes a nuisance, a burden, or a danger. Because psychotic behavior usually renders the person socially incapacitated, the public feels threatened by the person's behavior.

Officers must handle psychotic persons carefully. A show of force or intimidation or actions intended to "teach this person a lesson" or to "straighten him out" will not prove useful and will often exacerbate the situation that originally led to the police being called.

Psychotic behavior, though, is usually not a permanent situation. An individual may suffer a psychotic episode for days, weeks, or even months at a time, but the episode will eventually end. It is also possible that one may suffer from one isolated episode and never experience another episode. Acute psychotic episodes are behavioral reactions to extreme and often identifiable situational stress. The episodes usually have a rapid onset and constitute a marked departure from the person's previous functioning. The episodes may include intense anxiety, extreme mood fluctuation, cognitive confusion, disorientation, incoherent speech, withdrawal, or hallucinations and disorientation. Other persons suffer from long-term psychotic disorders that affect their personalities and lifestyles.

Though persons suffer minor psychotic symptoms, they function reasonably well most of the time. They may be referred to as weird or eccentric, but they are capable of maintaining a level of behavior that does not interfere with their own or others' routines. Under stress, however, they may have more severe psychotic episodes of short duration. The length of the psychotic cycles varies with each person.

Psychotic episodes may be months or years apart, or they may be so frequent as to require continuous care by mental health professionals. Psychotropic drugs are used to assist the person to come out of an episode and to prevent future episodes. Quite often the discontinuation of these medications causes the onset of episodes.

Psychoses are divided into two major types, organic and functional, and within each type there are specific classifications of disorders. Organic psychoses are serious disorders caused by a major injury to the brain, a disease, the use of a toxic agent or withdrawal from this substance, or a combination of any of these. Examples of these types of disorders include senility, delirium, intoxication, withdrawal, dementia, or substance abuse, especially PCP.

Functional psychoses, on the other hand, are disorders in which the brain appears to be normal, but the person experiences a major impairment nonetheless. Functional psychoses can be grouped into three general categories of disorders: affective, schizophrenic, and paranoid.

Affective (manic-depressive) disorders are characterized by a disturbance in mood--either elation or depression--that does not appear to be caused by an external event. A manic episode is one in which the person is in an elevated, expansive, or irritable mood. These moods are characterized by hyperactivity, talkativeness, inflated self-esteem, decreased need for sleep, distractibility, or excessive

involvement in activities having a high potential for painful consequences that are not recognized (e.g., buying sprees, foolish investments, sexual indiscretion). A depressive episode involves a loss of interest or pleasure in usual activities and pastimes. This disturbance is prominent and persistent and is also associated with physical symptoms, such as sleeplessness, loss of appetite, change in weight, and motor retardation. Hallucinations or delusions may be present and will be consistent with the mood. (American Psychological Association 1980: 253-59)

Schizophrenia is the most common of the functional psychoses. It can be viewed as a deterioration in one's personality so that feelings, thoughts, and behavior are not coherent. Schizophrenia also involves a deterioration from a previous level of functioning in areas such as work, self-care, and social interaction. This deterioration is often accompanied by hallucinations, rapid shift of subject areas while speaking, incoherence, moods inappropriate to the situation, confusion about one's identity, ambivalence, withdrawal, and unusual posturing. Behavior is often bizarre, meaningless, and inappropriate. Personal hygiene and nutritional needs may be ignored. Additionally, the person may suffer delusions of grandeur or persecution.

Paranoid psychosis is characterized by delusions of persecution or jealousy focused on a single theme or a series of connected themes. For example, the person may believe others are conspiring against him and as such are trying to cheat, spy on, follow, harass, drug, or poison him. The person is often resentful, angry, and

suspicious of others. The true paranoid is different from the schizophrenic in that daily functioning is not impaired and intellectual or occupational functioning remains intact while social functioning is impaired. The person behaves quite normally except in areas relevant to the delusion.

#### 8. MENTAL RETARDATION

Mental retardation, like mental illness, is a complex phenomenon caused by diverse etiological factors that may be biological, environmental, or a combination of both. Of the 300 possible causes, only about 25 percent involve known biological abnormalities, such as chromosomal and metabolic disorders. The remaining causes are not associated with known biological abnormalities and as such there is uncertainty as to the underlying cause. (American Psychological Association 1980: 36-38.) Some of the biological causes are associated with prenatal factors of the mother such as infection, excessive drinking, or malnutrition. Injury to the brain of the child during birth or during the development period is another biological cause. Environmental factors, such as deprivation of social, linguistic, or intellectual stimulation, are usually identified as causes when known biological causes are not present.

Mental retardation, unlike mental illness, is permanent, although a lessening of the degree of retardation is possible. Retardation is diagnosed when the following three criteria are met:

- significant subaverage general intellectual functioning;
- resulting in, or associated with, deficits or impairments in adaptive behavior;
- with onset before the age of 18.

General intellectual functioning is defined as an intelligence quotient (IQ) which is obtained by assessment with one or more individually administered intelligence tests. Significantly subaverage intellectual functioning is defined as an IQ below 70, plus or minus five points, on an intelligence test.

Adaptive behavior refers to the effectiveness with which an individual meets the standards of personal independence and social responsibility expected of his or her age and cultural group. Scales have been designed to measure adaptive behavior but none is considered scientifically valid or reliable. Thus, the measurement of this criterion is dependent on clinical judgment. Adaptive behavior includes basic social skills, such as personal interaction, proper dress, appropriate manners, and the development of values and ideals. Adaptive behavior also involves a recognition of the consequences of one's behavior and the ability to generalize from one situation to another.

When the above clinical conditions emerge before age 18, the person is considered mentally retarded. If the conditions develop after age 18, the diagnosis is a dementia, a type of organic psychosis.

For a diagnosis of retardation, all three criteria must be met. For example, an individual who has an IQ near but below 70, but whose adaptive behavior is appropriate to his or her age, would not be diagnosed as retarded.

Within the general category of mental retardation, there exist four levels which are reflective of intellectual development and adaptive behaviors: mild, moderate, severe, and profound.

Mild mental retardation is by far the most common level, occurring in about 80 percent of retarded individuals. Generally, these individuals possess an IQ between 52 and 69. Such individuals can develop social and communication skills during the pre-school period and have minimal sensorimotor impairment. Often, as children, these individuals are not distinguishable from normal children until a later age when difficulties with schoolwork begin to become apparent. With adequate training mildly retarded persons can acquire social and vocational skills adequate for minimal self-support, though guidance or assistance is often necessary during periods of unusual social or economic stress.

Moderate mental retardation is indicated by a general IQ range of 36-54, depending on the type of intelligence test. During the school period youngsters in this category can learn to communicate but they have a poor awareness of social conventions. Training in social and occupational skills is beneficial and often allows these persons to

contribute to their own support in adult life. They can learn to travel by themselves and they are usually able to perform unskilled or semi-skilled work in either a competitive atmosphere or a sheltered workshop. Supervision and guidance are necessary during periods of mild social or economic stress. Approximately 12 percent of all retarded persons fall into this category.

Severely retarded persons constitute about 7 percent of all retarded persons. Their general IQ is between 20 and 39. They exhibit poor motor and speech development during the pre-school period. They may develop the ability to talk and maintain basic hygiene during the school-age period. As adults they may be able to perform simple work tasks, but only under close supervision.

Profound retardation is characterized by a general IQ of 24 and below. These individuals have minimal sensorimotor functioning during the preschool period and slight improvement is possible in later years. Minimal self-care skills may also be developed but the individual usually requires a highly structured environment and constant supervision. Less than 1 percent of all retarded persons are in this category.

From this description of the four categories of retardation, it is apparent that there exists a tremendous variety in the skill levels of the mentally retarded. Because most of the 6 million retarded persons in the United States are only mildly retarded, they

have the capability to live in the community and maintain employment. As such, they are not much different from anyone else. Although they might have difficulty functioning in society, they remain in touch with reality. Thus, they are subject to the same influences as others and their emotional reactions cover a wide spectrum. Because of this, the retarded, like anyone else, can be affected by a mental illness. Their retardation, however, should not be construed as a susceptibility to mental illness and should not be confused with mental illness. The chart on the next page should help to differentiate between mental illness and mental retardation (Hoffman 1979:13).

APPENDIX C

RECOGNIZING AND HANDLING  
HUMAN BEHAVIORS AND CONDITIONS  
OFTEN CONFUSED WITH CHRONIC MENTAL ILLNESS

**RECOGNIZING AND HANDLING  
HUMAN BEHAVIORS AND CONDITIONS  
OFTEN CONFUSED WITH CHRONIC MENTAL ILLNESS**

Police officers will encounter three types of human behavior that are often confused with chronic mental illness: personality disorders, crisis behavior, and suicidal behavior or tendencies. Although these behaviors often require mental health counseling if they are to be alleviated or at least controlled, they are quite different from serious mental illness in both a legal and mental health sense, and police officers should be alert to the differences. In addition, officers must be able to distinguish mental retardation from mental illness if they are to resolve citizen encounters effectively.

**A. PERSONALITY DISORDERS**

The two types of personality disorders police officers are most likely to encounter are sociopathic and psychopathic disorders. These disorders are characterized by personality traits that are inflexible or maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Personality disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, although they often become less obvious during middle or old age.

Individuals with a personality disorder are often dissatisfied with the impact of their behavior on others. Such persons

experience disturbances in mood and are affected by depression or anxiety. They often appear odd or eccentric, dramatic, emotional or erratic, and anxious or fearful. They may be jealous, suspicious, devious, or self-centered. Often these persons are generally characterized as lacking self-control; they do not learn from past experiences; they lack good judgment; and they provoke trouble (American Psychiatric Association 1980:306; Matthews and Roland 1979:25). These characteristics often cause this type of person to obtain what he wants, when he wants it, and without consideration of others--they violate the law. These persons, however, are not seriously mentally ill; they remain in touch with reality and do not have delusions or hallucinations.

#### 8. CRISIS BEHAVIOR

Police officers often deal with persons who are experiencing a crisis of some sort. This can range from being locked out of the house to being the victim of a serious crime. A crisis for one person may not be a crisis for another; crises vary with time, place, and individuals.

