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Problem-Oriented Guides for Police
Problem-Specific Guides Series
No. 40

People with Mental Illness

by
Gary Cordner

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About the Problem-Specific Guides Series

The *Problem-Specific Guides* summarize knowledge about how police can reduce the harm caused by specific crime and disorder problems. They are guides to prevention and to improving the overall response to incidents, not to investigating offenses or handling specific incidents. The guides are written for police—of whatever rank or assignment—who must address the specific problem the guides cover. The guides will be most useful to officers who:

- **Understand basic problem-oriented policing principles and methods.** The guides are not primers in problem-oriented policing. They deal only briefly with the initial decision to focus on a particular problem, methods to analyze the problem, and means to assess the results of a problem-oriented policing project. They are designed to help police decide how best to analyze and address a problem they have already identified. (A companion series of *Problem-Solving Tools* guides has been produced to aid in various aspects of problem analysis and assessment.)

- **Can look at a problem in depth.** Depending on the complexity of the problem, you should be prepared to spend perhaps weeks, or even months, analyzing and responding to it. Carefully studying a problem before responding helps you design the right strategy, one that is most likely to work in your community. You should not blindly adopt the responses others have used; you must decide whether they are appropriate to your local situation. What is true in one place may not be true elsewhere; what works in one place may not work everywhere.

- **Are willing to consider new ways of doing police business.** The guides describe responses that other police departments have used or that researchers have tested. While not all of these responses will be appropriate to your particular problem, they should help give a broader view of the kinds of things you could do. You may think you cannot implement some of these responses in your jurisdiction, but perhaps you can. In many places, when police have discovered a more effective response, they have succeeded in having laws and policies changed, improving the response to the problem.

- **Understand the value and the limits of research knowledge.** For some types of problems, a lot of useful research is available to the police; for other problems, little is available. Accordingly, some guides in this series summarize existing research whereas other guides illustrate the need for more research on that particular problem. Regardless, research has not provided definitive answers to all the questions you might have about the problem. The research may help get you started in designing your own responses, but it cannot tell you exactly what to do. This will depend greatly on the particular nature of your local problem. In the interest of keeping the guides readable, not every piece of relevant research has been cited, nor has every point been attributed to its sources. To have done so would have overwhelmed and distracted the reader. The references listed at the end of each guide are those drawn on most heavily; they are not a complete bibliography of research on the subject.

- **Are willing to work with others to find effective solutions to the problem.** The police alone cannot implement many of the responses discussed in the guides. They must frequently implement them in partnership with

other responsible private and public entities including other government agencies, non-governmental organizations, private businesses, public utilities, community groups, and individual citizens. An effective problem-solver must know how to forge genuine partnerships with others and be prepared to invest considerable effort in making these partnerships work. Each guide identifies particular entities in the community with whom police might work to improve the overall response to that problem. Thorough analysis of problems often reveals that entities other than the police are in a stronger position to address problems and that police ought to shift some greater responsibility to them to do so.

The COPS Office defines community policing as "a policing philosophy that promotes and supports organizational strategies to address the causes and reduce the fear of crime and social disorder through problem-solving tactics and police-community partnerships." These guides emphasize *problem-solving* and *police-community partnerships* in the context of addressing specific public safety problems. For the most part, the organizational strategies that can facilitate problem-solving and police-community partnerships vary considerably and discussion of them is beyond the scope of these guides.

These guides have drawn on research findings and police practices in the United States, the United Kingdom, Canada, Australia, New Zealand, the Netherlands, and Scandinavia. Even though laws, customs and police practices vary from country to country, it is apparent that the police everywhere experience common problems. In a world that is becoming increasingly interconnected, it is important that police be aware of research and successful practices beyond the borders of their own countries.

The COPS Office and the authors encourage you to provide feedback on this guide and to report on your own agency's experiences dealing with a similar problem. Your agency may have effectively addressed a problem using responses not considered in these guides and your experiences and knowledge could benefit others. This information will be used to update the guides. If you wish to provide feedback and share your experiences it should be sent via e-mail to cops_pubs@usdoj.gov.

For more information about problem-oriented policing, visit the Center for Problem-Oriented Policing online at www.popcenter.org. This website offers free online access to:

- the Problem-Specific Guides series
- the companion Response Guides and Problem-Solving Tools series
- instructional information about problem-oriented policing and related topics
- an interactive training exercise
- online access to important police research and practices.

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The principal project team developing the guide series comprised Herman Goldstein, professor emeritus, University of Wisconsin Law School; Ronald V. Clarke, professor of criminal justice, Rutgers University; John E. Eck, professor of criminal justice, University of Cincinnati; Michael S. Scott, clinical assistant professor, University of Wisconsin Law School; Rana Sampson, police consultant, San Diego; and Deborah Lamm Weisel, director of police research, North Carolina State University.

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The Problem of People with Mental Illness

Problems associated with people with mental illness pose a significant challenge for modern policing.[1] This guide begins by describing the problem and reviewing factors that increase the challenges that police face in relation to the mentally ill. It then identifies a series of questions that might help you analyze your local policing problems associated with people with mental illness. Finally, it reviews responses to the problems and what we know about these from evaluative research and police practice.

Police officers frequently encounter people with mental illness—approximately 5 percent of U.S. residents have a serious mental illness,[§] and 10 to 15 percent of jailed people have severe mental illness.[2] An estimated 7 percent of police contacts in jurisdictions with 100,000 or more people involve the mentally ill.[3] A three-city study found that 92 percent of patrol officers had at least one encounter with a mentally ill person in crisis in the previous month,[4] and officers averaged six such encounters per month. The Lincoln (Nebraska) Police Department found that it handled over 1,500 mental health investigation cases in 2002, and that it spent more time on these cases than on injury traffic accidents, burglaries, or felony assaults.[5] The New York City Police Department responds to about 150,000 "emotionally disturbed persons" calls per year.[6]

It is important to recognize at the outset that mental illness is not, in and of itself, a police problem. Obviously, it is a medical and social services problem. However, a number of the problems caused by or associated with people with mental illness often do become police problems. These include crimes, suicides, disorder, and a variety of calls for service. Moreover, the traditional police response to people with mental illness has often been ineffective, and sometimes tragic.

§ Unfortunately there is not one standard definition of mental illness. Medical doctors, research scientists, psychiatrists, psychologists, and social workers define it differently depending on whether their focus is more on organic conditions, personality, or behavior. One working consensus definition designed for policy makers is "Mental illness is a biopsychosocial brain disorder characterized by dysfunctional thoughts, feelings, and/or behaviors that meet DSM-IV diagnostic criteria" (Kelly, 2002). The same report identifies the main examples of serious mental illness as:

- All cases of schizophrenia (a psychotic disorder)
- Severe cases of major depression and bipolar disorder (mood disorders)
- Severe cases of panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (anxiety disorders)
- Severe cases of attention deficit/hyperactivity disorder (typically, a childhood disorder)
- Severe cases of anorexia nervosa (an eating disorder).

Timothy A. Kelly (2002) "A Policymaker's Guide to Mental Illness." Washington, DC: The Heritage Foundation. http://www.heritage.org/Research/HealthCare/BG1522.cfm.

Over the last decade, many police agencies have sought to improve their response to incidents involving people with mental illness, especially emergency mental health situations. These new developments, however, have been targeted almost exclusively at improved handling of individual incidents. Little attention has been devoted to developing or implementing a comprehensive and preventive approach to the issue.

Common Situations

Police officers encounter people with mental illness in many different types of situations, in roles that include criminal offenders, disorderly persons, missing persons, complainants, victims, and persons in need of care (see table). According to one Texas study,[7] the five most frequent scenarios are as follows:

- A family member, friend, or other concerned person calls the police for help during a psychiatric emergency.
- A person with mental illness feels suicidal and calls the police as a cry for help.
- Police officers encounter a person with mental illness behaving inappropriately in public.
- Citizens call the police because they feel threatened by the unusual behavior or the mere presence of a person with mental illness.
- A person with mental illness calls the police for help because of imagined threats.

