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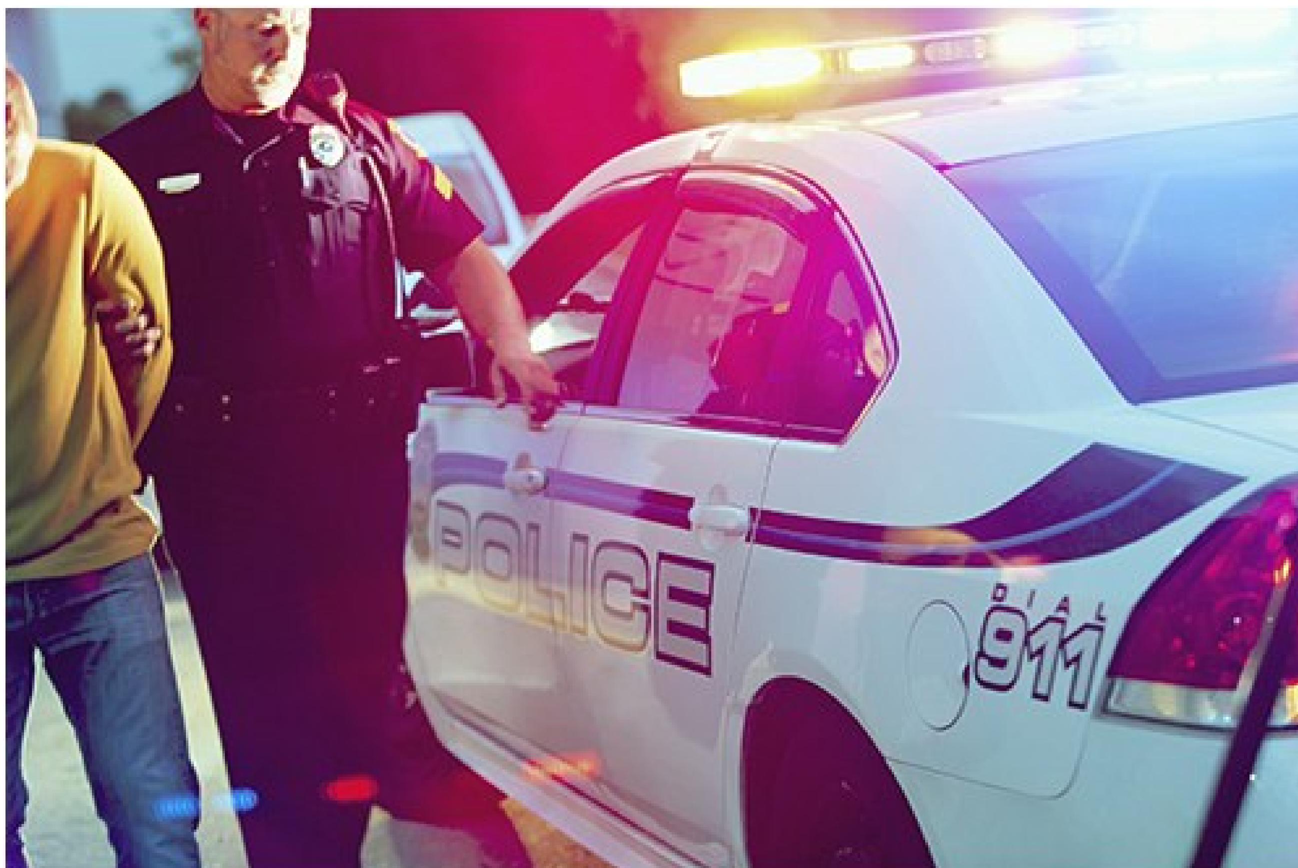
The Importance of Mental Health Training in Law Enforcement

By Nicholas Wilcox, M.S.



As mental health problems within communities have increased over the past 40 years, inpatient services have decreased. Therefore, police departments have had to meet the growing needs of individuals suffering mental health emergencies. Police officers not only are the first responders to these crises but often are the only source of immediate service for urgent mental health activities. Various efforts to address mental illness in communities have been instituted by police agencies; however, the implementation rate is incongruent with the number of mental health-related service calls.

Evolution of the Problem

In 1955, 75 percent of individuals who experienced mental health episodes were treated in inpatient settings; by 1977 only 7 percent received inpatient care.[1] This process, termed “deinstitutionalization” by the mental health community, describes the removal of essential patient services in favor of more decentralized approaches.[2] Deinstitutionalization has occurred over time since the mid 1950s and was implemented to reduce the costs incurred by mental hospitals and shift the care away from state institutions that had negative societal perceptions. This shift is problematic because it creates few inpatient, intensive care opportunities for individuals. Additionally, it requires that each episode begins a new treatment process. Prior to this individuals who experienced episodes in an inpatient setting could continue their existing treatment plans, as opposed to starting all over. First responders—specifically those in law enforcement—often are the first step in the process.

