Collaboration to Reduce Tragedy and Improve Outcomes: Law Enforcement, Psychiatry, and People Living With Mental Illness

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A homeless man, known as "the Street Corner Saint," lived in a small camp in a park in uptown Albuquerque. Each morning he would stand on the same busy corner and preach that the world would be saved once "Margaret realized her destiny." Despite efforts by police and local homeless providers, no intervention was successful. Local outreach groups got to know him and ensured that he ate every day. Despite the various services he was offered, he refused to move or leave his corner.

Meanwhile, the police received numerous calls about him from angry and concerned citizens. "He's bad for business!" "He scares kids!" When he was doing well, the Saint quietly displayed signs, answered questions about Margaret, whom he never identified, and counseled people on how to live happy lives. At his worst, he yelled at pedestrians and threw rocks near children.

When reports of his throwing rocks came in, police either arrested him or brought him to the hospital emergency department. At the emergency department, he presented well, was calm, and was soon discharged. When brought to jail, the Saint was found incompetent to stand trial and was released within a couple of days. For years, the Saint's life rotated through homelessness, brief jail stays, and hospital emergency department transports without admission.

Then a police psychiatrist who worked on the city police department's crisis intervention team was asked to intervene. The psychiatrist met with the Saint and established rapport. He also spoke with local homeless assistance providers, who gave him background and patterns that would later help to resolve the case: The Saint was never seen with recreational drugs, he had no known medical problems, and at times he reacted to internal stimuli. Notably, some years earlier, he had refused food and almost starved himself to death.

The psychiatrist also spoke with providers at the university hospital emergency psychiatric services. They discussed various options, planning to intervene the next time he decompensated. Months later, a report came to the psychiatrist that the Saint had lost weight and was refusing food. The psychiatrist evaluated him again, and because rapport had already been established, the Saint told him that he had stopped eating because Margaret had demanded that he purify himself by refusing food. The psychiatrist decided to have him transported to the hospital, where he was later admitted.

The Albuquerque Police Department had added essential components to the intervention—a psychiatric evaluation, increased coordination of care, and doctor-to-doctor conversations that ensured a proper evaluation and admission. Then a key moment arrived: the police, the police psychiatrist, and local homeless aid providers all met with the Saint and expressed their concern and desire to help. The Saint was moved by the group support, and he accepted housing. He has now been in services for over 3 years and is doing well.

BACKGROUND OF THE PROBLEM

Psychiatric interventions have moved toward the criminal justice system. Every large jail and prison in the United States must offer psychiatric services to inmates in order to comply with the Eighth Amendment and established case law (1). Nearly all sizable emergency departments have access to psychiatric consultation. Very few psychiatrists in the United States are employed by a law enforcement agency and work alongside detectives, conduct evaluations in the field, assist with training, and participate in community outreach (2, 3). The need for collaboration between psychiatry and law enforcement is stronger than ever. Over the past 20 years, the number of hospital beds has been cut, and interactions between psychiatric patients and law enforcement have increased (4–6). Partnerships between law enforcement and psychiatry can augment the efforts of psychologists and other clinicians who are more prevalent within law enforcement.

See related features: **Clinical Guidance** *(Table of Contents) and* **AJP Audio** *(online)*

A lack of data has fueled a cycle of misunderstanding between law enforcement agencies and psychiatrists, hampering effective partnerships. Because law enforcement agencies have always focused on crime and public safety, the mental health data they collect may be misleading. Typically, law enforcement service calls are coded so that criminal behaviors take precedence as the primary reason for a contact, so when a person with schizophrenia is involved in a "domestic dispute," this would not be tracked as a call involving mental illness.

Despite limited data, best estimates show that 3%−10% of all police calls involve people living with mental illness (see Table S1 in the data supplement that accompanies the online edition of this article). Many factors contribute to the wide variation in contact rates, such as access to services, outreach, mental health laws, local sociopolitical culture, various lengths of stay in jails and prisons, and difficulty identifying and categorizing people with mental illness.

