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Police Interactions with the Mentally Ill: May be we Should Ask Different Questions

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In 1955, the US made the move to deinstitutionalize thousands of severely mentally ill persons. President Jimmy Carter's commission on mental health (1978) indicated that "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services." Thus, the goal was to support individuals' mental health needs in the least restrictive environment. As always, the details of implementation were critical. From the outset, law enforcement saw the consequences and attempted to bring in outside help to address the newly emerging population. Unfortunately, whether due to the laws regarding least restrictive environments, professional or administrative budget cuts, law enforcement agencies were called upon to interact with the ever-increasing number of individuals with severe mental health issues but with limited resources. Prior to 1955, many of these newly deinstitutionalized individuals were considered too ill to be home. After deinstitutionalization, those same individuals were considered "not sufficiently ill" to have a bed in a care facility. Did anyone ask law enforcement what the consequences of this action would be? Did anyone ask the clinicians what the outcome would be?

With police shootings of mentally ill individuals on the rise and public complaints of excessive use of force, police aim to change public perceptions regarding their treatment of the mentally ill. This challenge is not easily met due to perceptions of mental illness, the growing number of police encounters with the mentally ill, the varied goals of the community and police groups as well as the availability and access to resources to treat mental illness. While both the public outcry and police policy amendments are admirable, perhaps the focus should turn to the public's understanding of mental health disorders.

The stated goal of the Police is to act with honor and integrity while protecting the public and the public's property. When encountering an individual who appears threatening either to themselves or others, the police are called upon to quickly assess the risk a person poses and then choose a custodial or noncustodial resolution to the interaction.

The community's desire is to be protected and to have law enforcement address those with mental health challenges in a sensitive and measured way, without loss of life or harm. If the outcome of Police action results in loss of property, freedom, or life, many in the community will judge the law enforcement officers as having failed in their duty.

Law enforcement officers may receive up to 48 hours of training in mental health issues. With that training, they are tasked with gathering information, identifying potential mental health issues, making a rapid risk assessment and then taking action; sometimes within moments of arriving at on scene. Further, the assessments and determinations must remain consonant with the Police's stated goals of protecting and serving the public and maintaining their own safety. In contrast to law enforcement, trained Forensic psychologists, having received between 2,000 to 6,000 hours of supervised training before licensing, are frequently tasked with

making risk assessments both before and after an individual is in custody.

Police perceptions of persons with mental health disorders have improved over the last few years with inclusion of clinicians in the field. Those pairings have many names including crisis intervention teams (CIT), Psychiatric Emergency Response Teams (PERT) and the System-wide Mental Assessment Response Teams (SMART). With the advent of these clinician officer teams, we have seen reductions in some forms of force against the mentally ill. Specifically, when CIT trained Law Enforcement Officers encounter highly ambiguous situations involving a psychiatric disturbance they are less likely to use excessive force. However, clinicians cannot always be out in the field doing risk assessments. What is needed is increased continuing education training in how to addresscommunity mental health disorders for all Law Enforcement Officers. If you were having a heart attack, would you ask a medical student 48 hours into their training to determine your course of treatment or would you ask someone who has been practicing for years? And as a patient, would you not give your doctor your medical and social history along with a list of your medications? Has the community given thought to who ought to be called when a family member or community member is showing signs of mental illness? Maybe it's not always law enforcement. As the saying goes "it takes two to tango." The police are working to grow in their understanding of mental health. Maybe it is time for their community partnersto go even deeper. Perhaps it is time for the community to receive training in what to expect when they call on law enforcement to address a mental health issue in their home on or their streets.

Accurate and detailed scientific findings still have purchase in the courts and are the cornerstone of both forensic science and forensic psychology. In an era where science is often out-shouted by pseudoscience, it is critical to remember that the public still needs data. Forensic psychologists should consider taking on outreach opportunities to clarify how mental health assessments are made and how those assessments couple with the work of forensic scientists to support law enforcement and the community.