

Law Enforcement Response to the Mentally Ill: An Evaluative Review

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Rarely does a police officer list providing services to the mentally ill as a reason for becoming a law enforcement professional. However, a review of case records illustrates the frustrating, and often tragic, outcome of police service calls for “mental disturbance.” A closer examination of these cases demonstrates the reality that police are usually the initial contact into both the criminal justice and the social service systems for mentally ill persons. Unfortunately, there exists a disconnect in the process from the first police contact to the next level of appropriate care due largely to a lack of proper training, resources, and collaborative community support. The purpose of this paper is to provide an overview of the research and public policy on law enforcement response to the mentally ill. An evaluative review of investigative efforts in this area reveals methodological shortcomings in the extant research which (a) prevent definitive conclusions regarding efficacy of police interventions (e.g., Memphis Crisis Model), (b) have significant implications for the development of policy, standard operating procedures, and training of law enforcement personnel, and (c) are potentially relevant to the safety of mentally ill persons who, as subjects or suspects, also become potential victims. Suggestions for directions that future research on policing and the mentally ill might take are offered. [*Brief Treatment and Crisis Intervention* 8:236–250 (2008)]

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Police Response to the Mentally Ill

Police officers are tasked with responding to the challenges and dangers of society that ordinary citizens and social service agencies are not equipped to manage. In addition to their

roles as investigators and protectors, police still maintain the responsibility of keeping the peace (Cordner, 2000). Law enforcement has been responding to calls for service that involve the mentally ill throughout the history of the profession. As first responders, police are often an

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unidentified, yet significant, influence in the lives of mentally ill persons. Indeed, Teplin's (2000) review of how officers maintain the peace with reference to the mentally ill underscores law enforcement's role as a major mental health resource. More recently, however, police departments are finding it necessary to carefully examine, and in many cases modify, their procedures dealing with the mentally ill. The heightened activity in this area is attributable to (a) legal reforms (e.g., deinstitutionalization) that have provided mentally ill persons with increased independence and autonomy, (b) public policy created to assist law enforcement in maintaining peace and safety, and (c) the relative lack of collaboration between police, social service systems, and the mentally ill individual.

Police Contact with the Mentally Ill: Historical Perspectives

The trend toward deinstitutionalization between the 1960s and 1980s is a major reason for the increased contact between the mentally ill and police (Zdanowicz, 2001). Teplin (2000) cited the curtailment of federal mental health funding, combined with legal reforms, which gave mentally ill people the right to live in the community without treatment, as the bases for their greater contact with police. Zdanowicz also cogently points out that legal reforms in the 1970s began criminalizing people with mental illness by instituting laws for involuntary treatment and laws that applied to nondangerous offenses (e.g., responding verbally to auditory hallucinations in public parks, sleeping on park benches).

Beginning in the 1950s, police adhered to the "professional model," which used experts from other fields (e.g., psychologists, advocacy lawyers) to bolster police reform and response to mentally illness (Cordner, 2000). This model emphasized the goals of (a) training, (b) special-

ization, (c) improved communication, and (d) the development of less-than-lethal weaponry (Cordner, 2000). Such goals, while highly commendable, were often not realized by police agencies. It seems likely that they were not actualized due to financial concerns, a lack of realistic application, and the inability of the consulting professionals to offer heuristic guidelines.

When police are currently confronted with a mentally ill person, they have three options: (a) transport them to a receiving psychiatric facility, (b) use informal verbal skills to de-escalate the situation, or (c) arrest (Teplin, 2000). According to Teplin (2000), these possible actions are based on two basic concepts that guide police in all citizen encounters: (a) the duty of the officer to protect and serve the community and (b) the governing reforms that stipulate the power of an officer to involuntarily protect an irrational person who may be of harm to self or others. More comprehensive and flexible approaches have recently been developed; however, these methods are the minority and have not been standardized. Examples include specialized police training and units, crisis intervention training, and community-collaborative programs.