When a person's material, personal, and social resources and problem-solving devices are not available or breakdown, a person can become temporarily unable to cope with the resulting stress. Often, a person in crisis seeks help from others to compensate for the temporary inability to cope. By seeking help from others they demonstrate that they understand that they are in crisis and remain in touch with

reality, which distinguishes them from the mentally ill. People in crisis, then, suffer from a temporary breakdown of coping skills that include perception, decision-making ability, and problem-solving ability. People in crisis often fear they are going crazy and may say so ("I must be losing my mind"). This distorted perceptual process should not be confused with mental illness, in which a person's usual pattern of thinking is disturbed. When a person is in crisis, the disturbance arises from and is part of the crisis experience, but there is a rapid return to normal perception once the crisis is resolved (Hoff 1984:81).

#### C. SUICIDAL BEHAVIOR AND TENDENCIES

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all who attempt suicide are mentally ill.

Suicide in the United States is the tenth leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually

a response to a life crisis which the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Police officers usually have the first contact with suicidal persons, and the attention given to the subject here is indicative of the importance departments should attach to preparing their officers to handle encounters with such persons. Officers must be aware of the signs of suicide and how to handle suicidal individuals in the event circumstances do not permit calling a special police or mental health worker.

Whereas persons who have personality disorders or are in crisis may have to be referred to professional counseling, suicidal persons must receive professional counseling. Making a referral or leaving a telephone number is not an adequate response; an officer or another responsible professional should remain with the individual until a mental health counselor is available. Under no circumstances should a suicidal person be incarcerated for attempting suicide. Also, officers should be alert to the signs of suicide in persons who are under arrest. Recognition of these signs prior to a person's being incarcerated can often prevent a suicide. The person can be kept under observation and provided mental health counseling during incarceration.

Counseling should not be confused with involuntary hospitalization. Though hospitalization may be appropriate in some circumstances, it should be initiated for suicidal persons only when natural social network resources are not available. The decision to commit a person must be based on a thorough psychiatric assessment and the suicidal person is no exception. Also, even if the person is found to be a serious risk for suicide, involuntary hospitalization may not be the best solution because the isolation of a hospital can contribute to the contemplation of suicide (Hoff 1984:81).

Suicide attempts can be understood best when seen as a result of poor communication. A suicide attempt is a person's way of trying to tell us one of two things. First, the suicide may be a final gesture in a long line of prior calls for help that have been ignored or gone unnoticed. For example, the boy who skipped school at age 11, experimented with drugs at age 12, ran away from home at age 13, and joined a gang of delinquents at 14, may attempt his first suicide at 15. Second, the attempt may indicate that the person has repressed his or her feelings for years and is no longer able to cope with the pressures of life. For example, the mother of five children who fulfills all their needs and those of her husband without any complaints may one day suddenly attempt suicide without any apparent warning.

Suicidal behavior can be viewed as a continuum or a path that a person travels, with suicide being the final destination. This outcome, however, is not inevitable. While traveling this path the person

gives clues to his or her distress, although they may not be as obvious in the case of the teenage boy. This suicide continuum, however, can be interrupted at any point if the clues are recognized; it is never too late to help a despairing person change his or her mind (Hoff 1984:179). In fact, by focusing on the ambivalence that usually accompanies suicidal tendencies, an officer will be more likely to be able to interrupt the continuum. Suicidal people usually struggle with two desires: the desire to live and the desire to die. By concentrating on the will to live and providing the person with realistic hope and alternatives, the officer may be able to prevent the suicide. Only through communication, though, can an officer recognize clues and prevent suicide.

Listed below are some of the major signs of suicidal behavior (Hoff 1984:185--93). A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if only one or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs in guidelines for officers will remove much of the guesswork associated with suicide assessment. As with the indicators of mental illness, recruit and in-service training on the subject of suicide should provide the context in which these signs are interpreted:

- Suicide plan - Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on

impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective than will a plan involving tranquilizers. Another element that contributes to a well thought-out plan is availability of the means. For example, if the person threatens to use a gun and he is a hunter, the means is clearly available. The final element of a plan is its specificity--time, place, circumstances. If a person indicates he will commit suicide within two days at a specific location and he has available the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

- History of past attempts - The majority of people who commit suicide have made previous attempts. The officer should, therefore, try to determine if the person has ever attempted suicide.
- The person's resources - Two types of resources, internal and external, should be assessed by the officer. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of external resources, such as family or friends, or an inability to communicate with those persons is also an indication of high risk.
- Recent loss - Any recent personal loss or the threat of losing a spouse, parent, status, money, or job increases the person's risk of suicide.
- Physical illness - Having a serious illness, especially one that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self-image increases the risk of suicide.
- Drinking and other substance abuse - Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, if someone is assessed as a potential risk, use of alcohol or drugs often increases this risk by causing a loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose.

- o Physical isolation - The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide. For example, the adolescent whose parents leave for a two-week vacation may feel isolated and this may serve as an impetus for suicidal tendencies.
- o Dramatic changes - A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment, such as relocation or retirement, can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.
- o Mental illness - Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. But if the person indicates that other people or voices are controlling his or her behavior, those signs should not be ignored.

In attempting to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter-of-fact way. He should talk about the finality of the act and use the terms "suicide," "death," and "kill yourself." That talking about suicide will only prompt the person to commit the act is a myth. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal

person. Often the suicidal person has been lacking communication and the officer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

Prevention-of-suicide guidelines should direct the officer to specific action. Recruits at the Madison, Wisconsin Police Department, for example, are instructed to follow the seven steps listed below:

- Obtain necessary personal data immediately - This includes the person's name, age, telephone number, address, place of work, and the names and the phone numbers of close friends and family.
- Bring the subject of suicide into the open - Discuss the problems, reasons, or thoughts that are causing the person to contemplate suicide. This should include the person's lifestyle, relationships with others, job, or any recent crises. Also ask such specific questions as:
  - Are you thinking of killing yourself?
  - How are you going to kill yourself?
  - Do you have the means for killing yourself?
  - When are you going to kill yourself?
  - What time of day are you going to kill yourself?

By gathering specific information, you will be better able to assess the person's intent to commit suicide. You should also talk about how the suicide will affect the person's close friends or family.

Also discuss with the person how the feelings of depression and suicidal tendencies are temporary and will subside with time and that it is inappropriate to make such a permanent decision when one is in a crisis state. Alternatives to suicide are always possible, though they may not be obvious to the person at the time.

- Remove the means - Insist that the person put away or get rid of any firearms, medications, or sharp objects. It is important that you convince the person to put away or give up the means and not take the means from the person. A show of force, rather than trust and rapport, can often trigger the suicide.
- Notify and meet with significant others - With the person's knowledge and approval, you should talk with close friends and family to gain further insight into the problem. Family and friends may also identify topics that should not be discussed with the person. Remember, however, that certain friends or family members may want the person to commit suicide and might provide false information or encourage the suicide if given the opportunity.
- Offer realistic hope - Providing false hope, stretching the truth, or denying the seriousness of the problem will not benefit the person in any way. Rather, you should present the person with a realistic view of how the problem can be overcome. Emphasize the temporary nature of the feelings the person is experiencing and how the proper network of support can help the person to overcome those feelings and eventually break the suicide continuum.
- Establish a specific plan of action - If the person does not meet the criteria for an emergency mental health detention (and many will not), you must see that the person receives emergency help. First, try to get the person to talk with a mental health professional so that a specific appointment for counseling can be made. Again, it is important that the person actively seek help. Making the appointment for the person or leaving the scene before the person has contacted the appropriate helping agency is not enough. On the other hand, do not threaten the person or use a power play to get the person to make the call. But by explaining how mental health professionals can help find solutions to the problem, you can often get the person to seek assistance of his or her own accord. If this is not possible, then you should contact the appropriate agency e.g., a suicide or crisis

hotline, a community mental health agency, or a mobile crisis unit. Professionals with these agencies can then talk with the person. Do not contact a non-professional to provide counseling, except as a last resort. This includes friends, family, clergy, or other community members. These persons do not have the training necessary to deal with a crisis of this nature and may only exacerbate the persons problems.

Dealing with a suicidal person requires a calm, matter-of-fact, but genuine concern for the person and is accomplished through communication. It requires an insistence, but not threats, on obtaining some type of mental health help. The officer must be actively involved in seeking information about the person's problems and in intervening in the person's life. And finally, the officer must pay close attention to the ambivalence that accompanies suicidal tendencies. The will to live and solutions to the person's problems should be stressed.

#### D. MENTAL RETARDATION

The majority of the mentally retarded are classified as mildly retarded and thus the majority of police contacts with the mentally retarded will be with persons included in this group. Such retardation is not easily detected through casual contact, however. The only way to determine with certainty that a person is mentally retarded is through the administration of comprehensive examinations which is usually done by a psychologist. (The information in this section is drawn from Kennedy, et al., 1982; Hoffman 1979; and Santamour and West 1979. Also see Appendix A for a more technical

discussion of mental retardation that may be helpful in preparing training materials.)

The retarded are usually aware of their differences and may become adept, intentionally or not, at camouflaging those differences to the casual observer. Determining whether a person is mentally retarded, therefore, will generally require more interaction with the person than if the officer were trying to determine mental illness. An officer should remember that retarded persons are more like the officer than unlike him. They are subject to the same influences as the nonretarded. They are sensitive to other's speech and actions and will respond in the manner in which they are treated. They should not be belittled and should be approached in a positive and direct manner.

The first reaction of any officer should be to stop or prevent a crime. The officer should then gather as much information about the incident or problem as possible. This may include interviewing witnesses and suspects or it may involve only an observation of the specifics of the crime. What may appear to be criminal involvement might actually prove otherwise. For example, the retarded person may be reported as a child molester because of his or her tendency to observe children at play.

While gathering basic information about the suspect or troublemaker, such as name, address, and background, the officer may

notice the first indicators of retardation. Further contacts with witnesses, family, friends, or neighbors may provide additional indicators and, more importantly, possible courses of action. If it is quickly and easily determined that the person is retarded, the officer should notify as soon as possible the person's parents, legal guardians, or those who provide care for the person. If this is not possible, the officer should attempt to contact a mental retardation agency for assistance.

If other persons are not available, the officer will have to interview the person to determine retardation. The officer should first arrange for a quiet and private setting. This will help the person relax, enable the officer to interview the person, and reduce any embarrassment the person might feel in a more public setting. When speaking to the person the officer should avoid any rapid-fire questions or attempts to intimidate or unnerve the person. This may only cause him or her to become frightened and refuse to answer. This does not mean the officer should not be firm and purposeful. The officer should speak slowly, use simple language, repeat if necessary, be patient, and avoid questions that require only a yes or no response. Allowing the person to talk freely is the best way to gain an understanding of whether he or she is retarded. Also, the use of any visual aids, pictures or diagrams, if available, may help the person understand the questions. The officer must recognize that the existence of one or two indicators is not conclusive evidence of mental retardation.