Of these typical situations, ones involving the threat of suicide were rated as the most difficult to handle. Each of the others listed above was rated as somewhat difficult to handle. The two behaviors that were rated as most problematic overall were threatening suicide and nuisance behaviors.

Roles of People with Mental Illness and Examples	
Role	**Examples**
Offender	• A person with mental illness commits a personal or property crime. • A person with mental illness commits a drug crime. • A person with mental illness threatens to commit suicide. • A person with mental illness threatens to injure someone else in the delusional belief that that person poses a threat to him or her. • A person with mental illness threatens to injure police as a means of forcing police to kill him (commonly called "suicide by cop").
Disorderly person	• A family or community member reports annoying or disruptive behavior by a person with mental illness. • A hospital, group home, or mental health facility calls for police assistance in controlling a person with mental illness. • A police officer on patrol encounters a person with mental illness behaving in a disorderly manner.
Missing person	• A family member reports that a person with mental illness is missing. • A group home or mental health institution reports that a person with mental illness walked away and/or is missing.
Complainant	• A person with mental illness calls the police to report real or imagined conditions or phenomena. • A person with mental illness calls the police to complain about care received from family members or caretakers.
Victim	• A person with mental illness is the victim of a personal or property crime. • A family member, caretaker, or service provider neglects or abuses a person with mental illness.
Person in need of care	• Police are asked to transport a person with mental illness to or from a hospital or mental health facility. • Police encounter a person with mental illness who is neglecting his or her own basic needs (food, clothing, shelter, medication, etc.).

These are the most common situations in which police encounter people with mental illness. It is important to realize, though, that when police officers handle some of these situations they do not always realize that mental illness is involved (such as a shoplifting or a disorderly person). Officers may try to handle the situation as usual (by giving directions, issuing commands, or making an arrest, for example) but not get the cooperation or compliance expected, sometimes leading to escalating tension. This highlights the importance of training in mental illness recognition as well as crisis management techniques.

Dangerousness

A fairly common perception is that people with mental illness are disproportionately involved in violent crime. This is true in one respect but not in another. A small subset of people with mental illness, those who are actively experiencing serious psychotic symptoms, are more violent than the general population. Research suggests several factors associated with this group's violent behavior, including drug and alcohol abuse, noncompliance with medication requirements, and biological or biochemical disorders.[8] In general, however, "violent and criminal acts directly attributable to mental illness account for a very small proportion of all such acts in the United States. Most persons with mental illness are not criminals, and of those who are, most are not violent."[9]

Police interactions with people with mental illness can be dangerous, but usually are not. In the United States, 982 of 58,066 police officers assaulted in 2002, and 15 of 636 police officers feloniously killed from 1993 to 2002, had "mentally deranged" assailants.[10] These represent one out of every 59 assaults on officers and one out of every 42

officers feloniously killed—relatively small portions of all officers assaulted and killed.

Encounters with police are more likely to be dangerous for people with mental illness than for the police. An early study found that an average of nine New York City police shootings per year between 1971 and 1975 involved emotionally disturbed people.[11] Between 1994 and 1999, Los Angeles officers shot 37 people during encounters with people with mental illness, killing 25.[12] A review of shootings by the police from 1998 to 2001 in the United Kingdom indicated that almost half (11 out of 24) involved someone with a known history of mental health problems.[13] It is estimated that people with severe mental illness are four times more likely to be killed by police.[14] Serious injury and death of people with mental illness at the hands of the police are especially tragic, for obvious reasons. Reduction of such injuries and deaths should be a high-priority objective for every police agency.

Harms

The harms associated with the police handling of people with mental illness are implicit in the situations and examples the table provides, but deserve some discussion. A person with mental illness may harm other citizens by committing personal or property crimes or engaging in disorderly and disruptive behavior. Alternatively, a person with mental illness may be harmed as a crime victim, as an abused family member or patient, as a person who suffers through self-neglect, or as a person whose mental health problem has left him or her erroneously subjected to criminal charges and jail confinement. Society in general may be harmed if excessive police, criminal justice, and/or medical resources are consumed by problems associated with people with mental illness.

It is important to keep the concept of harm in mind when addressing this particular problem, because there is a tendency to simply define people with mental illness as the problem, and getting them out of sight as the solution. In contrast to most police problems, however, this is not one that involves wholly voluntary behavior—rather, it involves behavior that medical conditions cause or compound. Consequently, police have to be careful not to blame people with mental illness, but instead focus on behavior that causes harm to self or others.

Related Problems

The police problem of people with mental illness is closely connected to three other problems noted below. This guide does not specifically address these problems, but addressing people with mental illness in your jurisdiction may require that you take on these problems, as well:

- homelessness
- drug abuse
- alcohol abuse.

The people the police encounter who have mental health problems or emergencies are also frequently homeless. For example, a Honolulu study found that 74 percent of law violators who the police believed to have a mental disorder were also homeless.[15] In London, about 30 percent of minor offenders referred for admission to a station-house diversion program for the "mentally disordered" were living on the streets.[16]

Similarly, the people with mental illness the police encounter are likely to have substance abuse problems. About three-quarters of jail and prison inmates with mental illness also have a substance abuse problem.[17] Current substance abuse was identified for about half of psychiatric emergency room referrals in New York State,[18] and nearly two-thirds of psychiatric emergency patients evaluated by a police-mental health outreach team in Los Angeles were known to be serious substance abusers.[19]

Factors Contributing to the Problem

Understanding the factors that contribute to your problem will help you frame your own local analysis questions, determine good effectiveness measures, recognize key intervention points, and select appropriate responses. Four important factors that strongly affect the current mental health situation in America are deinstitutionalization, criminalization, medicalization, and privatization.

Deinstitutionalization

Perhaps the single biggest factor affecting the policing of people with mental illness has been deinstitutionalization.[20] During the 20th century, and especially after 1960, public attitudes, laws, and professional mental health practices changed, leading to the closing of many state hospitals, psychiatric hospitals, and what used to be called insane asylums. Society's preference shifted away from institutionalizing people with mental illness. Unfortunately, adequate community-based services to pick up the slack were never provided. This vacuum persists to this day, to the extent of complete failure of the mental health system in many jurisdictions.

Criminalization

After deinstitutionalization, many people with serious mental illnesses were returned to the community, but adequate community-based services were not established. Predictably, calls to the police about crimes and disorder involving people with mental illness increased.[21] Police tried to handle many of these calls informally, but if the behavior persisted, options were limited. Frequently, efforts at civil commitment were unsuccessful (the person had to pose a danger to him- or herself or others), and other inpatient or outpatient mental health services were unavailable, cumbersome, or uncooperative. Inevitably, police often turned to arrest and a trip to jail as the only available solution to the immediate problem. This had the general effect of criminalizing mental illness and reinstitutionalizing people with mental illness—but in jail or prison instead of a psychiatric facility. One analysis concluded that "in 1955, [0].3 percent of the U.S. population was mentally ill and residing in a mental institution; whereas in 1999, [0].3 percent of the national population is mentally ill and is in the criminal justice system."[22]

Medicalization

The dominant treatment for mental illness has evolved from electric shock and psychotherapy more toward medication. To be sure, other treatments remain viable, and combined treatments are generally preferred, but today, medication plays a central role. Consequently, an important aspect of community-based mental health care is getting noninstitutionalized people with mental illness to take their medication as prescribed.[23] Factors that interfere with regular use of prescribed medications

include the negative side effects associated with some drugs, the high cost of medication, the tendency to self-medicate, the abuse of illegal drugs and alcohol, and the lack of monitoring/follow-up by the overtaxed community-based mental health system.

