

# LAW ENFORCEMENT RESPONSE TO PEOPLE IN CRISIS

Understanding the challenges  
of incidents involving persons  
with mental illness

A nationwide survey report  
May 2019

 LEXIPOL





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## MENTALLY ILL PERSON OR PERSON IN CRISIS

**This survey referred respondents to the following definition for a mentally ill person or person in crisis:** A person whose mental health symptoms or level of distress have exceeded the person's internal ability to manage his or her behavior or emotions in the immediate situation. While being under the influence of intoxicating substances often exacerbates mental health symptoms, behavior associated merely with being intoxicated does not indicate a person in crisis.



# 44MILLION

AMERICANS EXPERIENCE MENTAL ILLNESS



## INTRODUCTION

Nearly 44 million Americans experience mental illness each year.<sup>1</sup> Due to a lack of mental health resources, those with serious mental illness often become homeless or live with family members who lack the knowledge or resources to care for them effectively.

It's also not uncommon for people to experience short-term emotional crises brought about by specific events and/or exacerbated by drugs or alcohol. According to the Center for Disease Control (CDC), suicide rates rose more than 30% in half of the states since 1999. Almost 45,000 lives were lost to suicide in 2016 alone—and more than half of them did not have a known mental health condition.<sup>2</sup>

Whether experiencing suicidal despair, psychosis brought about by long-term drug use, or paranoia due to a medication interruption, people in crisis have an elevated chance of coming into contact with a law enforcement officer. When criminal conduct is involved, the person is often arrested. The National Alliance on Mental Illness estimates 2 million people with mental illness are booked into jails each year.<sup>3</sup>

Millions more encounters between people in crisis and law enforcement officers do not involve criminal activity, yet officers are called because there is no one else to respond.

Anecdotal evidence about the impact of this issue abounds—resources are strained, officers are burnt out or demoralized,

people in crisis suffer injuries and are even killed by officers who were called to help them. But data is often lacking. So in late 2018, [Lexipol](#) created a comprehensive survey with questions designed to reveal a more detailed picture of how this issue is unfolding in law enforcement agencies across the nation: How often do officers respond to those with mental illness? What makes these incidents so challenging? And do agency policies and training provide adequate guidance?

Partnering with law enforcement training company [Calibre Press](#), we surveyed officers across the nation—and received an overwhelming response. We are sincerely thankful for the 4,200 law enforcement officers who took the time to provide their responses, more than one-third of whom provided detailed accounts and many who participated in post-survey interviews. Their first-person accounts are included throughout this report.

One respondent described the issue as “criminal policing in the realm of social work.” Indeed, it is a complex problem that extends across many facets of society. The solutions will be complex and varied as well. We believe understanding the scope of the issue from the eyes of law enforcement is a good place to start building those solutions.





# RESPONDENT DEMOGRAPHICS

**4,209**  
TOTAL RESPONDENTS

**47%**  
OFFICERS  
(officer, deputy, detective, etc.)

**53%**  
SUPERVISORS  
(chief, sheriff, sergeant, lieutenant, etc.)

"I am a mom, wife, daughter and sister. Everyone wants me to quit this job for my safety. We deal with someone emotionally disturbed every night in our city, on patrol, or that someone else has sent to us on the Greyhound bus to go to our shelters. I have lucked up and been able to adapt. It gets very old, very fast. If they want to commit suicide, we give them a ride to the hospital. If not, we offer them a warm floor in the police department lobby until breakfast is served in our local shelters."

—Anonymous

**62%**  
MUNICIPAL  
POLICE DEPARTMENTS

**22%**  
COUNTY  
SHERIFF OFFICES

**16%**  
OTHER  
(state police, campus  
police, corrections)

## AGENCY SIZE



**23%** LESS THAN 25  
SWORN OFFICERS

**31%** 26 TO 100  
SWORN OFFICERS

**28%** 101 TO 500  
SWORN OFFICERS

**18%** MORE THAN 500  
SWORN OFFICERS



# HOW OFTEN DO THESE INCIDENTS OCCUR?

Understanding the issue of law enforcement interaction with mentally ill persons starts with assessing the magnitude of the situation. Every community is different, and we might expect larger jurisdictions to encounter people in crisis more often than small jurisdictions. Yet metropolitan police departments might also have access to more resources that help alleviate the strain these calls cause. Therefore, the overall effect lies not just in the number of calls, but in how prepared officers are to deal with them.