Whatever the cause of the variation, 3% may represent an underestimate, considering that 4% of the general population lives with a severe mental illness (7), 23% of jail inmates have psychotic symptoms (8), and more than 14% of men in jail have a severe mental illness (9).

In Albuquerque, law enforcement likely has contact rates much higher than 3%. A recent survey of Albuquerque police field officers showed that officers believed that one-third of their calls involved people with mental illness (10). Although "one-third" may represent survey bias more than accuracy, it may suggest that officers feel these calls are frequent, time-consuming, and memorable.

Albuquerque is a midsized city. The Albuquerque Police Department has more than 800 sworn employees. The department dispatched more than 488,000 calls in 2014 (11). If just 3% of those calls had a significant mental health component—a low estimate—that would be more than 14,500 calls. Moreover, these estimates show that in this locale, more emergency mental health evaluations are done by law enforcement than by three of the largest psychiatric emergency departments combined (see Tables S2 and S3 in the online data supplement). Law enforcement agents routinely make life-and-death decisions regarding dangerousness assessments, which can have tragic outcomes (see Table S4 in the data supplement). The Albuquerque Police Department also routinely conducts welfare checks and determines the need for medical or psychiatric transport. In Albuquerque, 20% of all high-acuity mental health cases seen in the University of New Mexico Hospital's psychiatric emergency department are brought in by the Albuquerque Police Department (see Table S5 in the data supplement).

THE UNIQUE ROLE OF THE PSYCHIATRIST IN LAW ENFORCEMENT

There are clear benefits to having a medical doctor in a law enforcement agency. The primary goal is to increase collaboration between different disciplines and cultures to improve safety and patient outcomes. Although psychiatrists' salaries are typically higher than those of other mental health professionals, psychiatrists play a unique leadership role within the field of mental health, which can potentially reduce liability. As physicians, they may facilitate expedient access to other providers and administrators in the mental health community. In many jurisdictions, a unique set of laws and regulations allows physicians to have a broad range of influence. Many jurisdictions require a physician's participation to enact civil commitments, to formally evaluate patients for treatment and fiduciary guardianship, to assign payees to manage people's disability checks, to prescribe medication, or to admit people to hospitals (12, 13).

As part of a larger team, psychiatrists can evaluate pharmacological treatments and medical conditions that are common in psychiatric disorders, such as delirium, thyroid disease, diabetes, infections, seizure disorders, strokes, and adverse effects of medications. When working with other mental health professionals, psychiatrists can effect positive changes in individual clinical cases and systems in ways that can support and enhance the efforts of psychologists and other providers (Table 1). Albuquerque may be unique in employing a full-time psychiatrist (N.R.).

COST-BENEFIT CONSIDERATIONS

Monetary concerns have been one counterforce to bridging law enforcement and mental health cultures. Nationally, however, evidence-based research and anecdotal evidence suggest that communities with strong law enforcement mental health programs can expect cost savings from reduced and efficient hospitalizations, reduced arrests and jail time, and reduced lawsuits (14, 15). In Louisville, Ky., a city of similar size to Albuquerque, the annual cost savings associated with the police department's crisis intervention team (CIT) were more than $1 million (16). The Louisville analysis did not include other potential benefits of the program, such as reduced liability, improved patient outcomes, and community satisfaction. Some evidence shows reduced arrest rates associated with jail diversion programs (17–19).

According to internal records, Albuquerque police mental health calls have increased by 48% over the past 5 years. To help field officers, the crisis intervention unit (CIU) has expanded its activities well beyond conducting home visits and has become more involved in training and community coordination. For example, in 2013, fewer than 30 field officers attended a 40-hour class on mental health interventions; in 2015, the CIU trained 228 officers.