Privatization

Many of today's community-based mental health facilities, especially group homes, are operated by private individuals or companies. To be sure, government-run mental health facilities can be inefficient, callous, and neglectful. However, private profit-making facilities introduce another issue—greed. Privately run facilities have an inherent incentive to cut expenses; this often translates into minimum staffing levels and low-paid staff, which in turn results in a facility that relies on the police to help manage patients/clients. As a result, police resources are wasted and people with mental illness do not get the quality of care that they deserve.

Understanding Your Local Problem

The information provided above is only a generalized description of police problems associated with people with mental illness. You must combine the basic facts with a more specific understanding of your local problem. Analyzing the local problem carefully will help you design a more effective response strategy.

Asking the Right Questions

The following are some critical questions you should ask in analyzing your particular problem of people with mental illness, even if the answers are not always readily available. Your answers to these and other questions will help you choose the most appropriate set of responses later.

Incidents

It is important to gather information about the quantity and types of incidents involving people with mental illness. A jurisdiction may find that one or two particular types of incidents constitute a large part of its problem, providing a focus for analysis and response. This information may be difficult to obtain, however, because many police agencies' call classification systems do not include a code for "person with mental illness," "mental health emergency," or "emotionally disturbed person."

If the police department's communications system does not provide reliable data, it may be necessary to do a special study in which officers and dispatchers record this type of information for some months to facilitate problem analysis. Another option is to backtrack from

known indicators of incidents involving people with mental illness. For example, if one call at an address is found to involve a victim with mental illness or a false complaint reported by someone with mental illness, all previous calls at that address could be analyzed to check for a hidden hot spot. Similarly, all previous calls involving the particular person (victim or complainant) could be extracted from the department's computer system to determine if the individual might be an unrecognized repeat victim or repeat false complainant.

You should not overlook other data sources. Hospitals (general and/or psychiatric), ambulance services, and community-based mental health agencies might have useful data on commitments, referrals, and transports. In addition, academic institutions and mental health advocates might have conducted studies of the mental health situation in your jurisdiction, or they might be willing to partner with the police agency in conducting such studies.

- How many total incidents involving people with mental illness does your agency handle in a year, and how much police time is consumed?
- How many of each type of incident involving people with mental illness does the agency handle in a year, and how much police time does each consume?
- How do police handle incidents (informal handling, formal referral, involuntary commitment, arrest, etc.) for each type of incident involving people with mental illness?
- How often do officers use force when handling incidents involving people with mental illness?
- How often are officers injured when handling incidents involving people with mental illness?
- What proportion of people with mental illness whom officers encounter are homeless and/or serious substance abusers?

Stakeholders

It is important to identify institutions, organizations, and individuals in the community who play significant official or unofficial roles in the mental health system. Since most police officers are not intimately familiar with all the players in the mental health system, these stakeholders and potential guardians may not be well known or obvious. Because these entities can contribute expertise, authority, and resources, though, it is very beneficial to identify them and, if possible, engage them as participants in collaborative problem-solving.

- What public and private *inpatient* and *outpatient* psychiatric/mental health facilities (psychiatric hospitals and wards) are located in or serve the jurisdiction?
- What other residential facilities serving people with mental illness (group homes, assisted living facilities, nursing homes, etc.) are located in or serve the jurisdiction?
- What other services for persons with mental illness are provided in the jurisdiction through the public health department, general hospitals, counselors, therapists, etc.?
- What laws and regulations govern the mental health system's operation in your jurisdiction?
- What advocacy organizations representing people with mental illness, such as the National Alliance for the Mentally Ill or the Mental Health Association, are in the jurisdiction?
- What types of mental health services does the local jail provide?
- What institutions and organizations provide services in the jurisdiction for people who are homeless or who have serious substance abuse problems?
- In regard to each of the items above, how does the system differ for minors (juveniles)?

Victims

Identifying victims is important because certain categories of people, or even some specific individuals, may be more heavily victimized than others, suggesting avenues for problem-solving activity. Victims in situations involving people with mental illness might include specific community members, mental health workers, family members, or the mentally ill themselves. When any of these people become crime victims, the police may be notified, although of course many crimes also go unreported. Unfortunately, even when reported, such crimes may not be flagged or marked as involving a person with mental illness. This can make it difficult to identify both one-time and repeat victims.

- When people with mental illness commit a crime, who are the victims (strangers, businesses, caregivers, etc.)? Who are repeat victims?
- When people with mental illness cause nuisances and disorder, who are the victims? Who are repeat victims?
- When crimes are committed *against* people with mental illness, who are the victims and what are their circumstances (family members, institutional residents, etc.)? Who are repeat victims?
- When people with mental illness are neglected and/or abused, who are they and what are their circumstances? Who are repeat victims of neglect and abuse?

Offenders

It is important to look for people who cause a disproportionate share of the problem. People with mental illness may be offenders, or others may commit offenses against them. As mentioned above, however, it

can be difficult to identify cases involving people with mental illness from police data, thus making it challenging to identify offenders and repeat offenders associated with such cases.

- Which people with mental illness commit personal and property crimes? Who are the repeat offenders?
- Which people with mental illness cause nuisances and disorder? Who are the repeat offenders?
- What crimes do people commit against people with mental illness? Who are the offenders? Who are the repeat offenders?
- Who neglects and/or abuses people with mental illness? Who are the repeat offenders?

Locations/Times

The locations and times of incidents and crimes involving people with mental illness may be important to identify. Typical locations include public places (such as parks, business districts), businesses, and residences. Particularly important to look at, though, are hospitals, clinics, homeless shelters, drop-in shelters, and group homes. These places may have concentrations of people with mental illness, or they may be common destinations for people who experience serious chronic mental illness or episodic mental health crises. There may also be certain times of the day, days of the week, or weeks of the year that the incidence of calls involving people with mental illness is particularly high. The routine schedules of agencies that assist people with mental illness might influence these peak times.

- Where do incidents and crimes involving the people with mental illness occur?
- Where are the jurisdiction's "hot spots" of incidents and crimes involving people with mental illness?

- Do different types of incidents and crimes involving people with mental illness cluster in different locations? If so, where are those locations?
- Are there particular times of the day, days of the week, or weeks of the year in which the incidence of calls involving people with mental illness is especially high or low?

Measuring Your Effectiveness

Measurement allows you to determine to what degree your efforts have succeeded, and suggests how you might modify your responses if they are not producing the intended results. You should take measures of your problem *before* you implement responses, to determine how serious the problem is, and *after* you implement them, to determine whether they have been effective. All measures should be taken in both target areas and surrounding areas, if applicable. (For more detailed guidance on measuring effectiveness, see the companion guide to this series, *Assessing Responses to Problems: An Introductory Guide for Police Problem-Solvers*.)

The following are potentially useful measures of the effectiveness of police responses to problems associated with people with mental illness:

- reduced victimization of people with mental illness
- reduced repeat victimization of people with mental illness
- reduced total calls for service involving people with mental illness
- reduced calls for service at hot spots (although you should take care to ensure that, for example, reduced calls from a group home are not caused by a facility operator's preventing residents from reporting abuse or neglect)

- reduced amount of police time consumed by calls involving people with mental illness
- reduced total calls for each type of situation involving people with mental illness (especially if police target their efforts toward specific types of situations)
- reduced arrests of people with mental illness (assuming that more effective alternatives to arrest are available)
- reduced civil commitments of people with mental illness (although it might be desirable to increase the volume of civil commitments for some period if civil commitment is a preferred alternative to criminal arrest)
- increased referrals of people with mental illness to community-based services
- reduced injuries to people with mental illness caused by police officers
- reduced injuries to police officers caused by people with mental illness
- increased "customer" satisfaction—post-incident satisfaction of complainants, victims, and offenders
- increased "expert" satisfaction—high ratings of police effectiveness by mental health and legal professionals.

Responses to the Problem of People with Mental Illness

Your analysis of your local problem should give you a better understanding of the factors contributing to it. Once you have analyzed your local problem and established a baseline for measuring effectiveness, you should consider possible responses to address the problem.