Rather, the officer must consider as many indicators as possible.

Basically, the officer should focus on four general indicators:

- communication and interaction skills
- task performance abilities
- personal histories
- physical appearance.

When talking with or interviewing a person who is in difficulty, the officer should look for the following communication problems:

- an inability to communicate at the level of others in same age group,
- difficulty in understanding questions,
- difficulty in answering questions, e.g., overreliance on "parroted" responses or offering standard responses,
- speech defects or impediments, including poor pronunciation,
- an inability to use abstract reasoning, and
- a limited vocabulary and limited grammatical skills.

The officer should always try to assess the person's ability to interact with others and the behaviors used when communicating or interacting. The following clues might be indicators of mental retardation:

- a preference by the person to associate with persons younger than himself or herself,
- an excessive desire to please others,

- reliance on a special person who provides help in certain situations or incidents (this person may not be present, but may be referenced),
- behavior that is noticeably on a level below the person's age,
- crowding personal space when interacting with others, and
- a tendency to be easily persuaded or influenced by others.

While interviewing the person, the officer should be aware of the person's reactions to the questions. Nonverbal behavior or body language often provides as much information as the answer itself. The officer should also listen carefully to the content of the answer. Avoiding questions regarding his or her background, such as special schooling or vocational training, large gaps in answers, or even silence may all be an indication of retardation. Rephrasing the question once or twice might help get an answer. Obvious reluctance to discuss what might appear to be a simple matter, such as education, is a valuable clue in itself and should not require a constant attempt to gain a satisfactory answer. Badgering the person might again result in uncooperative behavior. The officer should be patient, firm, non-threatening, and watchful for overcompliance, excessive agreeableness, or other attempts to please. As with lack of content, answers that seem to provide just the right information or too much information should alert the officer to a potential disability.

The ability to perform certain simple tasks may be lacking in a mentally retarded person. By asking the person to perform some of the tasks listed below, an officer may be able to determine if mental retardation is present. The officer should remember that the mentally retarded know they are different from other people. Thus, when asking someone to perform these tasks, the intent is to ascertain their cognitive skills and not to embarrass them. The officer should also try to keep the performance of the tasks within the context of the situation, not make it obvious that the person is being tested. For example, the officer can present the person with a handful of change and instruct the person to take enough to make a phone call to his or her guardian. If the person displays great difficulty in performing one or two tasks, however, continuing the exercise may easily cause harm to the person either by embarrassment or through a loss of self-respect. Some of the tasks that can be used are as follows:

- identifying oneself by name
- reading or writing
- identifying money and making change
- telling time
- using the telephone
- finding one's number in the telephone book
- giving directions to one's home, school, or work
- describing the appearance of a known person
- using public transportation.

Details about the person's history can also be helpful in determining if mental retardation is present. Determining the client's history will usually require interaction between the officer and the individual. The best way to determine the person's educational or

vocational history, for example, is to ask simple, straightforward questions that provide clues to the person's intellectual functioning and social adaptive skills. Any indication that the person's education was or is of a special nature can be a clue to mental retardation:

- Determine if the person attends or has ever attended a special school or a school with special education classes or classes for slow learners.
- Determine if the person attends or has ever attended a vocational education center.
- Determine if the person attends or has ever attended a sheltered workshop.

Most mentally retarded persons do not look any different from anyone else. Neither do they all look the same, as suggested by certain myths. There is as much variety in the physical characteristics of the mentally retarded as in the general population. Relying on physical appearance is not a good way to try to determine if a person is mentally retarded. Some of the mentally retarded, however, can be distinguished due to physical handicaps or poor motor coordination.

If it appears that a crime has been committed, the officer should pay close attention to the circumstances surrounding the incident, in particular, the suspected involvement of the person. As noted above, the mentally retarded are easily influenced by others and will often do things to please or gain the attention of others. Because the mentally retarded may not fully understand the significance of their

actions, they may unknowingly involve themselves in criminal activity.

Thus, officers should consider the following questions:

- Does it appear that the person took part in the crime to gain acceptance or to please others?
- Is the person noticeably younger than the other individuals involved?
- Did the person remain at the scene while others ran or did the person seem confused about whether something illegal had occurred?
- Was the person a follower rather than a leader in the crime?
- Did the person readily confess to the crime he was charged with?

DIFFERENCES BETWEEN MENTAL RETARDATION  
AND MENTAL ILLNESS

| <u>MENTAL RETARDATION</u>  | differs from | <u>MENTAL ILLNESS</u>  |
|--|--------------|--|
| A. Retardation refers to sub-average intellectual functioning.   |              | A. Mental illness has nothing to do with IQ. A person who is mentally ill may be a genius or may be subaverage intellectually. |
| B. Retardation refers to impairment in social adaptation.  |              | B. A mentally ill person may be very competent socially but may have a character disorder or other aberration.                 |
| C. Retardation usually is present at birth or occurs during the period of development.   |              | C. Mental illness may strike at any time.  |
| D. In mental retardation, the intellectual impairment is permanent but can be compensated through development of the person's potential.   |              | D. Mental illness is often temporary and in most cases is reversible. It is not a developmental disability.                    |
| E. A retarded person can usually be expected to behave rationally at his operational level.  |              | E. A mentally ill person may vacillate between normal and irrational behavior.   |
| F. A retarded person will not be violent except in those situations that cause violence in non-retarded persons.                           |              | F. A mentally ill person may be erratic or even violent.   |
| G. A mentally retarded person has a learning disability and could use the services of educators, psychologists, and vocational therapists. |              | G. A mentally ill person could utilize the services of psychiatrists, psychotherapists, or psychologists.                      |

APPENDIX D  
A GUIDE TO DEVELOPING A  
RESPONSE TO THE MENTALLY ILL\*

\* Reprinted with the permission of the Madison, Wisconsin Police Department.

Problem #2  
THE MENTALLY ILL

Madison Seminar on  
Problem-Oriented Policing  
July 30 - August 1, 1979

A. Defining the Problem

1. How much of police business involves dealing with the mentally ill? Are the number of cases in which mental illness is the central problem readily identifiable as such?
2. Of the total number of such cases, what percentage are cases in which a complaint is filed about the conduct of the mentally ill person, and what percentage are cases in which the mentally ill person summons the police?
3. What is the nature of the incidents requiring police attention in which mentally ill persons are involved? (e.g., trespass, assault, domestic disturbance, annoying or bizarre conduct, requests by the mentally ill for assistance)
4. Is it possible to subdivide the problems police confront in dealing with the mentally ill by categorizing individuals on the basis of the behavior they display to the police? Would this be desirable?
5. How often do the mentally ill with whom the police have contact engage in conduct that is dangerous to themselves (the mentally ill) or others? What do we know about these incidents? Were the individuals involved previously in contact with the police? What was the nature of these contacts?
6. Are problems relating to the mentally ill concentrated in specific areas of the city? If so, why?
7. Of those mentally ill individuals who themselves summon the police, how many call repeatedly? What is the nature of their problems?

8. Most states, in their treatment of the mentally ill, have recently adopted a policy of deinstitutionalization--attempting to keep mentally ill persons in the community and helping them to live as close to a normal life as their condition makes possible. This includes the expectation that they will learn to live within the boundaries of acceptable conduct commonly enforced by the police.
  - a. What implications has this recent change in policy had for this community?
  - b. What is an approximate estimate of the number of individuals now in treatment in the community who, several years ago, would have been institutionalized?
  - c. What services are available to these individuals?
  - d. What kinds of problems do they present?
  - e. Do the police know when they are dealing with such an individual, as distinct from a person who has never had contact with the mental health system?
  - f. Are such individuals, when they violate the law, to be processed through the criminal justice system? How does this square with the now well-established practice of avoiding the criminal justice system in dealing with those who appear to be mentally ill?

B. Established Authority

1. What authority do the police have for dealing with the mentally ill, short of criminal prosecution and use of emergency commitment proceedings? (If, for example, they are disturbing others by their conduct or simply frightening some individuals, can they be ordered out of a restaurant? a welfare office? the vestibule of an apartment house?)
2. What is the authority of the police to make an emergency commitment? What criteria must be met? What procedure must be followed?
3. Are the police acting properly if they arrest and jail an individual who commits a minor offense, but who is obviously mentally ill? What about the opposite? Are the police acting properly if they do not make the arrest? Are there specific factors that would justify taking one course or the other?

C. Police Practices and Their Effectiveness

1. What appear to be the objectives of the department in responding to the problem of the mentally ill?
  - identifying and dealing with potentially dangerous conduct?
  - eliminating conflicts that arise in the relationship between the mentally ill person and the rest of the community?
  - providing direct assistance and help to the mentally ill?
  - referring those who appear to be mentally ill to agencies that can be of help to them?
2. What is the relative importance of these objectives?
3. What priority does the department give to calls from mentally ill persons and to complaints received from others about their conduct?
4. How are telephone calls from mentally ill persons handled? What determines if a police officer is dispatched?
5. What guidance is provided to officers in deciding what to do in handling a case involving a mentally ill person?
6. What resources, if any, are available to an officer in helping the officer to make a judgment on what to do?
7. In choosing from available forms of action, what choices does the officer assume that he has?
8. Individual police officers frequently develop their own very special kind of response for mentally ill persons with whom they have frequent contact. What do we know about such responses? Are they proper? Are they effective? Do some officers consistently handle the mentally ill more effectively than others? What is it about their style of response that makes them more effective?
9. What effort is made, if any, to maintain a record of contact with mentally ill people so that officers having subsequent contact will know the nature of previous complaints and will know how officers responded to them?

10. Do the police ever take the initiative in trying to arrange consultations for an individual who frequently turns to them for help--or who is the source of frequent complaints--and who appears to be mentally ill? Should they?
11. What has been the experience of the police in utilizing emergency commitment proceedings?
12. What experience, if any, have officers had in responding to the urging of mental health workers that persons being treated in the community be dealt with as the officer would deal with the average citizen?
  - Has this resulted in an increase in arrests?
  - What has been the experience in jailing such individuals?
  - Is there a willingness on the part of the rest of the system to prosecute, or does a "taste of jail" become the final step in this procedure?
13. Are there cases that seem to fall "between the cracks"--with mental health workers unwilling to commit and police concerned about the danger that the person poses for himself or others? What is the specific nature of such cases?
14. What is the capacity of psychiatrists to predict dangerousness? Is there knowledge that should be conveyed to the police which they would have the capacity to use and apply in judging the potential for dangerous conduct?