As the widespread media coverage in the past decade has shown, these limited options for police response can lead to cases in which people are killed or injured (Huriash, 2001; Jenne & Eslinger, 2003; Vickers, 2000). Even more tragic is the increase in suicide by cop (sometimes referred to as police-assisted suicide) which is defined by Hutson et al. (1998) as "a term used by law enforcement to describe an incident in which a suicidal individual intentionally engages in life-threatening and criminal behavior with a lethal weapon or what appears to be a lethal weapon toward law enforcement officers or civilians to specifically provoke officers to shoot the suicidal individual in self-defense or to protect civilians." As a result of such public attention, the growing population of

homeless, the increase in mental disturbance service calls, and the evolving goals of law enforcement agencies, police are now faced with the challenge of how to develop and implement an effective standard operating procedure when dealing with the mentally ill and homeless.

Review of Research

The studies reviewed below were selected based on their (a) empirically oriented focus and (b) attempt to ascertain the utility of specialized training, departmental policies, and/or specialized programs designed to address the policing of the mentally ill.

In a *TELEMASP Bulletin* (Peck, 2003), 35 police and 6 Sheriff's departments were surveyed regarding their interaction with mentally ill persons. Results revealed a high frequency of interactions between departments and mentally ill individuals. Also, there was a consensus that a service call with a mentally ill person was "... slightly more difficult than the typical police transaction." A wide range of responses was compiled when asked how the departments normally handle the follow-up to a "mentally disordered" service call; most stated that they transport to either a community mental health center (CMHC) or to a hospital. When asked about specialized response policies, less than half of the surveyed departments referenced specialized training or program agreements with local community health centers.

Deane et al. (1999) surveyed 174 police departments about their methods of dealing with mentally ill persons. This study identified specialized departmental programs as either police-based specialized police response, police-based specialized mental health response, or mental health-based mental health response. However, results of the survey indicated that over half of the responding departments did not have any type of specialized response program or training

for dealing with mentally ill persons, which is consistent with the findings of the *TELEMAS Bulletin* (Peck, 2003). Further, the majority of officers who were part of a specialized program, as well as those from departments with no specialized response, self-rated their departments as moderately or very effective.

Similarly, Hails and Borum (2003) surveyed medium and large law enforcement agencies ($n = 84$) and reported a wide range of responses regarding use of training, exposure to mental health support and training, and use of specialized teams and responses when working with the mentally ill. These investigators found that 32% of the agencies had some type of specialized response when called to respond to a mentally ill person. Coincidentally, 21% of departments surveyed reported a specialized unit or team and only 8% reported access to a mental health mobile crisis team.

Finn and Stalans (2002) used police officers from public safety training centers to examine the influence of officer beliefs (using hypothetical scripts) in deciding whether to civilly commit, verbally resolve the situation on scene, or arrest. This study highlighted the impact of police discretion on decision making when faced with a potential case involving mental illness. A significant number of officers from the total sample ($n = 257$) was more likely to utilize civil commitment if they felt that (a) a community hospital would accept violent persons, (b) the victim was in danger of further harm, (c) the suspect was mentally ill, and (d) the suspect was cooperative. Additionally, it was found that police officers felt equipped to recognize the symptoms of mental illness without formal training. Finn and Stalans (2002) also concluded that a significant factor in decision making, with regard to mental disturbance service calls, is the available options (e.g., hospitals, mental health consultants) police have (or do not have) once they arrive on scene and assess that mental illness is a factor.

TABLE 1. Reviewed Research Articles

Authors	Participants	Method	Measurements	Outcome/Conclusion
Peck (2003)	35 Police department and 6 sheriff's department	Participant survey	Author-created survey: assessing police interaction with mentally ill	CIT-like programs are effective
Hails and Borum (2003)	84 Medium and large law enforcement agencies	Survey	None	Varied responses regarding training and use of specialized response
Finn and Stalans (2002)	257 Police officers from North Georgia in-service training	Survey—responses to scripts: analyzed using ANOVA	None	Officers are significant more likely to use civil commitment ($p < .05$) based on perceptions
Teplin (2000) and Teplin and Pruett (1992)	283 Police officers and 85 mentally disturbed persons	Observational, in-field study	Symptom checklist and "incident coding form"	Mentally ill suspects were arrested more often (46.7%) than nonmentally ill suspects (27.9%)
Engel and Silver (2001)	322 Police officers and 1,849 nontraffic suspects	Systematic observational in-field study	Incident coding form	Police are not more likely to arrest mentally ill civilians, 7.6% vs. nonmentally disordered civilians, 18.2%
Catalano et al., 2005	State of Florida's archived data on involuntary psychiatric hospitalizations initiated by law enforcement in specified time periods between 1999 and 2001.	Interrupted time-series design	None	Law enforcement initiated increased involuntary psychiatric hospitalizations in the weeks following the attacks of September 11, 2001. Concluding that perceived community risk may increase an officer's judgment that a person with mental illness is dangerous.