General Considerations for an Effective Response Strategy

The following response strategies provide a foundation of ideas for addressing your particular problem. These strategies are drawn from a variety of research studies and police reports. Several of these strategies may apply to your community's problem. It is critical that you tailor responses to local circumstances, and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve implementing several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem. Do not limit yourself to considering what police can do: give careful consideration to whom else in your community shares responsibility for the problem and can help police better respond to it.

You will note that one set of responses fits under the label "improving the police response to incidents." Normally, problem-oriented policing is not very concerned with improving *incident* response—rather, it is focused on the underlying problems and conditions that give rise to incidents. In the case of people with mental illness, however, it is widely recognized that traditional police

response to incidents has been unsatisfactory, and a tremendous amount of attention has been focused on improving incident response over the past decade. It has been much less common, so far, for police to take a problem-oriented approach to situations involving people with mental illness. The responses described below address both the incident-oriented and problem-oriented approaches.

1. **Working with the mental health community**. Mental health professionals and others who work with or as advocates for people with mental illness can be viable partners with the police. They can provide training and direct assistance during emergencies, as described below.[24] They provide inpatient and outpatient services for people with mental illness and operate emergency facilities. There seems to be a general recognition that "neither the mental health system nor the law enforcement system can manage mental health crises in the community effectively without help from the other."[25]

Working together can be a challenge, however. The police responsibility to reduce disorder and hold offenders to account does not always square with the clinical and treatment goals of mental health providers. For these reasons as well as privacy and confidentiality considerations, the law enforcement and mental health systems sometimes fail to share information fully or quickly. Also, each system has a tendency to want to unload problematic individuals onto the other system.[26] Police often complain about the difficulty of getting hospitals to accept responsibility for people in crisis, while mental health professionals often complain that the police are too quick to seek civil commitment and too prone to place criminal charges.

The police problems associated with people with mental illness provide an opportunity for collaboration and partnerships.[27] A number of agencies and individuals, besides the police, have a professional interest in, and responsibility for, preventing incidents and tragedies as well as improving immediate and follow-up services. Others, including people with mental illness and their families, have a more personal but no less compelling interest in the same ends. Police departments should take the lead, if necessary, in building collaboration and partnerships among these groups to enhance incident response, coordination, and prevention.

2. **Working with emergency hospitals**. Those emergency hospitals (whether general hospitals or specialized psychiatric hospitals) to which police may take people in crisis are important elements of the mental health system. Police agencies should meet with staff of these hospitals periodically to clarify expectations, develop workable protocols, and address problems and issues. For example, it should be clear when an officer must remain at the hospital and when hospital security can take over. It should be clear whether either the police or an ambulance is responsible for transporting a patient to another facility. It should be the responsibility of police commanders and specialists to work these matters out in advance, so that patrol officers with people in crisis at 2 a.m. do not have to argue and debate with hospital staff.

3. **Appointing police liaison officers**. Issues related to people with mental illness need champions within the police department, or else they run the risk of falling through the cracks. Some police departments appoint an officer or commander to serve as liaison to the entire

mental health community, including sitting on appropriate boards and committees. In addition, some departments appoint liaison officers for each mental health facility (hospital, shelter, group home, etc.) in the jurisdiction. These facility liaison officers can be particularly effective for problem-solving location-specific issues to reduce and prevent crimes, disorder, and calls for service at current and potential hot spots (see responses below under "Targeting Locations").

Specific Responses to People with Mental Illness

Improving the Police Response to Incidents

4. **Training generalist police officers**. Training should be regarded as a promising method for improving the police response to incidents involving people with mental illness, but it is no panacea and should not be regarded as the complete solution to the problem.[28] Some police academies use role-playing—sometimes with trained actors—to teach police officers how to handle incidents involving people with mental illness.[29] Proper training typically integrates lecture, discussion, tours of mental health facilities, and role-playing.[30] Many states now require that police officers receive preservice and in-service training in dealing with people with mental illness.[31]

Although some training on handling mental health crises is provided in most police academies,[32] it may not be adequate. A British survey found that 61 percent of police officers felt inadequately trained to deal with problems associated with people with mental illness.[33] A study of Pennsylvania police departments found that 47 percent of respondents disagreed that they were "qualified to manage persons with mental illness."[34]

The aim of training is typically "to enhance officers' understanding of mental disabilities and their symptoms, to increase the knowledge of available community resources and dispositional alternatives, and to develop some basic crisis communication skills."[35] It is also important to train police to "make decisions free of prejudice, preformed attitudes, and stereotypical approaches."[36] Evaluations indicate that such training can succeed in improving understanding and knowledge, but that it is more difficult to change police officers' attitudes and behaviors. Training that exaggerates the danger involved in police encounters with people with mental illness can lead to premature and excessive use of force, but realistic training with role-playing might significantly reduce police use of deadly force when dealing with emotionally disturbed people.[37] A review of the evidence on the effectiveness of training for generalist patrol officers concluded that "educational programs and crisis intervention training are probably not harmful and may be helpful, but there is good reason to believe that they are not sufficient to change fundamentally the nature of police encounters with mentally ill persons in crisis."[38]

5. **Providing more information to patrol officers**. Ordinary patrol officers called up on to handle incidents involving people with mental illness can benefit from at least two types of specific information. One is information about clinics, shelters, and mental health services that are available in the community. Armed with this type of information, officers may be able to effectively refer people with mental illness to agencies better suited to provide treatment and other services, and/or to provide such information to family members or other potential guardians. Departments might provide this information to officers via brochures, printed referral agency directories, or the agency's online intranet or web site.

A second type of information that might be valuable for patrol officers pertains to community members with a history of mental illness. People who repeatedly report fictional events, for example, or who have had mental health crises that led to violent encounters with officers, might be logged in a database or flagged in the department's dispatching system. The purpose of this information would be to forewarn an officer who subsequently is dispatched to a chronic caller's address, or who encounters a potentially violent person. Otherwise, especially in a large department, officers find themselves at a disadvantage dealing with people whom they know nothing about, despite the fact that the people have a history with other agency officers.[39]

Of course, the compilation and dissemination of this type of information raises some legal and privacy issues that have to be carefully addressed (one would hope that everyone with a police scanner would not hear that "a known mental case resides at that address" or some similar announcement). Another concern is labeling—advance information about a person's mental illness history might prejudice an officer's decision-making. One study found that advance information about a suspect did not affect officer arrest decisions in a minor crime situation, but officers were "less willing to investigate and take action on behalf of a victim with mental illness."[40]

6. **Using less-lethal weapons**. Police officers can resolve most tense and threatening situations involving people with mental illness by maintaining a calm demeanor, using good oral and nonverbal communication, and using proper tactics, but when those techniques fail, it is crucial to have additional alternatives short of deadly force. Too often in the past in encounters with people experiencing mental health crises, officers have used poor tactics and then

turned immediately to the use of deadly force.[41] Today, the practicality and effectiveness of less-lethal police weapons, including pepper spray and stun guns, have improved and police agencies should explore obtaining those that are reliable and affordable. In particular, less-lethal weapons offer police officers important alternatives in those situations when a person with mental illness is wielding a knife or a blunt object in a threatening manner, or when the person's strength threatens to overwhelm the officer. Needless to say, police agencies need to have clear policies and procedures in place that guide officers' use-of-force decisions and ensure that police use the least-necessary amount of force.

7. **Deploying specialized police officers**. In recent years, the most popular approach to improving police response to incidents involving people with mental illness, and especially crisis incidents, has been specialization. Departments have seen the value of preparing specialist officers or even special units to handle these situations, relieving regular patrol officers of that responsibility. Specialists can be carefully selected and given extra training, and then over time they acquire substantial experience, all of which should contribute to better performance.