D. Analysis

1. What is the proper role of the police in relating to the mentally ill? Should it be limited to incidents in which there is a potential of danger and to incidents which involve conduct (such as disorderliness) that is offensive to others? Or should the police go beyond and assume a responsibility for directing those who appear to be mentally ill on how they can obtain help, for aiding in the care of those who have obtained help, and for contributing to their integration into the community?
2. Is there need to provide police with the services of those trained in dealing with the mentally ill so that more professional judgments can be made in deciding how best to respond to the cases the police are called on to handle?
3. Is there any need to request legislation to provide special limited authority for the police to deal with the mentally ill in ways that do not require invoking either the criminal or the mental health systems? (e.g., authority to convey home similar to that now provided in many jurisdictions as an alternative for handling a person intoxicated by alcohol)
4. What additional training should be provided to police personnel?
5. Should the police be pressing the community to provide additional mental health services to meet the needs of those who are in treatment in the community and who spend much of their time on the streets or in public facilities? What is the specific nature of these needs?
6. What specific guidance can be provided to police officers for choosing from among the alternatives available to them? Specifically, what guidance should be provided in the use of emergency commitment powers?
7. What can be done to advise citizens of the rights of the mentally ill, the limitations on police authority, and the rationale behind community treatment so that fewer demands will be made for the police to deal with incidents that neither require nor justify police intervention?
8. Are there more effective ways in which police can handle their telephone contacts with citizens who are mentally ill?

APPENDIX E

EXEMPLARY DIRECTIVES AND OFFICER REFERRAL CARDS\*

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## HANDLING MENTALLY ILL PERSONS

GENERAL:

It is not unusual for the Police Officer to come into contact with a person who apparently suffers from what is commonly called "Mental Illness". When such contacts are made, the following procedure shall prevail.

The Omaha Police Division policy in regard to the mentally ill consists of three (3) principles:

1. Standing alone, mental illness signifies nothing and permits no special police responses. A mentally ill person has a right to be left alone so long as he does not violate any laws.
2. No person is to be taken involuntarily into police custody by reason of mental illness alone, but rather is to be taken into custody only if such person has also committed an arrestable offense, or has demonstrated by acts, observed by police officer or reliable others, that he threatens the lives or safety of himself and/or others.
3. No one is to be treated as being mentally ill unless a compelling necessity exists.

The interests which the first two principles protect is the basic right to be left alone until others are threatened with harm or one's own life is in danger. A man's peculiarity does not make him a second class citizen; and, contrary to what was thought for many years, mentally ill persons as a class are no more dangerous to others than mentally "healthy" people.

The third principle recognizes that the label of "mentally ill" carries with it a stigma which is equal to or greater than a stigma of a criminal conviction. Thus, the police officer must exercise extreme care in determining that a person is mentally ill.

GUIDELINES AND PROCEURES:A. RECOGNIZING MENTAL ILLNESS:

It is essential to make clear that the kind of mental imbalance that is the subject of this section, is no less than a fundamental derangement of the mind. In medical terminology, a person who suffers from this condition is called "psychotic". Although often such mental illness is quite easily recognized, there will be times when for the purpose of the procedures and guidelines which follow, there will be doubt whether the condition is present. To help the police officer in a particular case, he should keep in mind that there are two things to look for. Together they form an "Index of Suspicion" of mental illness.

1. That in response to questions or conversations, the person doesn't make sense; e.g., his conversation is confused, disjointed, etc., and
2. that the person does not know his name, the date, where he lives, and where he is at the moment.

HANDLING MENTALLY ILL PERSONS - continued;

If in addition to other suspicions that a person may be mentally ill, the officer observes that the person "doesn't make sense", and that he is unaware of who he is, where he is, etc., he may conclude for the purpose of his duties as a police officer that the person is in fact mentally ill.

**B. GENERAL APPROACH:**

Whenever in contact with a person whom he recognizes to be mentally ill, a police officer is to follow this guideline to avoid unnecessary ill will or difficulties.

1. Be honest and never try to deceive or trick the person.
2. Don't hurry. The more time spent with the person to achieve the officer's purpose, the better.
3. Be polite and respectful. Do not abuse.
4. Overall, try to establish, even if for the short time period involved, a relationship of concern and understanding.

Through this approach, the officer can more easily make an evaluation by observation and inquiry, and on the basis of that evaluation make a further decision as to the appropriate action to take.

**C. STEPS SHORT OF TAKING THE PERSON INTO CUSTODY:****1. VOLUNTARY REFERRAL:**

Situations where contact is made with people that are mentally ill are endlessly varied. Perhaps the contact may arise out of a normally uneventful incident on the street or during a family dispute call. In most of these situations, no special steps are required other than to be extra patient and calm. However, where the officer is convinced that the person is quite seriously disturbed and is in possible danger to himself or others, he is to tactfully inform the person that the Douglas County Hospital is equipped to handle his problems and that, if the person wishes, a police conveyance can be utilized to transport him to the hospital.

**2. WHEN THE PERSON REFUSES TO COOPERATE:**

If the person refuses to cooperate and if, because of his mental illness, the officer is concerned for his and others' welfare, and if adult members of the person's family or the person's guardian are known to him, the officer may wish to contact them and suggest that they try to influence the person to seek care.

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HANDLING MENTALLY ILL PERSONS - continued;D. TAKING THE MENTALLY ILL PERSON INTO INVOLUNTARY CUSTODY:

If, however, the mentally ill person refuses to obtain treatment voluntarily, procedures have been established for their INVOLUNTARY CUSTODY and treatment.

CAUTION:

The crucial word in the above is "CUSTODY".

The officer should take note of this word and, before subjecting anyone to INVOLUNTARY CUSTODY, make very sure of the grounds for the action.

The subject who is taken into INVOLUNTARY CUSTODY for treatment has rights the same as a subject who is arrested, the main difference being the place of confinement.

If all of a subject's legal rights are not observed, the officer subjects himself to the liability of lawsuit and to criminal prosecution.

83-1001 provides that any person may apply for VOLUNTARY ADMISSION for treatment of mental illness. The officer would be concerned with these persons only incidentally where transportation was being furnished as an accommodation or in the event of indigent persons.

INVOLUNTARY COMMITMENT:

"MENTALLY ILL DANGEROUS PERSON" shall mean any mentally ill person who presents:

- (1) A substantial risk of serious harm to another person or persons within the near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or
- (2) A substantial risk of serious harm to himself within the near future; as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm, or evidence of inability to provide for his basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

83-1020 provides that "Whenever any peace officer believes that any individual is a mentally ill dangerous person and that the harm described [in either of the definitions above] is likely to occur before mental board proceedings under this act may be invoked to obtain custody of the individual, such peace officer may immediately take such individual into custody, cause him or her to be taken into custody. . ."

HANDLING MENTALLY ILL PERSONS - continued;

The police officer in determining whether to take the subject into custody or not to do so (the individual officer MUST make this decision) should consider all of, but not limited to, the following:

- (1) Does the subject meet the definition of a mentally ill person above?
- (2) Would this subject come to harm or cause harm to others if allowed to remain free until a mental warrant could be initiated?
- (3) Could the symptoms be caused by something other than mental illness, e.g. drugs, diabetes, etc.?

The fact that a subject has threatened to harm himself or another may be considered but is not to be the only determining factor in the decision to take a subject into INVOLUNTARY CUSTODY.

Remember: The facts that the officer considers must also be considered by:

- (1) A mental professional; and
- (2) A mental health board; and
- (3) Perhaps by a court of law.

When the decision is made to take the subject into involuntary custody, the officer shall contact the Lieutenant of the Uniform Patrol Section. The Lieutenant shall meet with the officer, either at the original place of confinement or at the hospital. The Lieutenant shall confer with the officer and make a decision on the signing in of the mentally ill person to the hospital.

As with all mental commitments, the final responsibility for the signing in of mental patients under the involuntary admittance process is the responsibility of the officer at the scene who has personal knowledge of the situation.

However, no person shall be signed in as a mental case without clearance and consultation of the Lieutenant of the Patrol Section.

In all cases of subjects taken into involuntary custody, the officer must complete a Casualty Report form PO 197 (Crime Against Person) and a written certificate, PO 78, which shall allege that such officer believes that the subject in custody is:

- (1) A mentally ill dangerous person; and
- (2) That the harm described in the above definition is likely to occur before mental health proceedings under this act may be invoked to obtain custody of this subject;

HANDLING MENTALLY ILL PERSONS - continued;

And a summary of the subject's behavior supporting such allegations must be detailed in the certificate.

When the extreme measure of INVOLUNTARY CUSTODY must be taken, the subject shall be taken to a hospital where a medical professional and a locked custodial ward is available for the care of the mentally ill at all times.

All mentally ill dangerous persons shall be taken to:

- (1) County Hospital, or
- (2) Nebraska Psychiatric Institute, if Douglas County Hospital is full.

There have been occasions when a Field Officer, while talking with the Communications Operator, has alarmed the mental patient by referring to the medical facility by name:

To avoid suddenly alarming the mental patient, the Field Officer shall denote transporting a mental patient to a medical facility within the City of Omaha by contacting the Communications Operator and using "Signal AA". The Field Officer should give the Communications Operator the location of origin and the location of the medical facility without naming the medical facility.

An example communication would be:

"District 304, Signal A-Adam, A-Adam (using the letter and pronouncing the letter phonetically), 20th and St. Marys Avenue to 42nd and Woolworth Avenue."

The Communications Operator shall immediately telephone:

County Hospital Emergency      444-7777

83-1023 Provides that a mentally ill subject admitted by certificate must be "...evaluated by a mental health professional as soon as reasonably possible but not later than thirty-six (36) hours after his admission.

A "mental health professional" is defined for purposes of this section as "...a practicing physician licensed to practice medicine in this state..."

MENTAL WARRANTS:

If a private citizen believes that a subject is a MENTALLY ILL DANGEROUS PERSON he may go to the County Attorney. If the County Attorney concurs in the citizen's belief, there is a procedure set out in Section 83 of the State Statutes for petitioning the courts and for the serving of process.