TABLE 1. Continued

Authors	Participants	Method	Measurements	Outcome/Conclusion
Brakel and South (1968)	Two police counties	Observational, in-field study	Records review of 1. Hospital records 2. Police records	Police are able to discern mental status but lack community collaboration and referral support.
Sheridan and Teplin (1981)	838 Police referred	Pre/postuncontrolled	Records review of 1. Demographics 2. Pathology of patient 3. Type: police contact 4. Treatment and recidivism	Reduced recidivism and days as inpatients at CMHC as opposed to state hospital. (CMHC mean days as inpatient = 33.2 vs. state hospital mean days as inpatient = 137.5.)
Green (1997)	One Law Enforcement Officer (LEO) agency with one consulting agency and one in-house program	Case study evaluation using both qualitative and quantitative analysis	Quantitative: author-created incident forms Qualitative: interviews	The more senior of an officer, the less likely they will arrest or refer ($-0.26, p > .05$). Police need more options.
Borum et al. (1998)	Three LEO agencies with three different specialized programs; total $n = 452$	Case study evaluation with cross analysis within and between each case.	Patrol officer survey 1. 4-point Likert scale 2. Open-ended questions	Memphis CIT model was effective in maintaining safety (94.4%) and meeting needs of mentally ill (88.8).
Strauss et al. (2005)	485 Patients from Louisville University Hospital brought in by Louisville CIT over period of 1 month	Chi-squared used to analyze results from this time-series study	Records review interview	Data support effectiveness of CIT in identifying psychiatric emergencies
Deane et. al (1999)	174 Police departments from 194 U.S. cities with a Population of 100,000 or more	Survey analysis comparison	Department survey 1. 5-point Likert scale response. 2. Open-ended questions	55% departments had no specialized and 3% had a Memphis CIT-like model.

TABLE 1. Continued

Authors	Participants	Method	Measurements	Outcome/Conclusion
Steadman et al. (2000)	Same participant sample from Borum et al. (1998) regarding response to	Retrospective: to cross analyze each program regarding response to mental health emergencies Analytical review	Records review	Memphis CIT responded to 95% of mental disturbance calls ($p < .001$) and arrested only 6% ($p < .001$). Support use of procedural justice in training officers to respond
Watson and Angell (2007)	None	None	None	Supports Memphis CIT model
Dupont and Cochran (2000)	Outcome data on Memphis CIT	Literature review	None	Supports Memphis CIT model

In Honolulu, Green (1997) compared quantitative (148 incident forms assessing the decision a police officer makes when they encounter a person who is mentally ill) and qualitative (11 officers were further assessed with structured and semi-structured interviews) responses of officers to mentally ill and homeless person dispatch calls. The department had recently joined with a community agency in creating an in-house program called Project Outreach. The program was designed with the intent to educate and aid officers when responding to service calls involving a homeless person. Results indicated that the more years of experience an officer had, the less likely he/she would arrest or refer; it was more likely that they would do nothing. Green offered that this finding could be due to of these senior officers' lack of faith in the options available to them regarding mentally ill suspects/civilians. Conclusions of this study highlighted the conflicting roles of police (i.e., enforcer vs. peace keeper) and the limited options available to them with respect to these type of disturbance calls. In addition, this investigation underscored the overlapping nature of homelessness and mental illness with regard to police response in the community.