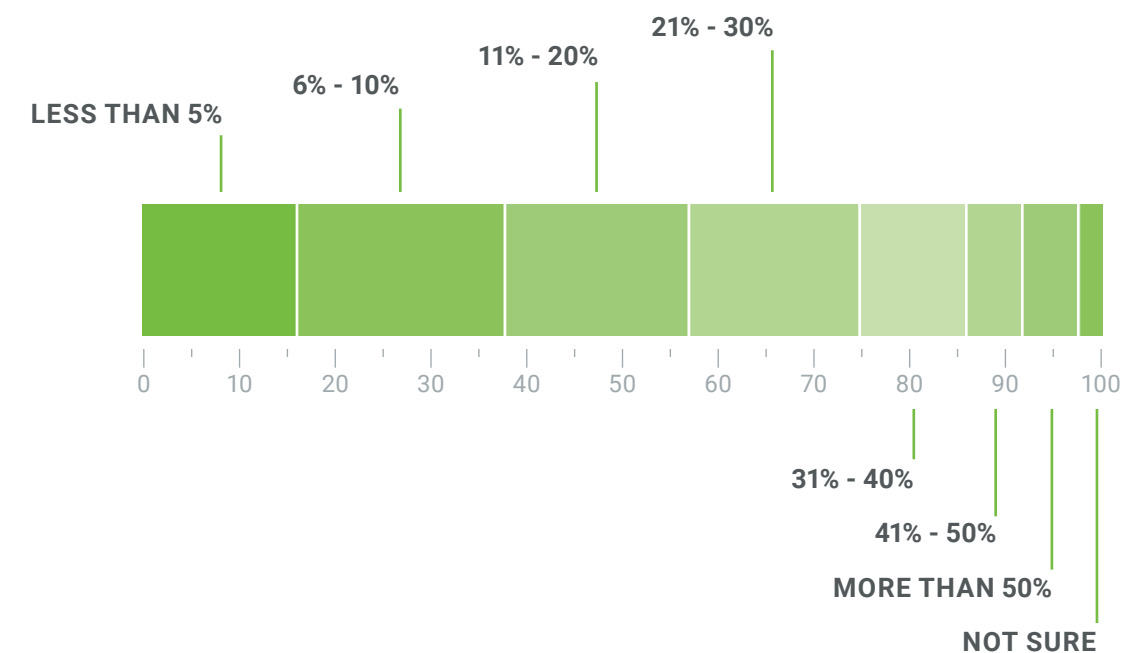
**99%** OF RESPONDENTS HAVE HAD AN INTERACTION (OR SUPERVISE AN OFFICER WHO HAS) WITH AN INDIVIDUAL WHO IS MENTALLY ILL OR WAS EXPERIENCING A MENTAL HEALTH CRISIS

“We have weekly contact with delusional subjects reporting crimes and paranoid delusions; however, since they are not evaluated by a hospital as ‘danger to self or others,’ there is no action we can take to force them to get mental health assistance, leading to repeated calls dealing with hours weekly of resources and time.”

Ronald Brandt  
Sergeant, Niles (IL) Police Department

**60%** OF OFFICERS SAY MENTALLY ILL INDIVIDUALS MAKE UP 11% OR MORE OF THEIR CONTACTS

WHAT PERCENTAGE OF YOUR CONTACTS WOULD YOU ESTIMATE INVOLVE PEOPLE WHO ARE MENTALLY ILL OR EXPERIENCING A MENTAL HEALTH CRISIS?



“We had a situation with an older female where our officers were called over 100 times in 3 months. We worked with mental health officials, family and adult protective services. Our sergeant even testified in court and the party was ordered forced medication, which eventually helped. Our sergeant still visits with the person even though it has been over a year. It took an enormous effort and many months, but we no longer get calls on this person.”

