



The Consensus Project: People with Mental Illness and the Police Response

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October 30, 2006



Publications on Improving the Police Response

- 1986, *Managing Persons with Mental Disabilities*, Gerard Murphy, PERF
- 1997, *Police Response to People with Mental Illnesses*, DOJ
- 2002, *Criminal Justice/Mental Health Consensus Project*, CSG
- 2004 and 2005, *Guides to assist in Implementing and Enhancing Police-Based Diversion Programs for People with Mental Illness*, TAPA Center



The Problem

“Officers complain that taking someone to the psychiatric service of the hospital is a tedious, cumbersome and uncertain procedure. They must often wait a long time ... and are occasionally obliged to answer questions ... that appear to place their own judgments in doubt.

--Egon Bittner

1967



The Problem Today

- Over the course of a six-year period (from 1998 to 2004), the Akron [OH] Police Department responded to 10,004 calls related to a “mental disturbance.” This represents 6.55% of the total call load (1,527,281 calls) during that period. [Teller, et al, 2006]
- Dispositions typically available to officers include informal resolution at the scene (occurring the majority of the time), transport to a mental health facility for evaluation, or arrest (Teplin 2000; Lamb 2002).
- Officers generally arrest people exhibiting signs of mental disturbance because the person fit into a “gray area”—the person was not sick enough for admission to the mental facility but was too disruptive to be ignored. The arrest rate of people with mental illness in this study was almost 16.5%, significantly higher than that for non-mentally ill suspects. (Teplin 1984).



The Problem Today

- The prevalence rate of severe mental disorder in jails is sixteen percent (Ditton 1999), and is nearly nine percent for male detainees entering jail (Teplin 2000) and from 12.2% to 18 % for female detainees (Teplin 2000; National GAINS Center 2001).
- In 1999, the Los Angeles County Jail and New York's Rikers Island jail held more people with mental illnesses than the largest psychiatric inpatient facilities in the United States. [Torrey, 1999]



The Problem Today



What are specialized police-based approaches?

Programs that are *police-based* include:

- **Crisis Intervention Teams**—A self-selected cadre of officers is trained to identify signs and symptoms of mental illness, de-escalate the situation and bring the person in crisis to an efficient, round-the clock treatment center.
- **Co-responder Teams**—A specially-trained officer pairs with a mental health professional to respond to the scene of a crisis involving mental illness.



Police-Based Approach Origins

- CIT was developed after a tragic incident in which a person with mental illness was killed by police.
- To improve safety during these encounters, this approach focused on an immediate de-escalation response – an immediacy law enforcement officers are best able to provide.
- Co-Responder emerged from concern with how frequently people in crisis who interacted with police did not become linked to treatments and services.
- To improve this access, this approach focused on timely connection to community-based mental health services – a linkage professional mental health practitioners are best able to provide.



Strengths and Weaknesses

CIT

- **Strengths**
 - Large group of self-selected officers receives intense training about mental illness.
 - The response is timely, which promotes safety of all involved.
- **Weaknesses**
 - Lack of true “expertise” about mental illness and little client-specific information
 - Few transportation resources
 - Difficulty establishing a linkage to range of treatments and supports

Co-Responder

- **Strengths**
 - Teams have access to information on individuals’ mental health issues.
 - Mental health professional can assist with transportation to a range of services and supports.
- **Weaknesses**
 - Response time can be lengthy
 - Requires rich mental health resources
 - Fewer officers get intense training



Outcomes of Specialized Police-Based Approaches

Reduced officer injuries

- CIT officer injury rates in Memphis decreased from one in every 28,571 events in the three-year period prior to implementing CIT, to one in every 142,857 events in the years following implementation. [Dupont & Cochran, 2000]
- San Jose Police Department's CIT program reported a 32 percent decrease in officer injuries over a one-year period following program implementation. [Reuland, 2004]



Outcomes of Specialized Police-Based Approaches

Reduced SWAT call outs

- The rate of TACT (similar to SWAT) calls in Memphis has decreased by nearly 50 percent since the implementation of CIT. [Dupont & Cochran, 2000]
- Since the implementation of CIT in Albuquerque, NM, the use of SWAT teams involving a mental health crisis intervention has decreased 58 percent. [Bower & Petit, 2001]



Outcomes of Specialized Police-Based Approaches

Reduced arrest rates

- Police-based programs made arrests in only 2% - 5% of calls involving a person with mental illness, as compared to a 13% arrest rate in the mental health-based approach. [Steadman, et al, 2000]
- Individuals with mental illnesses who are diverted from jail spent more time in the community without a concomitant increase in arrest. [Steadman & Naples, 2005]
- An analysis of Houston's 1,439 CIT calls revealed that only 17 people with mental illness had been arrested. [Reuland, 2004]



Outcomes of Specialized Police-Based Approaches

Increased access to mental health services

- People diverted from jail by police had greater access to both crisis and non-crisis services (emergency room, hospitalization, medication, and counseling), by an order of almost 10% across the board. [National GAINS Center, 2004]
- CIT-trained officers in Akron (OH) transported people with mental illnesses to psychiatric emergency services significantly more often than their non-CIT trained counterparts. This study showed no difference between the two groups in numbers of arrests. [Teller, et al, 2006]
- In Memphis' CIT program, the referral rate from law enforcement to the emergency service increased by 42 percent in its first four years. [Dupont & Cochran, 2000]



Law Enforcement / Mental Health Partnership Program

- Funded by the Bureau of Justice Assistance (BJA) in 2005
- Deliverables will include:
 - Training resource “Toolkit”
 - “Essential Elements” document
 - Interactive database of program information
 - Policy brief on statewide implementation efforts



How do these Essential Elements help?

- Ten elements were derived from recommendations made by a broad range of practitioners and other subject matter experts.
- They provide a common framework for program design and implementation to promote positive outcomes.
- They are sensitive to the distinctive needs and resources of each jurisdiction.
- As such, they reflect a *process-oriented* approach rather than a *model replication* approach.



What are the essential elements of these models?

1. Collaborative Planning and Implementation
2. Program Design
3. Specialized Training
4. Call Taker and Dispatcher Protocols
5. Stabilization, Observation, and Disposition



What are the essential elements of these models?

6. Transportation and Custodial Transfer
7. Information Exchange and Confidentiality
8. Treatment, Supports and Services
9. Organizational Support
10. Program Evaluation and Sustainability



Looking Ahead

- Multi-layered response models that address multiple problems
- Enhanced focus on data analysis to develop responses that reduce repeat calls
- MIOTCRA funding requires evaluation
- Studies of training benefits



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