Teplin (2000) examined how police handle mentally ill persons by randomly selecting 283 police officers to be observed in a large-scale study. This research employed a symptom checklist and a global rating scale to measure the presence of mental illness in the observed citizen. (Note: "Observed citizen" refers to the civilian to whom the officers are dispatched.) In addition, an Incident Coding Form was designed to measure officers' actions when dealing with the observed citizen. Approximately, 9.3% of the observed citizens were determined to be severely mentally disturbed, with 5.9% being a possible suspect and 3.4% not deemed a suspect in the police investigation. According to Teplin's (2000) findings, suspects with severe mental illness were more often arrested than

TABLE 2. Empirical Concerns

Concern in Current Research	Corrective Options for Future Research
1. Lack of objective and validated assessment tools	(a) Use combination of subjective and objective assessments (b) Use validated instruments (even if not validated on police officers) (c) Use archival sources, that is, records
2. Lack of comparison sample population	(a) Use control groups (b) Diversify sample populations by demographics and rank.
3. Lack of consumer population assessment	(a) Measure perceptions within the consumers and consulting agencies. (b) Record review: recidivism, treatment outcome, arrest rates, response rates, etc. Research that focuses on the role of consulting agencies to LEO

hospitalized or otherwise handled. However, nonsuspects were never arrested and were usually dealt with using verbal skills or by providing referral information.

Similarly, Engel and Silver (2001) examined how police respond to mentally ill persons and concluded that they do not criminalize men-

tally ill suspects nor are they more likely to arrest mentally ill persons. This investigation used data from the Police Services Study (PSS) conducted in 1977. They compared it to their data collected between 1996 and 1997 and systematically observed over 300 police officers, then recorded the officer's responses to mentally

TABLE 3. Practical Feedback

Law Enforcement Agency Feedback	Feedback to Be Used in Collaboration with Community Agencies and Professionals
1. Training <ul style="list-style-type: none"> a. Increased training for all officers regarding mental illness, homelessness, dangerousness, and appropriate responses Possible use of procedural justice as training framework b. Intensive and continual training for specialized response teams 2. Specialize community policing <ul style="list-style-type: none"> a. Separate crisis intervention from umbrella of community policing b. Collaborate with local community agencies, hospitals, and professionals c. Model type suggested: police-based specialized police response 	1. Referral agencies (hospitals, CMHC) <ul style="list-style-type: none"> a. Create a no-refusal policy b. Offer 24-h service c. Provide training for receiving personnel regarding type of police referrals, including police perspectives and culture education 2. Community/social justice system <ul style="list-style-type: none"> a. Educate about the conflicting roles of police officers regarding this issue. b. Create policy to support police-based specialized police response teams and community programs that work with the police agencies

disordered suspects. (Note: This study used the term “mentally disordered” as opposed to “mentally ill” specifically to reflect an officer’s immediate discretion in evaluating an individual’s behavior on scene, and not based on a psychiatric standard, such as the *Diagnostic and Statistical Manual of Mental Disorders*.)

Using a bivariate comparison of arrest rates and characteristics, officers were significantly less likely to arrest mentally disordered suspects when compared to nonmentally disordered suspects. Interestingly, mentally disordered suspects were more likely to be female, Caucasian, older, homeless, intoxicated, in possession of a weapon, and involved in less serious offences when compared to nonmentally disordered suspects. Similar results were found in Ostron et al. (1982). In both studies, it is noteworthy that the mental status of the suspect was not related to arrest. In other words, police officers were able to make a decision about arrest based on dangerousness and necessity, without relying on complex diagnostic assessments.

Strauss et al. (2005) further supported the effectiveness of a police-based Critical Incident Team (CIT) in the accurate assessment of psychiatric emergencies. These investigators reviewed data from 485 patients brought to the Louisville University Hospital by the newly developed and trained Louisville Metro Police CIT. The purpose of their study was to compare the psychiatric diagnosis as well as patient demographics and dispositions between individuals brought in by the CIT and those brought in from non-CIT court order (e.g., psychologists, family members) for psychiatric hospitalization. Results did not show a discrepancy and praised the CIT training for improving officers’ ability to assess a psychiatric emergency (Strauss et al.).

In another examination of officers’ assessments of imminent dangerousness, Catalano, Kessell, Christy, and Monahan (2005) reviewed the State of Florida’s archival data on involuntary

hospitalizations initiated in the weeks following the attacks of September 11, 2001. Using an interrupted time-series design, they concluded that officers presented more men and women for involuntary psychiatric hospitalizations in the weeks after the attacks. Their study supports the notion that level of perceived risk to the community is associated with the perception that an individual with mental illness is dangerous (Catalano et al., 2005).