The Memphis, Tennessee CIT (Crisis Intervention Team) model is the most pervasive.[42] A cadre of selected patrol officers (10 to 20 percent of those assigned to patrol) receive extra training (40 hours initially) and then serve as generalists/specialists—they perform the full-range of regular patrol duties, but respond immediately (from anywhere in the city) whenever crisis situations occur involving people with mental illness. In those situations, these officers assume on-scene command as soon as they arrive. They are trained to handle the crisis situations

as well as to facilitate the delivery of treatment and other services. In particular, they become knowledgeable about voluntary and involuntary commitment, plus they become well known to professionals in the mental health community, facilitating the delivery of treatment and other services to the people in crisis.

Evidence indicates that the CIT model has worked effectively in Memphis.[43] Response times are generally under 10 minutes, the CIT officers handle 95 percent of all mental disturbance calls, regular patrol officers support the program, police time spent waiting for mental health admissions is dramatically down, arrest rates of people with mental illness are low, referrals to treatment are high, police-caused injuries suffered by people with mental illness are down, officer injury rates are down, and call-outs of the Special Weapons and Tactics team are down. A recent CIT evaluation in Louisville, Kentucky also found that "in addition to reducing use of force, officer injury, and criminalization of mental illness, CIT programs may save money and reduce psychiatric morbidity by referring severely ill subjects to appropriate treatment earlier than might occur otherwise."[44]

Several limitations of the Memphis CIT model for smaller agencies should be noted.[45] First, in small agencies, at least half of, if not all, officers would need the specialized training so that a CIT officer would always be on duty; in such a situation, picking these officers could not be as selective as in Memphis, since every officer or every other officer would be selected. Also, the likelihood that those officers in a small agency would gain substantial additional experience in handling people in mental health crisis would be reduced, simply because the volume of such situations would be limited. In addition, a key factor in the success of the CIT model is networking and collaboration

between police and mental health service providers. In a small jurisdiction, however, such providers may be totally absent, and certainly not available around the clock. Consequently, the CIT model may not be as effective in smaller jurisdictions as it is in larger ones. That said, it may still be more effective than other alternatives, especially the alternative of providing officers with no special training in dealing with people with mental illness.

8. **Deploying specialized nonpolice responders**. An alternative to specialized *police* response to calls and crises involving people with mental illness is specialized *nonpolice* response. This usually involves response by social workers/mental health clinicians or some kind of combined sworn police and nonsworn civilian response.[46] The nonpolice approach is generally based on the belief that educated and trained mental health professionals have skills and knowledge that most police officers do not. The combined model adds the recognition that situations involving people in mental health crisis can be dangerous and may require the use of physical force and/or enforcement of the criminal law, capacities that are provided by police officers, not social workers or mental health clinicians.

Implementation of these nonpolice and combined models can be even more complicated and challenging than the Memphis CIT model, because social workers and mental health professionals are not routinely available 24 hours a day or typically dispatched to emergencies in the field. Nevertheless, models of this type have been used in Birmingham (Alabama), Knoxville (Tennessee), Burlington (Vermont), Los Angeles, San Diego, and a number of other cities.[47] Comparative analysis suggests that these nonpolice alternatives do not succeed in handling as high

a proportion of applicable calls and do not achieve as quick a response as the CIT model, but they may resolve a greater proportion of incidents at the scene or through referral, whereas the CIT approach tends to rely on transporting the person in crisis to a treatment location.[48]

The choice between police and nonpolice specialized responses largely depends on available resources. If a jurisdiction can afford both, it should employ both. Where available, the services of a trained clinician at the scene of a mental health crisis seems to help divert people away from the criminal justice and emergency medical systems in favor of informal handling and referral to nonemergency treatment providers. In most cases, however, sufficient social work/mental health resources are rarely available to provide prompt mobile response to a majority of incidents. In these situations, specialized police response seems to help prevent tragedies and unnecessary criminalization and to provide a number of other positive outcomes, as noted above.

Working with Stakeholders

9. **Initiating assisted outpatient treatment**. A result of deinstitutionalization is that many people with serious mental illness live in the community. For a variety of reasons, these people often fail to adhere to prescribed treatment, including medication. In most states, if a person is under court jurisdiction, a condition of remaining in the community can be compliance with prescribed treatment. Studies in New York, North Carolina, and elsewhere have demonstrated that when mechanisms are in place to encourage adherence to prescribed treatment, problems are reduced.[49] Assisted outpatient treatment (AOT), also called outpatient commitment, uses enforcement of treatment plans by mental health workers or others (sometimes including

police) to increase compliance. Results indicate that "AOT is effective in reducing the incidents and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance."[50]

10. **Establishing crisis response sites**. Several jurisdictions, including Memphis, Montgomery County (Pennsylvania), and Multnomah County (Oregon) have established specific facilities where police can transport people in mental health crisis, as an alternative to the general hospital emergency room or jail.[51] These sites are usually located within hospitals. What sets them apart from the norm is their identification as a central drop-off point, the availability of both mental health and substance abuse services, a no-refusal policy for police (although this does not mean that inpatient stays are guaranteed), and their streamlined intake procedures (usually 30 minutes or less for officers). These features have resulted in reduced police officer frustration and reduced reliance on arrest and jail to deal with people with mental illness.

11. **Establishing jail-based diversion**. It is inevitable that some people with mental illness will be arrested for minor crimes and disorder. When these people get to jail and are identified as suffering from serious illness, they can be diverted immediately after booking (with special conditions), as soon as the case is reviewed for prosecution (through deferred prosecution with conditions), or as soon as the case comes to court (by summary probation with conditions).[52] Techniques like these benefit the jail by removing detainees with mental illnesses who require services that the jail probably cannot provide, and they benefit the detainee by diverting them from jail to treatment. For these diversion options to be successful, though, resources must be in place to supervise

release conditions and provide treatment. Otherwise, diversion will just contribute to the deinstitutionalization/criminalization revolving door.

§ See the Problem-Oriented Guide titled *Analyzing Repeat Victimization*.

12. **Establishing mental health courts**. When people with mental illness do go to court for committing minor offenses and disorder, the experience is often unsatisfactory, because most prosecutors and judges lack the experience and expertise to handle such cases effectively, including knowledge about mental illness and awareness of treatment options. Also, general criminal court can be chaotic, causing lots of cases to receive only superficial attention. In this context, people with mental illness sometimes get much longer incarceration sentences than makes any sense, burdening the jail or prison and failing to address the defendant's real problems. Conversely, in other cases, people with mental illness get unsupervised probation without treatment conditions, compounding deinstitutionalization effects. One remedy for this dilemma is a specialized mental health court, in which one or a few judges hear all such cases and have ready access to mental health professionals.[53] These courts are in a much better position than a general criminal court to make adjudication and sentencing decisions that are tailored to the specific needs of each defendant, while at the same time protecting the community.

Protecting Victims

13. **Protecting repeat crime victims**. An effort should be made to identify repeat crime victims associated with people with mental illness, because previous victimization is generally the best predictor of future victimization.[§] When repeat crime victims are identified, the behaviors or conditions connected to their victimization should be identified to explore possible responses. For example, if

a person with mental illness is a repeat victim, an abusive caregiver might be uncovered. Alternatively, it might be discovered that the person frequents risky places or engages in risky behaviors. It is also possible, of course, that the crimes reported by the person with mental illness are imaginary and never happened. Identifying any of these "causes" could lead to solutions that reduce or even eliminate future victimizations. Alternatively, people with mental illness might habitually victimize others—caregivers, family members, employers.

§ Police agencies and individuals can obtain more information for and about victims from the National Organization for Victim Assistance, the National Center for Victims of Crime, the U.S. Justice Department Office for Victims of Crime, and the National Alliance for the Mentally Ill, among others.