The psychiatrist works within the overall CIT program, which is collaborative and complex. Since the expansion of the program in 2014, the CIU has kept more detailed and accurate data (20). Use of force, especially officer-involved shootings, has decreased, and jail diversion has increased. Furthermore, contributing factors other than the work of the psychiatrist and the CIT program have influenced clinical and legal outcomes, among them local and national attention to police interactions with people with mental illness, high-profile cases, and an agreement with the U.S. Department of

TABLE 1. Case Examples of Law Enforcement Mental Health Collaboration[a]

Chief Complaint	History	Status Quo, Before Crisis Intervention Team	Underlying Condition	Intervention
"Help me, ghosts are breaking into my home!"	Ms. A, a 56-year-old woman with depression and frequent calls to police, believed ghosts were stealing her possessions. Field officers found no immediate danger to self or others.	In order to intervene, police would have had to wait until Ms. A became an overt danger to self or others.	Thyroid dysfunction	An in-home evaluation revealed thyroid symptoms, but even more concerning, Ms. A had recently bought a gun to shoot ghosts. The gun was put in safekeeping, and the woman was transferred to the hospital.
"She's stolen all my stuff, and put in replicas!"	Mr. B, a 71-year-old man, continually called police because he believed his ex-wife had stolen his collection of baseball cards. Field police officers found no overt danger or any signs of theft.	Mr. B refused any medical transport and police had no authority to do otherwise.	Dementia	After a coordinated effort of social work and field evaluations, the team applied for a guardian for Mr. B; the psychiatrist formally petitioned the state, and a guardian was granted. Mr. B now has in-home services.
"My husband is scaring me!"	Mr. C, a 58-year-old man, acted out of character and verbally abused his wife, saying things like, "Shut up bitch, don't talk to me!" His wife said, "He gets so angry, he's calm now, but he can't sleep, I don't know what to do."	Emergency medical services and police were unable to transport Mr. C against his will because of lack of exigency; he was consistently calm at times of evaluation.	Anticholinergic crisis secondary to excessive use of over-the-counter medication for sleep	A detailed history from Mr. C's wife showed abuse of over-the-counter medications. Mr. C had signs of delirium. He was brought to the emergency department and admitted to a medical ward.
"The hospital never admits him!"	Ms. D, the mother of a young man with symptoms of mental illness, was frustrated because the hospital did not admit him. Even though she was scared of him, the hospital staff did not obtain sufficient information about the case to justify an admission.	Ms. D did not know how to properly identify, or relay, key information to the hospital. There were repeated evaluations without admission.	Schizophrenia	An in-home evaluation of the young man and his mother allowed the psychiatrist to gather key information, which was then relayed to the hospital psychiatrist, and the patient was admitted.

[a] For more, see the online edition of the *Journal* for a video of the authors discussing case examples and the Albuquerque CIT program.

Justice on steps to take for reform. The CIU has been a key component and facilitator for implementing positive changes for the CIT program and the community. For all Albuquerque Police Department calls coded as mental health–related in 2015, less than 2% resulted in use of force (including empty-hand techniques, impact weapons, pepper spray, and the use of electronic control devices). Moreover, less than 2% included arrests, and 80% ended as transports to a hospital.

The CIU also facilitates efficient use of services. A 2015 review of internal records showed that 15% of people evaluated by the psychiatrist in the field were brought to the hospital, and of those, 89% were admitted (21). Individuals evaluated in the field who do not need hospitalization are provided follow-up and resources (22).

ELEMENTS OF A CIT PROGRAM

CIT programs are born when law enforcement, their communities, and mental health professionals build partnerships. The Albuquerque Police Department program is built around three core elements, which can guide any program anywhere in the country: inclusive collaboration, training, and coordinated responses.

Inclusive collaboration. The Albuquerque CIT program partners with the University of New Mexico Department of Psychiatry and Behavioral Sciences, corrections departments, homeless assistance providers, hospitals, advocates, peers, and family members. Collaboration helps law enforcement agencies create access to a system of care. A program coordinator is involved in all aspects of the CIT program, promoting collaboration, recognition, transparency, and cross-agency development.

In any community, a good starting point is to have a designated program coordinator who builds partnerships through outreach, promotes the CIT program, collects and shares data, and is involved in all aspects of the program.