In 1963, the American Bar Foundation conducted an 18-month study to evaluate the response of police and other criminal justice agencies in dealing with the mentally ill in rural areas (Brakel & South, 1968). Specifically, the investigation examined the efficacy of diversion programs, which attempted to move the mentally ill person from police custody to a secondary social service (i.e., hospital, shelter). Results confirmed that while police are able to identify serious mental illness, they have minimal community support to then transport the person to a more appropriate level of care. These findings suggest a lack of collaborative effort between police agencies and social service systems prior to de-institutionalization.

Sheridan and Teplin (1981) examined the efforts of one program that served as an identified, “no-refusal” site (a CMHC) where police could transport mentally ill persons for psychiatric emergencies. The study compared police referrals to state hospitals with referrals to the CMHC using several variables, including (a) patient profile, (b) recidivism rates, and (c) length of patient stay. Results revealed reduced recidivism rates and shortened length of inpatient stays for CMHC referrals. Also, it was noted that while the paperwork and length of officer time spent remained the same for this program, “police-friendly” advantages included (a) a no-refusal policy, (b) increased rapport between officers and CMHC staff, and (c) 24-h availability of the program/CMHC.

Borum et al. (1998) compared three separate police agencies by their three distinct methods of addressing the mentally ill in crisis. They developed an officer survey in order to measure police perceptions of (a) how incidents are handled when dealing with the mentally ill, (b) helpfulness of the local mental health resources, and (c) the department's overall effectiveness. The three models of police programs included (a) police-based specialized police response, which uses sworn officers with exclusive mental health training to work with the mental health system as a specialized team (i.e., Memphis Crisis Intervention Team; CIT), (b) police-based specialized mental health response, which uses non-sworn employees of the department who are mental health professionals to provide consultation on an as-needed basis for the officers on duty (i.e., Birmingham Community Service Officers), and (c) mental health-based specialized mental health response, which uses established, independent, and mobile mental health crises teams to work collaboratively with police when needed (i.e., Knoxville program).

Results indicated that the police-based specialized response (i.e., Memphis CIT) as the model perceived as most effective in preparedness, meeting the needs of the mentally ill, reducing the numbers of mentally ill persons being jailed, minimizing officer time spent on these incidents, and ensuring community safety. Training appears to be the key in the Memphis CIT model (they originally brought trainers from the Galveston, Texas police department to initiate their program), and approximately 10% of their department is now CIT trained (Peck, 2003).

Steadman et al. (2000) conducted a more exclusive study to address the outcome quality of police responses to the mentally ill. They utilized the same three police agencies from their original 1998 effort, and used arrest rate, treatment modality (psychiatric hos-

pitalization), or on-scene resolution as their dependent variables (Borum et al., 1998). Using a cross-site comparison, the sample included approximately 100 dispatch calls from each site all dispatched as a "mental disturbance" (Borum et al., 1998). Results showed that the Memphis CIT (police-based specialized police response) was superior to the other two specialized responses with a 95% rate of responding, compared to Knoxville (mental health-based response) with a 40% rate of response, and only a 28% on-scene response for Birmingham (police-based mental health response). Overall, these specialized programs diverted persons from jail, as reflected by a 7% overall rate of arrest, with Memphis CIT leading that low arrest outcome rate at 2%.

Dupont and Cochran (2000) reviewed the literature not only in support of the police-based specialized police response model (Memphis CIT) but also to reflect challenges and changes that appear to hinder its growth and efficacy. It should be noted that they cited research that used their own specialized response model (Memphis CIT; Borum et al., 1998; Deane et al., 1999, Steadman et al., 2000) as well as their own research (Dupont & Cochran, 2000).

More recently, Watson and Angell (2007) discussed the impact of "procedural justice" on the outcome of police interactions with mentally ill populations. As defined in the article, procedural justice is an approach to handling situations (including police response incidents) with the mentally ill populations that focuses on "how officer behaviors may shape cooperation or resistance" (p. 787). The three components of procedural justice include (a) participation (e.g., two-way communication and active listening), (b) dignity, and (c) trust in the goal that all parties are working together in the best interest of the individual and public safety. These investigators cited the Broward County Mental Health Court Evaluation (Broward County, FL) and studies that support the use

of cooperation, destigmatization, and other aspects of procedural justice. They conclude by highlighting the importance of fairness in procedural justice and the potential positive implications of incorporating procedural justice in police training.