HANDLING MENTALLY ILL PERSONS - continued;

Therefore, if the officer is in doubt as to the need for immediate custody, he should advise the complainant to see the County Attorney for the issuance of a Mental Warrant. The County Sheriff will then serve the process.

RECORDS:

Records of mental fitnesses shall be accessible only to:

- (1) the subject,
- (2) the subject's counsel,
- (3) the subject's parents or guardian if the subject is a minor or legal incompetent,
- (4) the mental health board having jurisdiction over the subject,
- (5) persons authorized by an order of a judge or court, or
- (6) persons authorized by written permission of the subject.

BUT BE AWARE:

"Any person who willfully

- (1) files, or causes to be filed, a certificate or petition under this act, knowing any of the allegations thereof to be false,
- (2) deprives a subject of any of the rights granted the subject by this act, or
- (3) breaches the confidentiality of records required...[above] ...

shall be guilty of a misdemeanor and shall, upon conviction thereof, be punished by a fine of not more than one thousand dollars (\$1,000.00), or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment, in addition to any civil liability which he may incur for such acts."

Persons who are confined in a mental facility as mental patients are totally the responsibility of the staff of that mental facility. Police Officers should not assist or take responsibility for the control of such patients if a request is made to do so.

This is not to be confused with situations where a Police Officer is on guard duty involving an arrested felon who is undergoing medical treatment at the mental facility.

HANDLING MENTALLY ILL PERSONS - continued;

The Officer is to prevent the escape of such felon but is not to interfere or comment on the medical treatment of the felon in custody. He is acting strictly as a Detention Officer to prevent escape.

PROCEDURE FOR MENTAL PATIENTS TAKEN TO NEBRASKA PSYCHIATRIC INSTITUTE:

The following procedure will be followed when officers take mental patients to Nebraska Psychiatric Institute:

1. Upon arrival, the Officer will go to the information desk located inside the main entrance.
2. While at the information desk, the Officer will remove and unload his/her weapon and lock it in a metal cabinet provided and take the key with him/her.
3. Upon completion of assignment, the Officer will return to the information desk, unlock the metal cabinet and pick up his/her weapon.

Note: Exceptions to the above procedures where an Officer will retain his/her weapon prior to going into a mental patient area:

1. Officer is answering call of crime in progress.
2. Prisoner brought into the hospital who is under Police guard.

4-1700. DEALING WITH PERSONS WHO EXHIBIT ABNORMAL BEHAVIOR -- MENTALLY ILL PERSONS

4-1701. General Policy

The Department recognizes that police are not qualified to solve the underlying problems of people who exhibit abnormal behavior. Officers can learn to recognize abnormal behavior when they encounter it. Their response to a situation that involves abnormal behavior should reflect a sensitivity to the needs of the people involved, and a concern for the safety of themselves and others at the scene as well as a concern to alleviate the situation in a reasonable manner and length of time. Wherever possible and appropriate, an officer should direct a person exhibiting abnormal behavior to those agencies and persons that can provide professional help. This should be done in a manner that is the least disruptive to the lives of the individual involved and of their family, but which is still calculated to meet the needs of the individual and the department.

4-1702. General Considerations

Because of the varied types of calls they receive and their mobility within the community, the police officer is often expected to respond to a situation involving persons exhibiting behavioral abnormalities. The officer's course of action at this first encounter can both calm the existing situation and increase the chance that if subsequent treatment is needed for the individual it will be more effective. The following procedures will be helpful in this regard.

- 4-1702.1 Take time to look the situation over, and to gather and record as much information as possible. The officer should make note of all signs of abnormal behavior that is observed, the circumstances under which they are observed, and any other pertinent information about the individual they can learn. This information should all be included in the officer's report of the incident.
- 4-1702.2 Call for assistance and information relating to possible missing persons or elopee reports from the dispatcher. If possible, contact the Dane County Mental Health Center for background information they may have on the individual and for general advice.
- 4-1702.3 Do not abuse or threaten. Project yourself as a friend who is both concerned and anxious to help. A badly frightened or disturbed individual will become more difficult to handle if he/she sees the police officer as an enemy.
- 4-1702.4 Avoid excitement. Do not let crowds gather. Remove the disturbed individual from the scene of excitement and to a quiet atmosphere. If there are family or friends present who have a calming effect on the individual, they should be kept with him/her.
- 4-1702.5 Do not deceive the individual. Deception can create a lack of trust towards the officer and reduce the effectiveness or later treatment.

4-1702.6 If physical restraints become necessary, every effort should be made to avoid injury to the individual, to the officers, or to bystanders. If possible, the person should be restrained by holding his/her arms or by wrapping him/her in a blanket or a coat. An ambulance should be called to transport the individual. Ordinary handcuffs can cause severe injury to violently disturbed individuals, and should be avoided where possible.

4-1703. Dispositions

An officer's disposition in a given situation will depend on two factors: (1) the nature of the situation and (2) the behavioral aberration of the individual involved in the situation. The following is a list of dispositions which should be considered in turn:

1. Release of the individual with a referral made to a mental health agency.
2. Placing the individual in the custody of his/her family or friends.
3. Consultation with a mental health professional.
4. Arrest for a statute or an ordinance violation or emergency temporary detention.

4-1703.1 Release and Referral

If the situation that the officer encounters is of a minor nature and the person's behavioral aberrations do not appear incapacitating, release and referral may be the appropriate response. Before the officer releases an individual s/he should be reasonably confident that the situation will not reoccur, and that the person who exhibited the abnormal behavior can be safely left on his/her own. The officer should not release persons who remain extremely excited or who are in a generally helpless state. The individual should be transported away from the scene of the incident if this can be done voluntarily, and if the officer feels this will help alleviate the situation. Before the officer releases the individual s/he should refer the individual to an agency that might provide professional help to the individual. However, the officer should not refuse to release him/her merely because it appears the referral will be ignored. When a referral has been made, the officer should notify the agency and give the agency as much information about the situation and the individual as she/he can. This will be done by forwarding a copy of the officer's report to the agency. The individual should be told that the officer is making a referral and that the individual can expect a contact within a day or so by a mental health professional.

4-1703.2 Release of the Individual to the Custody of Family or Friends

If the situation that the officer encounters is of a minor nature, but the behavior of the person involved appears severe enough to make release of the individual on his/her own unsafe, she/he should, if possible, be placed in the custody of someone who can care for him/her. Generally, this will be the individual's family or friends. She/He

should also be placed in the custody of his/her family or friends if the officer concludes that the situation will reoccur if the individual is left on his/her own. This alternative should be followed when the person involved appears to be severely retarded, senile, emotionally upset or confused so as to be unable to care for his/her own safety. The officer should give a complete account of the situation to the person in whose custody she/he leaves the individual who exhibits abnormal behavior. The officer should refer the family to one of the agencies on the referral list and notify the agency of the referral by forwarding a copy of the officer's report to the agency. The individual and family should be told that the officer is making a referral and that they can expect a contact by a mental health professional within a day or so.

#### 4-1703.3 Consultation with Mental Health Professional

If the situation exists where you do not feel comfortable simply releasing and referring the individual, you should seek consultation from a mental health professional. This is done by contacting the Dane County Mental Health Center's Crisis Intervention Staff, either in person at 31 South Henry Street between 8 am and 5 pm Monday through Friday, or by phone at 251-0411, 24 hours a day. The Crisis Staff have the capability to respond in person to the scene if necessary. At this time, the mental health professional will consult with the officer and the individual to advise the officer before the officer decides on a final disposition. Do not simply drop a person off at the Dane County Mental Health Center. Contact someone willing to take responsibility for the individual and provide that mental health professional with all information you have regarding the person and the circumstances surrounding his/her behavior. The officer should keep the safety of the mental health professional in mind in determining whether s/he will leave the individual in question in the custody of the mental health professional.

#### 4-1703.4 Arrest for a Statutory Violation

Arrest, of course, is always the appropriate disposition when a felony has been committed. Arrest is also appropriate if the situation is one in which the officer would normally make an arrest if there were no signs of abnormal behavior, and the officer concludes that the signs of abnormal behavior observed are minor or unrelated to the violation. In addition, arrest may be the most appropriate disposition if the individual exhibits signs of abnormal behavior from which the officer concludes that the person cannot be safely released on his/her own, and the following factors are present: (1) the original incident involves some violations of a statute by the individual; (2) no one can be located who can safely take custody of the individual; (3) the individual will not voluntarily admit himself/herself to a medical facility; (4) the criteria for emergency temporary detention as laid out in the next section, do not exist. Ordinance violations do not allow the court to order treatment, therefore, in those instances, statutory violation should be used.

4-1703.5 Emergency Temporary Detention

Emergency Temporary Detention Pursuant to a Police Officer's Statutory Authority

The Police Officer's Affidavit for Temporary Custody is a form to be used in conjunction with an officer's statutory authority, granted under Wisconsin Statutes Section 51.15(1), to place into temporary custody, persons who are violent or who threaten violence and who appear irresponsible and dangerous. When an officer uses this authority, they are initiating a process that may result in the detained person being involuntarily committed to a mental institution. The statutory requirements for the use of this authority are analogous to the requirement that there be probable cause to make an arrest without a warrant. If these statutory requirements as judicially interpreted do not exist, an officer has no authority to use the procedure.

Blank Police Officer Affidavit forms are available in the office of the Lieutenant of Patrol, at the Dane County Mental Health Center, at the emergency room of each hospital in the Madison area, and at the Psychiatric Intervention Clinic at University Hospital. Additional forms may be obtained at County Court Branch 1.

1. Conditions for Use

The Police Officer's Affidavit will be used only when the following conditions exist:

- a. The statutory requirements as interpreted and listed below exist:
  - (1) The officer shall have observed or have learned from a reliable source of specific violent or dangerous acts, or attempts or threats to perform specific violent dangerous acts by the individual.
  - (2) The officer shall have reason to believe, based on their own observations or on information provided by the mental health professional, that the behavior was the result of some mental abnormality.
  - (3) The person's conduct constitutes an imminent danger of substantial physical harm to himself/herself or others.
- b. The officer determines that none of the earlier listed dispositions is appropriate.
- c. The mental health professional concurs with the officer that the behavior observed was the result of a mental abnormality.

2. Procedures for Use

When it is anticipated that temporary detention will be initiated pursuant to an officer's specific statutory authority, the officer should follow the procedure outlined below.