Training. CIT programs provide foundational and advanced knowledge of mental health, de-escalation, and resources. All

of the CIT training at the Albuquerque Police Department touches on at least one of three topics: safety, destigmatization, and accessing resources. Albuquerque has a 40-hour basic class and an 8-hour advanced class. In any community, even in courses with fewer hours, training on severe mental illness must serve the function of promoting safety, decreasing stigma, or finding resources—otherwise why teach law enforcement personnel about mental illness at all?

Coordinated responses. Coordinated responses are the active component of a CIT program that is supposed to make life better and safer for the citizens. In Albuquerque, real-time responses have clinical guidance and try to focus only on situations where police are truly needed. This includes the CIU detectives, field officers, clinicians, the psychiatrist, and other civilians.

In any community, coordinated responses can start with just one or two officers who have an interest in working with people with mental illness, and with the support of a law enforcement agency, officers can be assigned as mental health detectives or program coordinators.

Data on the effectiveness of CIT programs around the country are still relatively sparse. The concept itself of the CIT program is only 30 years old. Although the adaptation, implementation, and study of CIT programs are still in the early stages, best-practice guidelines and advice for starting CIT programs are available (23, 24). Some aspects of CIT programs have been studied more extensively than others. The most widely studied is the 40-hour class for field officers, which includes both classroom instruction and scenario-based practice. For example, studies have looked at students' perceptions of and attitudes toward people with mental illness, as well as use of force and arrest rates among officers who have attended classes (25, 26).

CONCLUSIONS

Having a psychiatrist working within a law enforcement agency can add important value in serving the community. The psychiatrist can advise, supervise, and consult with other clinical providers in the community and with those working within law enforcement.

Having a full-time psychiatrist in a law enforcement agency can be a daunting or even impossible task for many jurisdictions. No doubt there are other opportunities for psychiatrists to help span the boundaries between law enforcement and mental health. This may include offering to teach law enforcement agencies pertinent issues about mental illness, and, just as important, law enforcement professionals may educate psychiatrists on safety and law enforcement's role in mental health. By encouraging law enforcement agencies to consult on difficult cases, it is possible to help shape the system by networking and helping other mental health professionals to be more involved with law enforcement agencies. Working relationships can lead to other positive outcomes, such as pursuing grant funding for collaborations between law enforcement and mental health personnel.

Asking questions and learning can form the foundation of an effective partnership. The more mental health professionals understand about law enforcement, the more they can help their communities. Opportunities for engagement may include participating on community oversight boards and scheduling meetings with law enforcement command staff or with local deputies and police officers. Collaborations may be initiated by simply contacting law enforcement offices in a nonurgent context to start a valuable dialogue.

Discussions on mental health and law enforcement can be provocative and lead to emotional reactions from both the general public and law enforcement personnel, and concerns about tragic outcomes can elicit the strongest reactions. Questions about these types of tragedies are best answered in person, although they are often addressed through media exchanges, which can distort the intent of both those asking the questions and those in law enforcement responding. For example, a variation of the following question is frequently asked when there are deadly encounters between law enforcement and people with mental illness. "Why don't police just shoot people in the leg?" Although this question can be frustrating at times, law enforcement personnel have a clear and important answer. Law enforcement officers are trained to stop potentially fatal threats of physical harm to themselves or others with the use of lethal force. Lethal force options like a firearm should not be used to maim individuals for being resistant to law enforcement. If an officer shoots for the leg, which is a very difficult target, the threat of deadly violence continues even if the assailant is wounded. By asking questions, and understanding the answers, psychiatrists may be more equipped to lead productive discussions in their communities.

Psychiatrists have always taken an active role in helping the most disenfranchised people in our communities. By focusing some of our professional energy on cross-collaboration with law enforcement, we can increase understanding, reduce liability, and, most importantly, improve patients' lives and the stability of our communities.

Increased collaboration between psychiatrists and law enforcement will help prevent situations in which police officers are placed in the awful position of having to use lethal force against a person with mental illness.

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