Police Response: The Reality of Mental Disturbance Service Calls

Matthews (1970) reviewed the 1968 American Bar Foundation study as one of the first comprehensive investigations on this topic (Brakel & South, 1968). The review indicated that police are often blamed for the misfortunes of this growing problem. Specifically, Matthews describes how police are often “pigeonholed” into making a medical decision with little training and few, if any, response options. In addition, this exploratory investigation provided recommendations for increased officer training, specialized response squads, improved community mental health facilities, and adequate legal authority for emergency detention and admission.

Expanding on the work of Matthews (1970), Sheridan and Teplin (1981) examined the utility of a police referral program that designated an intake unit at a CMHC. They found that streamlining the process of how police refer mental disturbance service calls to hospitals bolstered the program’s effectiveness. Additionally, they showed that a collaborative response between law enforcement and the CMHC reduced recidivism rates in referred psychiatric patients.

Teplin’s research in the early 1980s mirrored the abovementioned study with in-field investigators who rotated between each of the officer’s 24-h shifts and between all districts of the city being examined (Teplin, 2000, Teplin & Pruett, 1992). This work verified that police are not arresting mentally disabled persons at an increased rate when all variables (e.g.,

dangerousness of scene, available resources, potential victims) are taken into account. It appears that officers are arresting when they feel there is no alternative (e.g., involuntary hospitalization) to control the situation and maintain community safety (Teplin, 2000). This study also underscored the lack of options for officers responding to a mentally ill person and the high frequency with which officers attempt to resolve situations by informal means (i.e., without arrest or hospitalization).

Specialized Police Response Models and the Role of Crisis Intervention Training

Deane et al. (1999) provided a preliminary epidemiology for the subject of police response to the mentally ill, including the existence of specialized programs, perceptions of effectiveness in managing the mentally ill, and the availability within each department for officers to receive specialized training. They reported that although more than 50% of departments nationwide do not have a specialized program/response, the majority of departments self-rate themselves as effective in managing these types of service calls. This stands in contrast to research that points to the effectiveness of specialized response programs (Borum et al., 1998; Green, 1997; Sheridan & Teplin, 1981; Steadman et al., 2000). However, more recent efforts suggest that the number of law enforcement agencies reporting specialized training and units for dealing with the mentally ill populations is increasing (Hails & Borum, 2003). Nevertheless, the abovementioned surveys have their limitations and, generally, concede that a standardized procedure or “model” for police response to the mentally ill is problematic.

Borum et al. (1998) provided a framework that supported the police-based specialized police response (i.e., Memphis CIT) using the variables of perceived preparedness, quality of response to the mentally ill, diversion from

jail, officer time spent on these calls, and community safety. In addition to providing evidence supporting the need to develop specialized response programs, their study offered a structure for further evaluation of such specialized approaches, including (a) the variable of community safety, (b) the needs of the civilian in crisis, (c) realistic perceptions, and (d) repercussions of officer response.

Steadman et al. (2000) expanded on their earlier work (Borum et al., 1998) by refining outcome variables and using a more homogenous sample. Their study continued to support the Memphis CIT model (i.e., police-based specialized police response) with findings of higher response rates and fewer arrests. The outcome variables of this investigation shifted from subjective perceptions of police officers and used arrest rates, treatment modalities, and referral sources to bolster their findings in support of police-based specialized police response models.

Although the work of Strauss et al. (2005) does not address the generalized effectiveness of CIT training, it supports an important aspect of CIT. They provided support for the contention that CIT training provides officers with the ability to accurately evaluate the need for psychiatric emergency services. It is important to note that additional research confirmed that officers (CIT trained or not) are generally able to identify when mental illness is the primary factor in a disturbance call (Brakel & South, 1968; Finn & Stalans, 2002). An integral component of CIT training is the utilization of crisis intervention and active listening skills (i.e., paraphrasing, reflecting emotions, open-ended questions) that assist an officer in de-escalation and appropriate community resources (Cochran, 2008). It would appear that to comprehensively address police response to mental illness, it is important to include both psychoeducation concerning mental health issues as well as crisis intervention skills training.