- a. The dispatcher and OIC should be notified that the officer will be seeking mental health consultation reference the individual in question.
- b. Call Dane County Mental Health Center's Crisis Intervention Service, [REDACTED], for consultation. At this point, a determination will be made whether Crisis personnel will respond to the scene, or whether the subject should be conveyed to the Mental Health Center, for further evaluation.
- c. The investigating officer should give to the mental health professional all the pertinent information relating to the individual for whom emergency detention is contemplated. This information should include the nature of the original situation, all signs of abnormality that the officer has observed, the specific acts, attempts or threats of violence made by the individual and the circumstances under which they occurred, background information about the individual, and the reasons that emergency detention is being sought.
- d. If the mental health professional agrees that the conduct in question was the result of a mental abnormality, the officer should complete five (5) copies of the Police Officer's Affidavit for Temporary Custody. Copies may be made on a copying machine. One copy of the Affidavit will be given to the individual. The officer will read the Constitutional Rights attached to the Affidavit, along with giving the individual a written copy of these rights.
- e. If the mental health professional does not agree that detention is appropriate, the officer should proceed with the commitment only after after getting concurrence from the OIC.
- f. Mendota Mental Health Institute, the detention facility, should be notified by phone that a patient will be transported there to the Administration Building at Mendota and taken to the Admissions Office. At this time, Mendota should also be advised as to whether security personnel are needed to assist in admission. The patient should be turned over to the hospital personnel along with a copy of the Affidavit. The officer should endorse on each additional copy of the Affidavit the date and time the patient was received by Mendota Hospital. If necessary, the officer should remain with the patient until the admission is complete.
- g. The original Affidavit shall immediately be returned to the office of County Court Branch I. If the office is closed, slide the original Affidavit under the door. The officer will also complete an officer's report on the incident, attaching the remaining Affidavits to the report.

4-1704. Referral List - Mental Illness & Abnormal Behavior

The following is a list of agencies to which an officer might wish to refer an individual exhibiting abnormal behavior.

1. Dane County Mental Health Center  
31 South Henry Street  
Phone: 251-2341

Provides the most complete range of out-patient treatment and counseling available in Dane County. Coordinates all of Dane County's mental health facilities and can make further referrals. Treats mental illness, alcoholism, drug dependency and other emotional problems. Emergency Mental Health Service by phone available to the general public at 251-2345.

Limitations - does not provide any in-patient services.  
Fees - based on ability to pay.

2. Catholic Social Services  
25 South Hancock  
Phone: 256-2358

Provides counseling by psychologists and social workers in areas of mental illness, alcoholism, drug dependency and family-related problems.

Limitations - no in-patient services. Have a part-time staff psychiatrist.  
Fees - based on ability to pay.

3. Private Clinics and Private Practitioners

The Madison area has many private psychiatric and psychological clinics and private practitioners. Although the individual clinics may have some specialty, among them the full range of counseling and treatment for all mental disorders is available.

Limitations - The clinics cannot actually provide hospitalization but they can arrange for hospitalization.  
Fees - The fees a patient must pay vary considerably from clinic to clinic. Psychiatrists are listed in the Madison phone book yellow pages under "Physicians and Surgeons". Psychologists are listed under "Psychologists".

4. Hospitals

The following hospitals provide emergency psychiatric care through the hospital emergency room.

- a. Madison General Hospital  
202 South Park Street  
Phone: 267-6206

- b. Methodist Hospital  
309 West Washington Avenue  
Phone: 251-2371
- c. St. Mary's Hospital  
707 South Mills Street  
Phone: 256-6000
- d. University of Wisconsin Hospital  
600 Highland Avenue  
Phone: 262-2398
- e. Veteran's Administration Hospital (For veterans only)  
2500 Overlook Terrace  
Phone: 256-1901

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I. POLICY

Police encounters with persons displaying symptoms of mental disorder require the exercise of extreme caution and adherence to established guidelines in order to protect the rights of individuals and insure public safety. It is the policy of the Department that non-arrest resolutions of mental cases will be attempted whenever possible. Ideally, contacts with mentally disturbed persons will result in a referral to appropriate facilities on a voluntary basis. When public safety demands otherwise, involuntary detentions must be resorted to; however, the placing of criminal charges for the purpose of taking such persons into custody is to be avoided if possible. The effective and humane disposition of mental disturbance calls requires adherence to the procedures set forth in this General Order. A coordinated effort between the police, courts, and mental health agencies is essential to the achievement of a professional approach to the problem.

II. STATE LAW

The Code of Virginia, Section 37.1-67.1, sets forth the procedures to be followed regarding the involuntary detention of mentally disturbed persons. There is no authority for a police officer to take a mentally disturbed person into custody without a warrant or detention order. Persons who appear mentally ill may be arrested for the commission of a specific offense, but the placing of charges such as Disorderly Conduct is appropriate only as a last resort.

III. PROCEDURES

A) Voluntary admissions to mental health facilities

- 1) Persons who appear to be in need of mental health treatment, and do not pose an imminent danger to themselves or others, should be referred to a mental health facility. A family member or other responsible person is often available to assist

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the disturbed person in seeking such treatment. Emergency clinics are operated at the Woodburn Center and the Mount Vernon Center for Community Mental Health. Northern Virginia Mental Health Institute is a public in-patient facility for Northern Virginia.

- 2) Persons who have been or are under the care of a private physician should be referred to the physician, if possible.
- B) Involuntary Admissions
- 1) If no emergency exists, a relative or any responsible person may petition a judge of the Fairfax General District Court to order the detention and a hearing for a person who is believed to be in need of mental health treatment. This procedure applies during hours when the court is in session.
  - 2) During hours when the court is not in session, persons may seek the issuance of a mental detention order from the magistrate on duty at the ADC, Groveton, or Mason.
  - 3) Police officers should refrain from initiating involuntary admissions unless there is no relative or other responsible person available and/or the suspect mentally ill person appears to be dangerous to himself or others.
- C) Mobile Crisis Unit
- 1) The Woodburn Center operates a Mobile Crisis Unit during the hours of 1600 to 2400 seven days a week. The Unit is comprised of three mental health professionals: a psychiatric nurse, a psychologist, and a psychiatric social worker. Two of the above persons will be working as a team during the stated hours.
  - 2) The mission of the Mobile Crisis Unit is two-fold.

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- a) To respond to calls from Judges, Special Justices, and Special Magistrates for the purposes of evaluating persons to determine whether detention is warranted, or in affecting feasible alternatives to involuntary detention.
- b) To respond to Police Department requests for assistance in cases involving mental health problems where counselling is of potential benefit. Assistance may be provided by telephone consultation or by response to the scene where appropriate.
- 3) If the person in need of mental health treatment is an imminent danger to himself or others or in need of medical treatment and immediate involuntary detention is appropriate, the procedures outlined under III. D) below shall be followed in lieu of contacting the Mobile Crisis Unit. If a family member is available, that person should be the petitioner.
- 4) If the person appears willing to talk with a mental health professional, but is unwilling or unable to come to a mental health facility, contact the Mobile Crisis Unit for telephone consultation or to arrange for a field visit if appropriate. The Mobile Crisis Unit may be contacted as follows:
  - 560-0224 - Unpublished, for police and court use only; or
  - 573-5679 - Mobile Crisis Unit public line.
- 5) If the Mobile Crisis Unit responds to a scene to assist the Department, police officers shall remain at the scene until the Mobile Crisis Unit arrives and the safety of all persons is assured.
- 6) In cases where the Mobile Crisis Unit responds

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to a scene, but determines that involuntary detention is unavoidable, a family member or a police officer shall be the petitioner. The procedures outlined in III. D) below apply where a police officer is the petitioner. Members of the Mobile Crisis Unit do not have the authority to detain a person suspected of being mentally ill.

- 7) Where the Mobile Crisis Unit makes a field contact at the request of the court, a Special Magistrate may be designated to request simultaneous assistance from the Police Department. Upon such request, appropriate police manpower will be dispatched to the scene to meet with the Mobile Crisis Unit and provide security assistance until there is a reasonable certainty that no imminent danger to the persons involved exists, and that immediate detention is not appropriate. If immediate detention is appropriate, utilize the procedures outlined in III: D) of this Order.
  - 8) The Mobile Unit is unable to provide transportation. In some voluntary cases the police may be requested to transport after voluntary treatment has been arranged. Whenever possible, a member of the Mobile Crisis Unit will be requested to accompany such cases in the police vehicle.
- D) Emergency Admissions Initiated by Police Officers
- 1) During Court Hours.
    - a) Contact a judge of the Fairfax General District Court and explain the circumstances which indicate the need for immediate detention.
    - b) The judge will ascertain the availability of detention facilities and issue instructions concerning custody of the individual.
    - c) The hearing time, date, and location will be established by judicial authority and

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the police officer will be required to attend unless the detainee agrees to voluntary admission and waives the right to a hearing.

2) During hours when court is not in session

a) Contact the magistrate at Fairfax or Groveton and relate the circumstances which warrant immediate detention.

b) The magistrate will determine the availability of detention facilities and then contact a Special Justice or a judge for the authority to detain, if necessary, as outlined below.

c) Magistrate must have advice from a person skilled in the diagnosis and treatment of mental illness prior to issuing an order on their own authority; otherwise they must receive authorization from a judge or Special Justice.

d) Upon receipt of verbal authority to detain, the officer will take the person into custody and proceed to the facility designated for detention. Another officer will secure the written detention order and deliver it to the designated facility. The detention order must be presented to the designated facility prior to admission of the detainee.

E) Custody and Transportation of Mentally Disturbed Persons

1) Proper restraining devices will be used if necessary to prevent injury to the individual or the officer. The decision to use handcuffs will be based on the totality of circumstances and the potential for violence exhibited by the detainee.

2) Persons taken into custody shall be transported in a cruiser equipped with a safety shield.

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If possible, two officers should handle the custody and transport of mentally disturbed persons. Extremely violent persons may require special restraints and transportation by ambulance to the detention facility. If ambulance transportation is used, one officer will accompany the ambulance crew during transport if requested by them.

