Policing and Mental Health:
A Working Roundtable Discussion

Problem Statement

With a well-intentioned push from civil rights advocates and state lawmakers motivated to reallocate tax revenues in the 1950s, state hospitals in the United States began a mass deinstitutionalization of those suffering from mental illness and cognitive impairments. A series of appellate court cases and a congressional commission, combined with changing social norms, political activism, and development of anti-psychotic medications solidified the move from institutions to the community. As a result, from 1955-1994, 92% of the people who would have been institutionalized, were "in the community."[1]

Problematically, "the community"—an intangible, unstructured, arguably mythical, "something"—was now tasked with assuming care and treatment for those who would've been institutionalized. The congressionally funded Community Mental Health Centers didn't materialize as planned—only 800 of the planned 2000 were built.[2] As a result, services were haphazardly assembled into siloed agencies for mental health care, medical care, housing, drug treatment, and employment. "The ultimate result was a version of "the community" consisting of the flotsam of patients tossed back at their families (chiefly their parents) if they had any, but mostly the creation of single-room occupancy hotels (SROs) in the psychiatric ghettoes of cities."[3]

Caselaw steadily required states to push those with mental and cognitive impairments into the communities. Beginning with *Lake v. Cameron* in 1966, state hospitals were required to discharge patients to the "least restrictive setting."[4] In 1975, the U.S. Supreme Court declared that "a State cannot constitutionally confine[,] without more[,] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[5] And in 1999, the U.S. Supreme Court declared mental illness a disability covered under the Americans with Disabilities Act, requiring all governmental agencies to make reasonable accommodations to place and move those with mental illness into community-based treatment rather than institutions.[6]

A variety of factors contemporaneous and subsequent to deinstitutionalization resulted in many of those with mental illness facing homelessness, lack of access to regular treatment and prescribed medications, and increased access to alcohol and illegal drugs. Reduction in federal block grants for mental health treatment and the implementation of the Social Security Act, has led to privatization of mental health care and, as a result, dramatically shifted the landscape of mental health services in the United States. In this new landscape, those needing care became responsible for navigating and accessing it on their own—a difficult or impossible reality for many.

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[1] E. F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (John Wiley & Sons, 1997).
[2] Robert Weisberg, *Restorative Justice and the Danger of "Community,"* 2003 Utah L. Rev. 343, 366 (2002).
[3] *Id.* at 365.
[4] 364 F.2d 657, (D.C. App. 1966).
[5] *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
[6] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

This complex combination places many of those with mental illness in the natural path of law enforcement. Criminal statutes for trespassing, disorderly conduct, resisting arrest, failure to comply with an officer's commands, and drug possession, among others, are consistently implicated as police engage with the mentally ill.

Adding in the general public's discomfort with the signs, symptoms, and life consequences of mental illness and mental health crisis—thanks in large part to media depictions of the mentally ill as dangerous and criminal—has inevitably resulted in calls to the police to address both legitimate criminal concerns and to ease situational discomfort for the community.

The community regularly calls upon police to address a broad swath of behaviors and concerns that often are not connected to crime. As a result, invoking the peace-keeping or community caretaking role has evolved to be central to modern policing. Since the 1990s, there has been a 227% increase in mental health related calls, and estimates show that law enforcement spends at least 20% of patrol time responding to these calls.[7] Increased contact with police has led to prisons and jails becoming the largest providers of mental health services in the nation. Deinstitutionalization from state hospitals has ultimately resulted in re-institutionalization in the carceral system.

Many cities, including Tempe, have employed a Crisis Intervention Team (CIT) model for police response to those suffering from mental illness. However, police intervention in non-violent, non-criminal, or low-level criminal conduct places officers in a "gray zone" of interacting with individuals with unmet mental health needs. This "gray zone" utilizes a "vast array of lower intensity and less formal interactions" to address these marginalized members of the community.[8] Both the formal CIT model, and the types of interactions encompassed in the "gray zone" require training either not typically mandated, or minimally covered, in police academies. Nationally, police cadets receive approximately 840 hours of instruction in academy, yet on average only 10 hours are devoted to mental illness—yet cadets receive an average of 71 hours of firearm handling training.

A recent push to divert mental health service calls to mental health service providers instead of police can potentially reduce police involvement in non-criminal matters and increase access to care for individuals experiencing mental illness and crisis. These non-police system models and CIT pre-arrest diversionary programs for criminal matters can connect individuals back to care and treatment before moving to court intervention. Both the non-police dispatch models and pre-arrest diversion programs have the potential to reduce repeated contacts with law enforcement and ensure that individuals receive necessary care.

The potential benefit for reshaping interactions between police and those suffering mental illness is enormous for all involved. More conservative estimates show that those suffering from a mental illness account for almost ¼ of all fatalities involving law enforcement and are 16 times more likely to be killed in encounters with law enforcement. Engaging daily with those in crisis undoubtedly affects responding officers. All involved parties are situated to benefit from rethinking law enforcement's role and manner of engaging in the mental health sphere.

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[7] L.J. McTackett et al., Thomas, S.D.M. *Police Perceptions of Irrational Unstable Behaviours and Use of Force*, 32 J Police Crim Psych 163, 163–171 (2017).

[8] Jennifer Wood et al., *The "Gray Zone" of Police Work During Mental Health Encounters: Findings From an Observational Study in Chicago*, 20 Police Quarterly 81, 83 (2017).

Questions to consider:

- What role should CITs play and how can CITs be supplemented to produce best results?

- Could training – perhaps increased and/or different – for patrol officers, result in better outcomes when law enforcement officers inevitably engage with those with mental illness (for both officers and the individuals they encounter)?

- How can non-police dispatching ease the burden on law enforcement and improve outcomes for those with mental health needs?

- What is law enforcement's role in responding to those suffering mental illness and crisis, when those individuals may not be situated to respond positively to offers for services and treatment?

- Should there be a different police response to violent, or high-level, criminal conduct committed by those with mental illness than those without mental illness? Why or why not?
    - Does mental illness excuse or does it explain criminal conduct? Is this a clear line or does it shift with time/age/situation?

- How can peer supports and navigators collaborate with law enforcement and mental health service providers to both improve outcomes and produce best results?

- How should the conversation acknowledge and address law enforcement's daily exposure to individuals in crisis and how this exposure affects individual officer's well-being? What structures currently exist to destigmatize mental illness within police culture?

- What are the necessary components of a mental health infrastructure (housing, substance abuse treatment, medical and mental health treatment)? Can a robust infrastructure meaningfully reduce the burden on law enforcement to be the first responders for mental illness in the community?