Additional Barriers and Concerns

Defining Training in the Field of Law Enforcement

In a continuation of their work, Dupont and Cochran (2000) reviewed their findings and made suggestions for future work. First, they proffered that basic officer training will prove to be inadequate in addressing this growing and volatile, problem without continual review and experiential learning. Expanding on their concern for the generalization of training effects, Dupont and Cochran (2000) point out that the survival model of training regarding self-defense and firearms not only exceeds the real-life frequency of such an occurrence (particularly when compared to the rate of incidents involving mentally ill individuals in crisis) but also seems to inappropriately mold an officers' perception of dangerousness. Referring to the 21-foot rule of weapon drawing, Dupont and Cochran (2000) question the validity of this rule when dealing with a subject suspected of mental disturbance. Dupont and Cochran (2000) refer to the common misperception that all police officers have the same mandated training and available resources. Steadman et al. (2001) concur that for specialized response programs to work effectively, training is a crucial element. However, Steadman et al. (2001) emphasized the importance of consulting mental health professionals and other administrative and social service systems in law enforcement training.

The Mental Health Care System as a Barrier

The mental health care system itself appears to be a barrier for progress regarding this issue of policing the mentally ill (Dupont & Cochran, 2000; Matthews, 1970). Social service agencies often refuse to admit intoxicated or psychotic

persons referred by police. In addition, the “revolving door” phenomenon of recidivism supports the reality of overworked and underpaid staff in receiving facilities, such as hospitals (Dupont & Cochran, 2000). More specifically, Dupont and Cochran (2000) address the challenges of responsibility and organized delivery of care when police respond to mental disturbance service calls. The first dilemma concerns an officers’ attempt to avoid making an arrest by transporting to a receiving agency and continuing their patrol duties. Further, many treatment facilities require police custody in the waiting area for individuals transported for a mental disturbance.

There is also a lack of a systematic and hierarchical structure that links first responders (e.g., police or emergency medical services) with the appropriate level of care to the mental health system (e.g., medical vs. psychiatric hospitals, social service shelters vs. drug rehabilitation centers). Steadman et al. (2001) address this problem and recommend the following: (a) use of designated drop-off sites and (b) police-friendly procedures that include (a) a no-refusal policy, (b) an intake process with streamlined paperwork, and (c) consistent procedural steps. If not addressed, these overlapping problems reduce the options an officer has available.

Implications of the Research: Empirical and Practical

The purpose of this paper was to review the extant research in order to evaluate and potentially enhance the current development of specialized programs, as well as to provide direction for further study in this area. Our review of work in this field revealed three overlapping concerns that should be addressed in future research regarding the police response to the mentally ill.

Clinical and Actuarial Assessment

Several studies used self-rating surveys to measure officer perceptions (Borum et al., 1998; Deane et al., 1999; Steadman et al., 2000). Indeed, there is a lack of validated assessment methods for law enforcement officers, and observational studies have been negatively critiqued. Mastrofski and Parks (1990) provide in-depth analysis of observational research, specifically, in examining the activity of police officers. The work provides evidence that observational studies can be scientifically bolstered, in the absence of validated assessment tools. Because psychosocial research mandates parametrically sound evaluation instruments, studies in this area should not adhere to a lesser standard.

In addition, records review was used in only two studies; further, this strategy was merely employed to either identify their sample or to describe the patient population (Sheridan & Teplin, 1981; Steadman et al., 2000). Records review is an easily accessible, verifiable, and thorough assessment strategy that should be included in research regarding police department response.

The role of clinical assessment in the context of this paper refers to the use, proficiency, and efficacy of crisis assessment when working with mentally ill persons. A review of specific crisis assessment and intervention techniques useful for working with the mentally ill is a broad topic that extends beyond the scope of this paper. However, it should be noted that the ability of officers to both identify the need for mental health services, and appropriately utilize basic crisis intervention techniques on-scene, is a strength of the CIT model. This again highlights the importance of interagency collaboration and the cooperative use of available mental health crisis teams.

Expanding Samples

Another concern characterizing research in this area were the samples employed. Police participants often reflected a diverse police

population, with the exception of officer ranks (Borum et al., 1998; Teplin, 2000; Teplin & Pruett, 1992). As noted in Bellah (2002), the acceptance of specialized response to the mentally ill needs to be addressed first, and foremost, with supervisory and command staff. In addition to developing a representative police sample, research in this area can be improved by employing appropriate control groups to further validate results.