The effects of deinstitutionalization can be explained through a fictional example. In 1950 John Doe, Sr., suffered his first schizophrenic break. He was arrested by a police officer during the occurrence and formally diagnosed while incarcerated. He spent the next two years in a state mental hospital, where he suffered 20 subsequent episodes that promptly were managed. John was released from the hospital, but was voluntarily readmitted six months later. He remained there for 18 months, during which he suffered another eight episodes. Between 1950 and 1954 John experienced 28 episodes during inpatient care.

John’s son, John Doe, Jr., experienced a similar course of events 30 years later. Unlike his father, the 28 episodes John, Jr., suffered from 1980 to 1984 occurred while he was living in the community. Each of his episodes resulted in arrest and involvement with the criminal justice system. John Doe, Sr., had one arrest on his record by 1954; in contrast, by 1984 John Doe, Jr., had 28. Instead of reducing the financial expense to the state, deinstitutionalization shifted the cost from state mental hospitals to law enforcement.

Programs for Change

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Police officers have a great deal of discretion when interacting with persons with mental illness at a scene; unfortunately, the most common case disposition is arrest.[3] The correctional system has become the primary vehicle for mental health treatment as state mental hospitals and inpatient treatment options dramatically have decreased. The top three most populous mental health institutions in the United States are jails—New York, New York's Riker's Island; Chicago, Illinois' Cook County Jail; and the Los Angeles County, California, Jail.[4]

A primary concern for officers often is how to effectively de-escalate mental health incidents involving agitated individuals when appropriate procedures are unknown to them. The Crisis Intervention Team (CIT) model is a promising resource for police departments to address and resolve these concerns. The CIT model involves 40 hours of course-based training led by mental health professionals. Its curriculum includes the signs and symptoms of mental illness, medications, de-escalation skills, and treatment options available in the community.[5] Numerous CIT-certified officers have indicated that their specialized training better prepared them for potential events on the street.[6]

Jail diversion initiatives are another important resource, with community-based programs designed to provide greater public safety and reduce the number of incarcerated individuals with mental illnesses. Diversion initiatives are available postarrest to redirect offenders with mental illness into mental health courts. These courts differ from standard criminal courts in that their primary goals are to provide treatment options that would not otherwise be available to offenders and to decriminalize nonviolent actions that are a byproduct of mental illness. By doing so incarceration rates are lowered, the needs of individuals are addressed more adequately, and resources are better employed.

Implementation of a Successful Program

Providing meaningful first-responder services to individuals with mental illness requires the implementation of several core components. First and foremost, a training model must provide a detailed program for officers to follow—the CIT model is one such strategy. The program must partner with local mental health professionals and foster an ongoing, deeply ingrained relationship.[7] Roles must be established at every level of the police organization, from dispatchers to responding officers, supervisors, and administrative personnel. The program should be tailored to fit the community—a "one size fits all" approach does not work with the CIT model. Finally, a significant partnership with community leaders and the mental health community should be established to educate the public on the goals of the program.[8]

Implementation of a broad mental health response program must take into account members of law enforcement reluctant to buy into its goals. Police officers are trained to question their environment and the actions of individuals. Police administrators are seasoned officers with decades of experience as frontline first responders. The CIT model imposes changes on the culture of law enforcement and the way officers interact with persons with mental illness. As a result, some officers may question the necessity of a revamped response process and doubt its methodologies.

The CIT model and jail diversion initiatives hinge on the availability of mental health services and practitioners. The further away these services are geographically, the more logistical challenges exist to implement a successful program. These issues are less common in metropolitan areas than in largely rural areas. One of the key aspects of the CIT model is the relationship between law enforcement and mental health professionals. Police administrators and officers must be willing to perform the additional groundwork to meet the needs of the mental health community.

Conclusion

The gradual but substantial shift away from treating persons with mental illness at state mental hospitals has overwhelmed the criminal justice system with an influx of offenders with mental health issues. Police officers frequently are the first step in implementing the mental health treatment process. Some departments have executed programs, such as the CIT model, to train officers as basic frontline caretakers in the assessment and management of offenders with mental illness. CIT-modeled programs potentially can reduce officer line-of-duty injuries, diminish departmental costs associated with use-of-force incidents and unnecessary arrest procedures, provide safer streets for communities, and adequately and efficiently address the needs of citizens with mental illness.

Police officers have a *parens patriae* obligation to protect those with disabilities.[9] Their actions when interacting with persons with mental illness have ripple effects across the criminal justice system and the communities they serve. Implementing industrywide mental health response programs can provide officers additional training to successfully interact with individuals suffering mental health crises and de-escalate these situations.

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Endnotes

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