- 3) Persons taken into custody who are in apparent need of medical treatment independent of their mental disorder must be taken to the Fairfax Hospital prior to being taken to the detention facility.
- 4) Persons taken into custody will remain the responsibility of the police officer until custody is assumed by receiving personnel at the detention facility. If the officer has the proper detention order upon arrival at the designated facility, there should be minimal delay in relieving the officer of custodial responsibility. In the case of an escapee, the arresting officer shall transport the subject to the nearest special magistrate, who will either find bed space for the subject, or make arrangements to transfer custody to the Sheriff's Department. Until placement is determined by the magistrate, the arresting officer is responsible for custody of the escapee.
- 5) If an officer is guarding a mental patient at the Fairfax Hospital and for reasons of personal safety feels that physical restraints are necessary for the patient, due to the individual's conduct, the officer should contact the Administrative Nursing Supervisor. The Administrative Nursing Supervisor should be requested to observe the patient's actions or conduct and to contact the appropriate physician, if restraints are required. Nothing in this section shall preclude officers from restraining individuals without prior approval in an emergency situation.

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- 6) Officers shall cooperate fully with and assist personnel at the detention facility. This includes compliance with any detention facility regulations concerning the securing of police weapons.
  - 7) If an officer is required to guard a mental patient at Fairfax Hospital, the officer may contact the Administrative Nursing Supervisor to request that the person be placed on another ward, if the officer feels that giving up his revolver represents a threat to his/her safety. Space availability will be a factor.
  - 8) The officer transporting the detainee shall advise the Emergency Operations Center of his destination and estimated time of arrival so that a telephone call can be made alerting the receiving facility that a mentally disturbed person is en route.
- F) Hearings Following Involuntary Detention.
- 1) The officer executing the detention order is not required to attend the hearing unless he is named as the petitioner. This should only occur in cases where immediate detention is necessary and there is no relative or other responsible person available to request detention.
  - 2) A preliminary hearing will be held within 24 hours of detention, normally at 0830 hours on the morning following detention. If the officer is the petitioner, he must be present at the preliminary hearing. The detainee may waive his right to a final hearing and agree to voluntary admission during the preliminary hearing.
  - 3) A final hearing will be held within 48 hours

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of detention unless waived by the detainee.  
The officer's presence is necessary at this  
hearing if he is the petitioner.

G) Service of Mental Detention Orders/Warrants, Escape Warrants

- 1) EOC personnel who receive a request for the service of a warrant/order shall record the necessary information for the dispatch of an officer. The warrant desk shall be notified of the warrant/order and such warrant/order shall be entered into the Department's active warrant file.
- 2) The officer receiving the warrant/order shall immediately verify that it has been properly completed and signed. Special instructions, as to the time of service or place of detention, shall be noted.
- 3) If the warrant/order cannot be served within the same shift as received, or at the time designated, the issuing authority shall be notified and the reason service cannot be made shall be provided. The issuing authority shall determine whether another attempt at service should be made later or whether the warrant/order should be returned to the court or detention facility.
- 4) Persons served with mental petitions for detention at the Northern Virginia Mental Health Institute during the periods between 1700 and 0800 hours on regular weekdays, on weekends and State (not County) holidays, must first be taken to the Woodburn Center for Community Mental Health, where they will be examined by a physician. The officer(s) must remain at Woodburn during this time. At the conclusion of the examination, the officer(s) will then take the person to the Northern Virginia Mental Health Institute for detention.

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H) Reporting Procedures

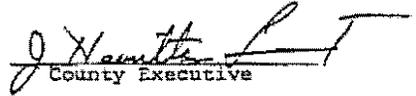
- 1) A complete investigation report shall be submitted by the assigned officer, detailing the circumstances of the incident. 10-99 clearances of such cases are not acceptable. The assigned officer shall contact the Warrant Desk whenever the warrant/order is served or returned to the issuer. The warrant control procedure shall be in accordance with General Order 601, Arrest Procedures, IV) B).
- 2) The custody of persons for the reason of alleged mental illness or escape from involuntary commitment shall not be recorded on any Department arrest document, either summons or CCRE. All facts and circumstances shall be included in the investigation report.
- 3) Any problems which arise concerning court procedures, contact with Special Magistrates, or personnel at the receiving facility shall be forwarded by memorandum to the appropriate bureau commander.

This General Order becomes effective December 1, 1982, and rescinds all previous rules and regulations pertaining to the subject.

ISSUED BY:

APPROVED BY:

  
 Chief of Police

  
 County Executive

OFFICER REFERRAL CARDS

Montgomery County, Pennsylvania

|   |   |                    |
|---|---|--------------------|
| Telephone 279-6100  | <b>MONTGOMERY COUNTY MH/MR EMERGENCY SERVICE</b><br><br><b>IMPORTANT INFORMATION</b><br>How to use the<br><b>MONTGOMERY COUNTY<br/>         MH/MR EMERGENCY SERVICE<br/>         FOR<br/>         DRUG/ALCOHOL/PSYCHIATRIC CRISES</b><br>Building 16, Norrisstown State Hospital<br>Norrisstown, Pa. 19401<br>For assistance with REAL and IMMEDIATE LIFE-<br>THREATENING situations when dealing with a person<br>whose behavior is out of control and who appears to be<br>mentally ill CALL:   | Telephone 279-6100 |
|   | MONDAY THROUGH FRIDAY — 9 a.m. to 5 p.m.<br>Voluntary Examinations Only<br><br><b>AREA      Montgomery County Mental Health Centers</b><br>461 Community Counseling Service<br>1314 High St., Pottstown 19464      326-9250<br>462 Penn Foundation for Mental Health<br>807 Lawn Ave., Sellersville 18988      257-6551<br>463 COPE Professionals<br>English Village Prof. Center<br>Suite 208 - North Wales 19454      643-8522<br>464 Abington Hospital MH/MR Center<br>Old York Rd., Abington 19001      576-2525<br>465 Central Montgomery MH/MR Center<br>1100 Powell St., Norrisstown 19401      277-4600<br>466 Lower Merion Counseling Service<br>2A Rittenhouse Pl., Aramore 19003      648-6512 |                    |
| <p>The Montgomery County Emergency Service deals with<br/>         urgent Drug/Alcohol and Psychiatric crises where immediate<br/>         intervention minimizes risk to client and/or others.<br/>         If client is in need of admission and is unwilling or unable<br/>         to sign a Voluntary Admission (201), the Mental Health Act<br/>         provides for an Involuntary Commitment (302).<br/>         This means that if Police officers upon personal observa-<br/>         tion of conduct that indicates a person "poses a clear and<br/>         present danger to self/others and is severely mentally disabled"<br/>         can take this person to Building 16, or 2) A physician, relative,<br/>         friend or other responsible party can make an application for<br/>         emergency examination, "setting forth facts that a person is<br/>         severely mentally disabled."<br/>         The Evaluating Physician determines whether a 302 admission<br/>         is appropriate.</p> <p>Procedure to follow:</p> <ol style="list-style-type: none"> <li>1) Bldg. 16 is the designated facility for Involuntary Emer-<br/>             gency Examinations in Montgomery County--24 hours/day,<br/>             seven days/week.</li> <li>2) For Voluntary Examinations only, Monday through Fri-<br/>             day, 9AM to 5PM, call the Mental Health Center in your<br/>             Catchment Area listed on the back of this card.</li> <li>3) After 5 p.m. on weekdays and on weekends, call direct to<br/>             Bldg. 16 for Voluntary Examinations - 279-6100.</li> <li>4) For advice concerning Emergency Procedures, call 279-6100<br/>             at any time.</li> </ol> <p style="text-align: center;"><b>for<br/>         DRUG/ALCOHOL/PSYCHIATRIC CRISES<br/>         CALL:<br/>         279-6100<br/>         24 hours a day, 7 days a week</b></p> |   |                    |

Madison, Wisconsin

|   |   |
|---|---|
|  | <b>CRISIS INTERVENTION SERVICE<br/>         TELEPHONE NUMBERS</b>   |
|   | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">             Restricted to Professional Use Only<br/>             Do Not Release to Others           </div> <p style="text-align: center;">             Emergency Number<br/>             For Use by General Public<br/> <b>251-2345</b> </p> |
| <p>31 South Henry Street<br/>         Madison, WI 53703<br/>         251-2341</p>   |   |



APPENDIX F

ASSESSMENT QUESTIONNAIRE FOR  
POLICE OPERATORS, DISPATCHERS  
AND PATROL OFFICERS

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QUESTIONS FOR ASSESSING MENTAL HEALTH PROBLEMS

To aid operators, dispatchers, and officers, the following questions should be asked of a caller who is mentally disabled or who is complaining about a mentally disabled person (MDP).

1. Is the MDP using or threatening violence?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
  
2. Is the MDP threatening suicide?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
  
3. Is the MDP acting dangerously towards himself or others?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
  
4. Has the MDP been neglecting personal care or bodily functions?  
NO YES
  - a. Has the MDP mutilated himself? NO YES
  - b. Has the MDP neglected bathing within the past few days? NO YES
  - c. Has the MDP neglected eating within the past few days? NO YES
  - d. Has the MDP neglected taking prescribed medications? NO YES
  - e. Has the MDP been sleeping irregularly? NO YES

The above questions pertain to state law criteria for involuntary commitment. If the answers to these are positive then an emergency exists which requires a patrol response.

5. Has the MDP recently suffered a traumatic experience?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
  
6. Does the MDP have a history of mental illness?  
NO YES Illness \_\_\_\_\_  
Doctor \_\_\_\_\_  
CMHC \_\_\_\_\_  
Hospital \_\_\_\_\_

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7. Does the MDP feel that his behavior is controlled or influenced by outside forces?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
8. Does the MDP ever receive messages from strangers, radio, or television?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
9. Does the MDP hear voices when others do not?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
10. Does the MDP see things when others do not?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
11. Does the MDP indicate that others are plotting against him or are after him?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
12. Does the MDP claim that others can read his thoughts?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
13. Does the MDP claim that he can read other's thoughts?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
14. Is the MDP overly concerned with religion or death?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
15. Is the MDP oriented to his environment, i.e., time, place, and person?  
YES NO, specifically \_\_\_\_\_  
\_\_\_\_\_

16. Did the mood of the MDP drastically change during the course of the conversation or interview?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_
17. Was the mood of the MDP appropriate for the nature of the call?  
YES NO, specifically \_\_\_\_\_  
\_\_\_\_\_
18. Does it appear that the MDP is under the influence of alcohol or illegal drugs?  
NO YES, specifically \_\_\_\_\_  
\_\_\_\_\_



**APPENDIX G**  
**SUGGESTED TRAINING MATERIALS**

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APPENDIX G1  
TRAINING FILMS

The Cry for Help--Produced by the United States Public Health Service, 1963, 33 minutes, B&W, 16 MM optical sound. Rental fee of \$25 for three days; purchase price \$200. Order from National Audiovisual Center, Government Services Administration, Order Section/RA, Washington, D.C. 20409; 301/763-1896.