14. **Providing services to victims**. From the standpoints of equity and prevention, it is important to provide information and services to people *with* mental illness who are crime victims, as well as to people who are victimized *by* people with mental illness.[54] In either instance, standard victim services should be provided as well as information specifically associated with mental illness. It should be noted that a person with mental illness who is a crime victim may experience more trauma than another person, including the possibility that memories of past abuses can be triggered. Similarly, family members of a person with mental illness who are victimized by that person may experience extra fear, anger, remorse, or even guilt because of the intimate relationships involved.[§]

In one case in Baltimore County, Maryland, police responded frequently to a residence based on complaints from neighbors about trash and property in disrepair.[55] They made referrals to social services agencies, but both the police and social services responses were fragmented, resulting in no improvement and continued calls. When the situation was finally targeted, it was determined that the real victim was a mother who lived in the house with her grown daughter. The daughter, who suffered from mental illness, abused and intimidated her mother. This led to a case management focus with services for the mother and

involuntary commitment of the daughter, as well as the establishment of a Vulnerable Adults Assistance Network in the county designed to address future situations more promptly.

Targeting Offenders

15. **Targeting repeat criminals**. It is widely recognized that a relatively small proportion of offenders commit a relatively large proportion of offenses. If people with mental illness are identified who are repeat criminal offenders, attention should be focused on them. This may involve criminal charges, involuntary commitment, better guardianship, court-ordered medication, restraining orders, or any number of other techniques, depending on the circumstances. The key is to focus attention on anyone who is responsible for a disproportionate share of a problem.

Similarly, there may be community members who commit repeat crimes against people with mental illness. These might include assault, theft, harassment, or fraud. The perpetrators might be caregivers, family members, neighbors, or relative strangers. Because people with mental illness who report crimes are sometimes treated with skepticism and suspicion, those who repeatedly victimize them may be more difficult to identify than should be the case. Police efforts to identify and target these people should be given high priority, though, because they are repeat criminals and because of their victims' particularly vulnerable nature.

16. **Targeting those responsible for repeat or chronic disturbances**. Chronic disturbances involving people with mental illness are among the most frustrating situations for police, because there are few options available to officers. If a person with mental illness is merely being loud, being annoying, or acting strangely, involuntary civil commitment is not usually an option, because the person is not putting himself or others in danger. In response to any particular incident, officers might attempt informal "soothing or smoothing,"[56] look for a guardian, command the individual to cease or leave, or make an arrest for disorderly conduct. When the same person engages in the same behavior repeatedly, however, officers may run out of options quickly, especially if the jail tightens its criteria on accepting people with mental illness. The situation is exacerbated if there are complainants who expect the officer to do something.

Although easy solutions may not be available, it is nevertheless productive to target those people responsible for repeat or chronic disturbances. In San Diego, for example, police received an average of four calls per month about a man who was disruptive and threatening in his neighborhood.[57] Previous responses were found to have been ad hoc and ineffective. When police targeted him, they were able to meet with him, gather his history, and then use criminal charges and probation conditions to exercise greater control over him. At the same time, the police organized and empowered the community to apply more supervision over the man and gather better evidence in case additional charges or probation revocation became necessary. The end result was a 75 percent decrease in calls and a community that was more satisfied that the police department had helped them address a chronic problem.

In Charlotte, North Carolina, police were called to a single residential address over 100 times in regard to trash, property in disrepair, and threats to neighbors.[58] An unmarried couple lived at the residence. When police targeted the situation, they learned that the woman suffered from mental illness and that she had completely intimidated her common-law husband, in addition to terrorizing the neighborhood. Police identified relatives of the man, and gained their assistance once a long-term involuntary commitment for the woman was obtained. The house and property were then completely cleaned up. The man chose to remain at the residence. Once the woman was released from inpatient care, she moved to a different residence and started working. During the follow-up period, both people were reported as doing well, and the police department received no further calls.

17. **Targeting those responsible for repeat calls for service**. In addition to chronic disturbances, some individuals are responsible for a disproportionate volume of calls for police service. In the case of people with mental illness, this might involve a large number of false, imaginary, or trivial calls. If police can identify and target these repeat complainants, they may be able to reduce the volume of calls substantially. For example, in Georgetown, Texas, police discovered that they had received 70 calls over eight years from a particular address.[59] Upon investigation, they found an elderly woman suffering from mental illness who was living in a very deteriorated home, but who refused to move or make repairs. With persistence and patience, officers were able to get her some greatly needed medical attention. With medical professionals involved, they were then able to make a case for involuntary commitment, after which the woman moved into a group home and exhibited much better physical and mental health. The police received no more calls from the address or from the woman.

In Ithaca, New York, calls from emotionally disturbed people were the police department's most common noncrime calls.[60] Police officers were familiar with a number of chronic callers, but the department had not adopted a systematic approach other than responding to each incident as it was reported. A new system was adopted in which calls from or about people with mental illness were handled as they were received, but also referred to community-based officers and mental health providers for next-day follow-up. People were recontacted and an effort was made to coordinate a variety of service providers. Chronic calls were all but eliminated.

Targeting Locations

18. **Targeting hot spots**. Crime, disorder, and calls for service tend to be concentrated in a subset of all locations in any jurisdiction. This general pattern seems to hold with regard to problems associated with persons with mental illness. In Lexington, Kentucky, for example, of 507 calls for service in one year that could be identified in dispatch data as involving a person with mental illness and that had exact addresses, 20 percent occurred in just 17 locations, each of which had three or more calls during the year.[61] Those locations included a psychiatric hospital, a general hospital, two shelters, three group homes, and 10 apartment buildings. Moreover, when all calls for service at each of those locations were then examined, it was apparent that the calls initially identified as involving people with mental illness were just a small portion of the total volume of calls at these locations. The two shelters totaled 641 calls for the year, the psychiatric hospital 133, and the three group homes 134. At five of the apartment buildings, further investigation revealed a total of 122 calls from five persons known to be suffering from mental illness (i.e., one person per building), plus another 76 calls with no complainant name.

Of course, identifying hot spots is just the first step. Once a chronic repeat call location is identified, it is important to analyze the situation to determine the nature of the calls and why they are occurring, as a prelude to implementing tailored responses. The situation might involve a single chronic false complainant, a poorly managed group home, or a hospital with inadequate security staff.

Effective responses at hot spots clearly depend on problem analysis. In Overland Park, Kansas, police identified a man in an apartment complex who made chronic unfounded calls to 911.[62] The man had ignored previous suggestions and encouragement to take advantage of available mental health services. Finally, officers contacted mental health providers directly and asked them to reach out to the man. He did accept the services that were recommended, and the police department received no further calls.

19. **Regulating facilities more effectively**. One effective approach to a mental health facility hot spot might be to apply or enhance external regulation. In San Diego, calls to the police from an apartment building had increased from three to 13 per month.[63] Analysis revealed that the apartment building had been turned into an independent living facility for people with mental disabilities, with four residents living in each of eight units. Further investigation determined that independent-living facilities were intended for people capable of living on their own, which was not the case for the residents of this building. The independent-living designation was being used fraudulently because such facilities were largely unregulated by the state, in contrast to group homes. The facility's operators were simply ignoring state regulations

so that they could make more money, one result of which was a high volume of calls to the police. Another result was that residents were underserved and endangered. The police threatened the operators with a civil injunction and called in state regulators. Within a short time, the facility was closed and the residents were dispersed to more appropriate accommodations.

In Lancashire, England, police found that some mental health facilities had high rates of walk-aways and missing persons.[64] Their analysis indicated that key factors included the physical features and security of the facilities as well as management practices. The constabulary appointed liaison officers to work with each mental health facility to improve its security and practices, and then took the extra step of negotiating very specific performance targets for each facility. In the future, if a facility exceeds its annual performance limit for missing persons, it will come under government review and run the risk of losing its license and social services funding.