Collaboration

Common dependent variables included community safety and the subjective perception of the officers (Borum et al., 1998; Sheridan & Teplin, 1981; Steadman et al., 2000). Much of the research indicated that cross-training, ongoing and frequent communication, and collaborative program development would best serve police agencies if they included consulting mental health professionals (Borum, 2000; Dupont & Cochran, 2000; Steadman et al., 2001). Yet, only one study (Sheridan & Teplin) surveyed a consulting mental health agency and the mentally ill subjects/consumers themselves. Further, results of those investigations were not compared to police perceptions of the program (Sheridan & Teplin). Indeed, officer perception is critical and directly impacts program efficacy. However, the goal should be a collaborative examination of officer perception, community safety, the safety of the mentally ill and homeless, and the availability and perception of the social service system.

Other Need Areas

The current literature reveals a lack of follow-up studies with different agencies and participants, despite the replicable methodologies many investigations offered. Stronger assessment components, more diversified samples, and inclusion of control groups would greatly enhance the study of this topic. However, at a basic level of empirical interest, follow-up efforts would

provide important evidence regarding the long-term utility of specialized response programs. Unfortunately, only one investigation (Sheridan & Teplin, 1981) developed a pre/postprogram design; and this effort only assessed outcome variables for the mentally ill and the psychiatric provider.

Beyond longitudinal and replicable investigations in this area, additional work is needed to focus on such variables as (a) the amount and type of specialized training, (b) the extent of community acceptance of specialized teams, (c) the effects of a no-refusal dispatch policy/no-refusal acceptance policy combined with a specialized team/training, and (d) the impact of continuous, positive contact between a specialized response team and the chronically mentally ill and homeless.

Practical Applications

Overall, this review provides support for deploying specialized law enforcement response programs to address the needs of mentally ill persons. Most research, to date, has focused on the Memphis CIT model. In 1988, the Memphis Police Department joined with their local chapter of the National Alliance for the Mentally Ill and instituted a new community-policing approach that created specialized teams of officers trained to manage people in crisis: the Crisis Intervention Team (Vickers, 2000). The Memphis CIT consists of uniform patrol officers who volunteer and receive a minimum of 40 h of specialized training, preparing them to be called upon when a service call involves a mentally disordered person.

Research shows that the Memphis CIT model of police response to the mentally ill is functional, generally accepted by police departments, and most importantly, effective (Dupont & Cochran, 2000). While this model has demonstrated efficacy, perhaps, even greater utilization of this model would be achieved by (a) determining, specific factors most responsible for

effectiveness of the model, and (b) garnering further data supporting the replicability and generalizability of the approach. In addition, the current literature does little to address specific training variables (e.g., length and format) that might have a bearing on eventual skills applied in the field.

An important element in this area is collaboration among mental health professionals, social service agencies, and law enforcement. Coggins and Reddy-Pynchon (1998) examined the development of the United States Secret Service Mental Health Liaison Program designed to assist the Secret Service in ascertaining threat potential and in following up with appropriate intervention. These investigators stated that appraisal of their program supported its success and was based on (a) careful review of the provisions offered by the consulting entity (e.g., local mental health correspondent, specialized response program), (b) evaluation of viewpoints of both the mentally ill and police, and (3) examination of the consultant or specialized program's records, reports, data, and/or any other evaluation products used in their program.

Police agencies are evolving to create operational and effective programs that meet the needs of the community and the intrinsic attributes of law enforcement culture. The scope of research and program development in the future should include empirical research and interagency collaboration, with an overarching goal of realistic and efficacious officer response options and improved outcome for the mentally ill.

Summary

Police officers are responsible for maintaining and enforcing public order. Their role as both first responders and peacekeepers remains a challenge in many ways, as has been illustrated by this review. The law enforcement response to mental disturbance calls with ethical, practical, and effective strategies requires interagency

collaboration. A review of relevant research highlights several concerns with regard to research methodology, public policy, police interventions, as well as a frequent lack of community-wide collaboration. However, the research also illustrates numerous examples of effective police-based interventions and collaborative policies and procedures. In particular, current research supports the utilization of specialized law enforcement response to meet the needs and demands of the mentally ill population with safety and dignity.

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