A training film for police officers and law enforcement agencies, designed to develop a feeling of concern and understanding in handling the suicidal person. Presents some of the major causes of suicide and problems of handling. Teaches law enforcement officers to recognize their "cry for help."

Handling Suicide Threats--A Harper and Row Criminal Justice Media program produced by Bay State Film Productions with Dr. Morton Bard serving as consultant, 23 minutes. One week rental fee of \$75 for film or video; purchase fee of \$450 for the film and \$400 for the video. Order from MTI, Teleprograms, Inc., 3710 Commercial Avenue, Northbrook, IL 60062; phone toll free 1-800-323-5343; in IL, AK, and HI call collect 312/291-9400.

Discusses and demonstrates strategies that begin with the initial call-in and dispatcher's response and follow-through to the tactical and psychological techniques necessary to develop interface between the responding officer(s) and the person attempting suicide. Case histories illustrate both what to do and what to avoid doing.

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Topics covered include: the importance of officer attitude in this type of crisis intervention, motivating factors behind suicide attempts, methods for ensuring the safety of bystanders and officers, and specific techniques for dissuading a person attempting suicide.

The Mask--Produced by the United States Public Health Services, 1965, 33 minutes, B&W, 16 MM optical sound. Rental fee of \$25 for three days; purchase price \$205. Order from National Audiovisual Center, Government Services Administration, Order Section/RA, Washington, D.C. 20409; 301/763-1896.

Informs the police that alcohol may mask symptoms of both physical and mental disorders and suggests a system of observation that begins when a person is first seen by the police. It emphasizes the significance of alcoholism as a problem and stresses the increasingly humanitarian role of the police.

Mental Disorders--Produced by Police Science Services. Eighty color slides and carousel tray with narration cassette, instructor's guide, 25 questions and answers, and 25 student handouts. Rental fee \$125. Order from: Police Science Services, United Learning, 6633 West Howard Street, Niles, IL 60648; 800/323-9468.

When a person suffers a severe mental attack at home or in a public place, a police officer is usually the first responsible person to reach the scene. Topics include behavior expectations, crowd control, stabilizing actions, securing professional help, mental derangement in ordinary offenses, and securing and transporting subjects.

Mental Illness--Published by Harper and Row, Inc., 20 minutes, 16 MM color. Available for rental and purchase. Order from MTI Teleprograms, Inc., 3710 Commercial Avenue, Northbrook, IL 60062; phone toll free 1-800-323-5343; in IL, AK, and HI, call collect 312/291-9400.

Discusses how mental illness can affect anyone. Explains how many behaviors fall into a normal range. However, if the behavior is inappropriate for the setting, then mental illness should be considered. Offers guidelines for officers to follow in identifying and interacting with the mentally ill and identifies specific reactions by officers that should be avoided.

One Step Ahead Series

Based on practices developed by mental health consultants Peter Moriarity and Martin S. Samuels under the auspices of St. Francis General Hospital, Pittsburgh. Guides accompany each film. Each production can be rented for one week at \$75, film or video; purchase prices for each production are \$475 for the film and \$430 for the video. Order from MTI Teleprograms, Inc., 3710 Commercial Avenue, Northbrook, IL 60062; phone toll free 1-800-323-5343, in IL, AK, and HI call collect 312/291-9400.

One Step Ahead I--Produced for MTI by American Image Films, Ltd., 28 minutes. Explores the various types of emotional crisis situations and presents viable solutions based on the degree of violence involved. Shot in actual patient-care facilities, it presents

three main goals of crisis control: to deal humanely with the disturbed person without causing emotional trauma; to avoid causing injury or physical pain; and to control the crisis by always being "one step ahead" of any situation. Included are the verbal control response, the simple physical "basket-hold" form of restraint, and the "basket-hold and takedown" method for controlling extremely violent patients.

One Step Ahead III: Verbal Techniques--Produced by Producer Services Center, 20 minutes. Focuses on proper intervention techniques which can de-escalate a volatile situation and calm a potentially aggressive patient. Shows several verbal techniques in action and stresses their use in responding to the client needs while avoiding physical confrontation.

Suicide--Produced by Police Science Services. Eighty color slides and carousel tray with narration cassette, instructor's guide, 25 questions and answers, and 25 student handouts. Rental fee \$125. Order from Police Science Services, United Learning, 6633 West Howard Street, Niles, IL 60648; 800/323-9468.

Suicide attempts present emergency problems that are not easy to solve on the spur of the moment. This set of materials will help both the officer on the scene and the dispatcher to stabilize the situation until a psychiatrist or trained social worker arrives.

What Would You Do?--Available to rent or purchase, 15 minutes, VCR, color. Order from MTI Teleprograms, Inc., 371D Commercial Avenue,

Northbrook, IL 60062; phone toll free 1-800-323-5343; in IL, AK, and HI call collect 312/291-9400.

Presents six two- or three-minute scenarios involving the mentally ill and retarded. After establishing the situation, the narrator poses questions for the viewers regarding the possible actions an officer could take. Group discussions of appropriate actions should then follow.

APPENDIX G2  
SUGGESTED READINGS

The Police Role

Bittner, Egon. "Police Discretion in Emergency Apprehension of Mentally Ill Persons." Social Problems, Vol. 14, 1967.

One of the original and certainly one of the most comprehensive discussions of the police role regarding the mentally ill. The primary concern of this piece is on the rules and considerations underlying the exercise of discretion in emergency apprehensions. Organizational and attitudinal factors are examined as are conditions surrounding emergency apprehensions and non-official ways of dealing with mentally ill persons. The author concludes that the tasks of managing the mentally ill are a legitimate part of police work and of what the public expects of officers.

Matthews, Arthur A. "Observations on Police Policy and Procedures for Emergency Detention of the Mentally Ill." The Journal of Criminal Law, Criminology and Police Science, Vol. 61(2). June, 1970.

Discusses the issue of police handling of the mentally ill from legal and medical perspectives and how these perspectives affect law

enforcement policy and procedures. Both formal and informal procedures used by officers are discussed as well as procedures established by local mental health agencies. Additionally, there is a discussion of appropriate police roles and responsibilities for managing the mentally ill.

Snibbe, John R., and Homa M. Snibbe. The Urban Policeman in Transition. Springfield, Illinois: Charles C. Thomas, 1973.

A collection of essays and articles dealing with the changing roles in police work. Works by Bodin, Jacobson, Snibbe, and Sokol discuss the role of police officers in relation to the mentally ill, relationships between police and mental health agencies, and an examination of police referrals and emergency detentions for examination.

The Police and Community Mental Health

Gesnik, Bernard I., Nancy Pierce, and Michael Puls. "Law Enforcement and Crisis Intervention Services: A Critical Relationship." Suicide and Life Threatening Behavior, Vol. 7(4), Winter, 1977.

Explains how the police department and community mental health center work together to provide officers with 24-hour mental health assistance. Discusses the planning, training, implementation, and maintenance phases of the relationship-building process. Particular

emphasis is given to the importance of mutual planning, cross-training and frequent liaison between the two professions. A key element in the success of this relationship is the identification of a sworn officer to coordinate the department's policy, procedure, training, records and liaison regarding encounters with the mentally ill.

Hanewicz, Wayne B. Lynn M. Fransway, and Michael W. O'Neill.

"Improving the Linkages Between Community Mental Health and the Police." Journal of Police Science and Administration, Vol. 10. 1982.

Describes in detail the process utilized to establish law enforcement-community services interfacing policies and corresponding methods to promote interorganizational growth and communication. Specific steps are recognized as aiding in the identification of the particular problem, the development of policy and procedure, the use of policy and operational teams to develop and implement changes, and continual evaluation of the policies and procedures. An evolving, flexible process allows for internal and external changes in both the law enforcement and mental health agencies as well as in the coordination of services.

Monahan, John, ed. Community Mental Health and the Criminal Justice System. Elmsford, New York: Pergamon Press, 1976.

A collection of essays and articles dealing with interaction between these two systems. Topics include interaction among police, jails, prosecutors, the judiciary, and mental health agencies; changes in mental health law; differences between the two systems; principles of mental health practices; and the benefits of coordination. Noted authors include Saleem Shah, Philip Mann, Allan Beigel, and Marc Abramson.

Managing Encounters

Russell, Harold E., and Allan Diegel. Understanding Human Behavior for Effective Police Work. New York: Basic Books, Inc., 1976.

Describes the origins and complexities of human behavior, explaining the development and functioning of the normal personality and the conflicts that may lead to abnormal behavior. Guiding principles for understanding mental illness are presented as is a virtual catalog of the kinds of deviant behavior an officer is likely to encounter. Case histories illustrate typical crisis situations and suggestions are provided for identifying and managing the mentally disabled. A final section looks at the police officer as a person, discussing his needs and expectations, and the normal stresses and dissatisfactions his job is likely to create.

Goldstein, Arnold P., et al., Police Crisis Intervention. Elmsford, New York: Pergamon Press, 1979.

A detailed guide outlining a four-step action plan for dealing with virtually any crisis call. Five contributing authors address family disputes, mental disturbance, drug and alcohol intoxication, rape, and suicide by providing specific recommendations for managing each of these crises. Also discussed is the effectiveness of crisis intervention training from both a contextual and procedural perspective and includes an outline and recommendation for Structured Learning Training, a four-procedure, active training technique.

Matthews Robert A., and Loyd W. Rowland. How to Recognize and Handle Abnormal People. Arlington, Virginia: Mental Health Association, 1979.

A four-part manual designed to aid in the management of the mentally disabled, drug addicts, sex offenders, and alcoholics. Part One is concerned with recognizing and handling individuals believed to be mentally disabled. Part Two describes special mental conditions that might be encountered by officers. Abnormal group behavior is discussed in Part Three, and Part Four addresses personal problems an officer can experience as a result of his or her work.

Kennedy, Margaret, et al. Mentally Retarded Offender: A Handbook for Criminal Justice Personnel. Cleveland: Federation for Community Planning, 1982.

Provides a basis for identifying mentally retarded persons in the criminal justice system and for adequately handling mentally retarded persons. Topics include defining mental retardation; describing, identifying, and interviewing mentally retarded persons; assessing court cases; determining the disposition of a court case; and supervising and habilitating mentally retarded offenders. Includes a glossary and bibliography.



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