Responses with Limited Effectiveness

20. **Arresting people with mental illness**. Except when people with mental illness commit serious crimes, arrest is generally not an effective response. When police arrest people with mental illness for minor crimes and disturbances, it is frequently because they cannot identify any other options and are desperate for a short-term solution. Even so, jails often refuse to accept the arrestees, resulting in their almost-immediate release. Long-term solutions are not usually reached either, because prosecutors often refuse to file charges. Making arrests in these situations typically frustrates both police officers and the people who get arrested, while accomplishing little or nothing.

In those instances when arresting someone with mental illness does result in jail and prosecution, police may feel satisfied that a short-term solution has been achieved, but evidence indicates that the costs are considerable, as explained below.

21. **Incarcerating people with mental illness**. People with mental illness may end up in jail awaiting trial, in jail serving a sentence, or in prison serving a sentence. They end up in jail and prison in large numbers—about one in six inmates has a mental illness, and the jails serving New York, Los Angeles, and Chicago each hold more people with mental illness per day than any hospital in the United States.[65] Sheriffs, jail administrators, and prison wardens regularly express their frustrations over the stresses and strains caused in their institutions by the inappropriate criminal justice incarceration of persons with mental illness.

Neither jail nor prison is a good setting for mental health treatment, if such treatment is even available. People with mental illness often get worse while incarcerated, and tragedies involving victimization and suicide are too common.[66] In the long run, criminal justice incarceration of the mentally ill harms the lives of those people, interferes with the proper operation of jails and prisons, and accomplishes little or no long-term solution to the original crime-and-disorder problems that led to arrest and incarceration in the first place. Referral, treatment, and civil commitment for people with mental illness should be preferred over arrest and criminal justice incarceration as responses to minor crime-and-disorder problems.

22. **Ignoring the needs of people with mental illness**. Police officers sometimes get frustrated by people with mental illness, and respond by doing nothing. They may ignore disruptive behavior, hoping that no citizen will complain, or refuse to respond when chronic complainants call to report a crime, or try to trick or distract a person whose behavior seems driven by mental illness. The real purpose of these responses is to extricate the officer from the immediate situation, leaving the problem unresolved. Doing nothing, while understandable when officers have little training about mental illness or few viable response options, nonetheless demonstrates poor policing.

Appendix: Summary of Responses to People with Mental Illness

The table below summarizes the responses to people with mental illness, the mechanism by which they are intended to work, the conditions under which they ought to work best, and some factors you should consider before implementing a particular response. It is critical that you tailor responses to local circumstances, and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve implementing several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem.

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
General Considerations for an Effective Response Strategy					
1.	20	Working with the mental health community	Police develop partnerships and collaborate with mental health agencies and advocacy groups	…the collaboration is focused on identifying and solving specific problems	Mental health agencies are typically underfunded and overwhelmed; police may want to help support and empower advocacy groups to increase their influence on legislation and funding
2.	21	Working with emergency hospitals	Police meet regularly with the staffs of emergency hospitals to address issues and problems	…a sense of teamwork and shared responsibility can be developed	Protocols must be developed in advance and effectively implemented so that patrol officers are not faced with debating doctors and nurses in the middle of the night

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
3.	21	Appointing police liaison officers	Helps police and other organizations maintain focus on and develop expertise in mental health issues	…liaison officers have credibility within the police agency so that they quickly hear about complaints and problems	Liaison officers to the entire mental health system should have sufficient rank to represent the whole police agency and establish standing with doctors, psychiatrists, etc.; liaison officers to specific facilities can be area specialists (beat officers) or mental health specialists
Specific Responses to People with Mental llness					
Improving the Police Response to Incidents					
4.	22	Training generalist police officers	Improves police officers' awareness and understanding of mental illness and thereby improves their responses to incidents	…the training is hands-on, realistic, and focused on making good decisions that protect the safety of the individual, the general public, and officers	It is important to demystify mental illness and help officers overcome stereotypes and prejudices
5.	23	Providing more information to patrol officers	Increases the likelihood that people with mental illnesses will be properly referred to treatment services	…adequate mental health services are available and the police data and communications system forewarns officers about previous incidents and encounters involving specific complainants, suspects, victims, subjects, and addresses	Storing and communicating information about individual histories of mental illness and mental health crises raises significant privacy issues; legal restrictions may vary from state to state

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
6.	24	Using less-lethal weapons	Reduces the likelihood of serious injury or death to people with mental illnesses	…less-lethal weapons are effective, noncontroversial, and immediately available to officers in the field	Less-lethal weapons may affect a person in mental a health crisis differently from other persons; agencies must assure that officers do not resort to less-lethal weapons before exhausting nonviolent alternatives
7.	25	Deploying specialized police officers	Improves the police response to situations involving mental illness through the delivery of specialized knowledge, skills, and experience	…mental health practitioners are included in the training so that familiarity, trust, and teamwork are developed	Deploying around-the-clock specialists and developing a team approach with mental health practitioners may be difficult for small/rural police agencies and in jurisdictions that lack their own mental health facilities
8.	27	Deploying specialized *nonpolice* responders	Improves the response to situations involving mental illness through the delivery of specialized knowledge, skills, and experience	…sworn and non-sworn personnel work together as a team	It is important to have clear guidelines about the differing roles of sworn and non-sworn responders and clarity about decision-making authority

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Working With Stakeholders					
9.	28	Initiating assisted outpatient treatment	Increases the likelihood that people with mental illness will receive proper treatment and medication, thereby decreasing the likelihood of the need for police intervention	…mental health workers enforce court-ordered treatment compliance	Compliance enforcement has been shown to reduce incidents, arrests, victimization, violent episodes, and homelessness
10.	29	Establishing crisis response sites	Improves the response to people in mental crisis through readily available specialized services	…intake procedures are streamlined, a no-refusal policy is in place, and both mental health and substance abuse services are available	Police should understand that a no-refusal policy does not guarantee extended or inpatient stays, just a guarantee that the facility will accept the person for evaluation
11.	29	Establishing jail-based diversion	Improves the mental health treatment of offenders and reduces the use of scarce jail resources	… when screening occurs immediately after booking	Immediate diversion will generally be available only for minor offenders; more serious offenders may be considered for diversion at the prosecution or adjudication stages
12.	30	Establishing mental health courts	Enhances the special expertise of judges in adjudicating mentally ill offenders	… when specialized judges and courts work closely with mental health agencies and advocacy groups	Small jurisdictions may not have the resources or volume of mental health cases to support specialized judges or courts

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Protecting Victims					
13.	30	Protecting repeat crime victims	Increases the likelihood that people with mental illness who are repeat crime victims, as well as repeat victims of offenders with mental illness, receive special attention	… repeat victims are identified sooner rather than later in the course of their repeated victimizations	It is important to try to identify guardians (official or unofficial) who can both protect vulnerable victims and influence them to change any risky behavior
14.	31	Providing services to victims	Increases the likelihood that crime victims who have mental illness, as well as victims of offenders with mental illness, will recover from their victimization and successfully navigate the legal system	… victim services agencies, mental health agencies, and mental health advocacy groups collaborate	Police must be careful not to dismiss victimization claims by people with mental illness; while false reports are common, so is victimization of people with mental illness by family members, unprofessional service providers, and others

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Targeting Offenders					
15.	32	Targeting repeat criminals	Increases the likelihood that people with mental illness who commit repeated crimes, as well as offenders who commit repeated crimes against people with mental illness, are targeted for special attention	… repeat offenders are identified sooner rather than later for special enforcement, prosecution, and/or treatment	Repeat offenders often go unrecognized and fall through the cracks of the criminal justice system; concerted effort is required to keep this from happening
16.	33	Targeting those responsible for repeat or chronic disturbances	Increases the likelihood that people with mental illness who repeatedly create disturbances are targeted for special attention	… guardians and handlers (including family members and service providers) can be persuaded to exercise more supervision and influence over disorderly behavior	Restoring order and resolving disturbances are among the most challenging police responsibilities; particularly when these involve a person with mental illness, informal alternatives are preferred, and jail should be avoided
17.	34	Targeting those responsible for repeat calls for service	Increases the likelihood that people with mental illness who repeatedly call the police about trivial or imaginary problems are targeted for special attention	… repeat complainants receive follow-up visits to identify underlying issues and implement systematic responses	Because chronic complainants may initiate calls from various locations, it is necessary to analyze calls for service to identify repeat complainants as well as repeat addresses

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
18.	35	Targeting hot spots	Concentrates attention on locations with multiple incidents and/or calls for service involving people with mental illness, thereby correcting conditions that create incidents	… guardians and managers can be persuaded to exercise more supervision and authority over hot-spot locations	Hot-spot analysis related to calls and crimes involving people with mental illness is challenging because police data systems often do not include categories or flags indicating mental illness
19.	36	Regulating facilities more effectively	Compels mental health service facilities to improve their practices, thereby reducing the likelihood that police will need to intervene	… liaison officers work with each facility to analyze problems, recommend solutions, and monitor compliance	Because mental health facilities are often profit-making businesses that are poorly regulated by governing authorities, they frequently arise as hot spots; these facilities typically account for a disproportionate share of calls and crimes involving people with mental illness and should be a principal target of problem-oriented policing
Responses With Limited Effectiveness					
20.	37	Arresting people with mental illness	Intended to deter offenders through punishment and incapacitation	… arrested people are promptly diverted into the mental health, medical, or social service systems	People with mental illness who commit serious crimes should be arrested, leaving decisions about criminal liability to the courts; minor offenders, however, are not likely to be prosecuted, adjudicated, or incarcerated, making arrest an ineffective response from every perspective

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
21.	38	Incarcerating people with mental illnes	Intended to deter offenders through punishment and incapacitation	… mental health services are available in the jail	Incarceration of people with mental illness is never beneficial for the individual or the jail; it harms the individual, creates risks for other detainees, and greatly complicates the operation of the jail
22.	39	Ignoring the needs of people with mental illness	Done in hopes that the problem will go away	… problems are minor and other stakeholders shoulder the responsibility	Ignoring people in need is an abdication of a basic police responsibility

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Gary Cordner is Foundation Professor of Police Studies at Eastern Kentucky University (EKU), where he also directs the Regional Community Policing Institute and the International Justice & Safety Institute. Past positions include dean of the College of Justice and Safety at EKU, president of the Academy of Criminal Justice Sciences, editor of Police Quarterly and the American Journal of Police, and police chief in St. Michaels, Maryland. Research interests include community policing, problem-oriented policing, police administration, and homeland security. Professor Cordner, who earned his Ph.D. from Michigan State University, has served as a judge for the annual Herman Goldstein Award for Excellence in Problem-Oriented Policing since 1996.

Recommended Readings

- **A Police Guide to Surveying Citizens and Their Environments**, Bureau of Justice Assistance, 1993. This guide offers a practical introduction for police practitioners to two types of surveys that police find useful: surveying public opinion and surveying the physical environment. It provides guidance on whether and how to conduct cost-effective surveys.

- **Assessing Responses to Problems: An Introductory Guide for Police Problem-Solvers**, by John E. Eck (U.S. Department of Justice, Office of Community Oriented Policing Services, 2001). This guide is a companion to the *Problem-Oriented Guides for Police* series. It provides basic guidance to measuring and assessing problem-oriented policing efforts.

- **Conducting Community Surveys**, by Deborah Weisel (Bureau of Justice Statistics and Office of Community Oriented Policing Services, 1999). This guide, along with accompanying computer software, provides practical, basic pointers for police in conducting community surveys. The document is also available at www.ojp.usdoj.gov/bjs.

- **Crime Prevention Studies**, edited by Ronald V. Clarke (Criminal Justice Press, 1993, et seq.). This is a series of volumes of applied and theoretical research on reducing opportunities for crime. Many chapters are evaluations of initiatives to reduce specific crime and disorder problems.

- **Excellence in Problem-Oriented Policing: The 1999 Herman Goldstein Award Winners.** This document produced by the National Institute of Justice in collaboration with the Office of Community Oriented Policing Services and the Police Executive Research Forum provides detailed reports of the best submissions to the annual award program that recognizes exemplary problem-oriented responses to various community problems. A similar publication is available for the award winners from subsequent years. The documents are also available at www.ojp.usdoj.gov/nij.

- **Not Rocket Science? Problem-Solving and Crime Reduction**, by Tim Read and Nick Tilley (Home Office Crime Reduction Research Series, 2000). Identifies and describes the factors that make problem-solving effective or ineffective as it is being practiced in police forces in England and Wales.

- **Opportunity Makes the Thief: Practical Theory for Crime Prevention**, by Marcus Felson and Ronald V. Clarke (Home Office Police Research Series, Paper No. 98, 1998). Explains how crime theories such as routine activity theory, rational choice theory and crime pattern theory have practical implications for the police in their efforts to prevent crime.

- **Problem Analysis in Policing**, by Rachel Boba (Police Foundation, 2003). Introduces and defines problem analysis and provides guidance on how problem analysis can be integrated and institutionalized into modern policing practices.

- **Problem-Oriented Policing**, by Herman Goldstein (McGraw-Hill, 1990, and Temple University Press, 1990). Explains the principles and methods of problem-oriented policing, provides examples of it in practice, and discusses how a police agency can implement the concept.

- **Problem-Oriented Policing and Crime Prevention**, by Anthony A. Braga (Criminal Justice Press, 2003). Provides a thorough review of significant policing research about problem places, high-activity offenders, and repeat victims, with a focus on the applicability of those findings to problem-oriented policing. Explains how police departments can facilitate problem-oriented policing by improving crime analysis, measuring performance, and securing productive partnerships.

- **Problem-Oriented Policing: Reflections on the First 20 Years**, by Michael S. Scott (U.S. Department of Justice, Office of Community Oriented Policing Services, 2000). Describes how the most critical elements of Herman Goldstein's problem-oriented policing model have developed in practice over its 20-year history, and proposes future directions for problem-oriented policing. The report is also available at www.cops.usdoj.gov.

- **Problem-Solving: Problem-Oriented Policing in Newport News,** by John E. Eck and William Spelman (Police Executive Research Forum, 1987). Explains the rationale behind problem-oriented policing and the problem-solving process, and provides examples of effective problem-solving in one agency.

- **Problem-Solving Tips: A Guide to Reducing Crime and Disorder Through Problem-Solving Partnerships** by Karin Schmerler, Matt Perkins, Scott Phillips, Tammy Rinehart and Meg Townsend. (U.S. Department of Justice, Office of Community Oriented Policing Services, 1998) (also available at www.cops.usdoj.gov). Provides a brief introduction to problem-solving, basic information on the SARA model and detailed suggestions about the problem-solving process.

- **Situational Crime Prevention: Successful Case Studies**, Second Edition, edited by Ronald V. Clarke (Harrow and Heston, 1997). Explains the principles and methods of situational crime prevention, and presents over 20 case studies of effective crime prevention initiatives.

- **Tackling Crime and Other Public-Safety Problems: Case Studies in Problem-Solving**, by Rana Sampson and Michael S. Scott (U.S. Department of Justice, Office of Community Oriented Policing Services, 2000) (also available at www.cops.usdoj.gov). Presents case studies of effective police problem-solving on 18 types of crime and disorder problems.

- **Using Analysis for Problem-Solving: A Guidebook for Law Enforcement**, by Timothy S. Bynum (U.S. Department of Justice, Office of Community Oriented Policing Services, 2001). Provides an introduction for police to analyzing problems within the context of problem-oriented policing.

- **Using Research: A Primer for Law Enforcement Managers**, Second Edition, by John E. Eck and Nancy G. LaVigne (Police Executive Research Forum, 1994). Explains many of the basics of research as it applies to police management and problem-solving.

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