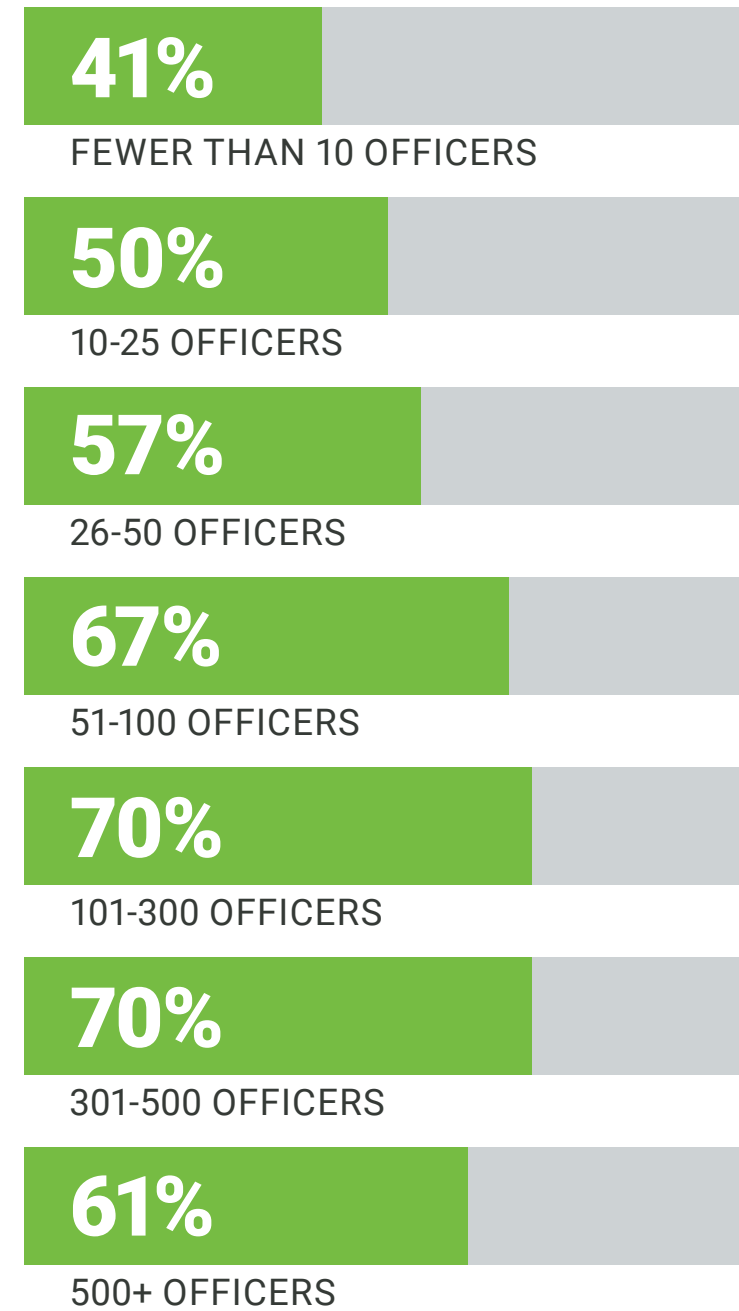
Jeff Carr  
Chief, South Jordan (UT) Police Department



Agency size has an impact on the percentage of contacts involving mentally ill subjects. In the smallest agencies (10 officers or fewer), 41% of respondents

said mentally ill subjects make up 11% or more of their contacts. As agency size increased, that percentage rose as high as 70% of officers.

### PERCENTAGE OF OFFICERS WHO SAY MENTALLY ILL SUBJECTS MAKE UP AT LEAST 11% OF THEIR CONTACTS, BY AGENCY SIZE



“Our agency does an excellent job responding, de-escalating and taking [mentally ill] subjects into custody without major incident. However, it very rarely has any positive or lasting effect or result in the end. Almost 50% of our calls involve mentally ill individuals. It seems like we ‘Baker Act’ [Florida Mental Health Act] more people than we arrest.”

Jeremy Bird  
Sergeant, Port Orange (FL) Police Department



# WHAT DO THESE INTERACTIONS LOOK LIKE?

“These incidents are usually dealt with relatively peacefully, but there are no local resources to provide [the individuals], no place to take them and no mental health teams to respond and assist. Only in the most extreme cases can an involuntary commitment be made. In most cases, we do what we can to stabilize, avoid using force and disengaging. When an arrest is necessary, force is often necessary as well. In that case we attempt to minimize the degree of force. If the elements of an involuntary commitment are not present, then the county jail is the only alternative. When the subject is released from jail (or the hospital), usually the next day, the cycle starts all over again.”

Sean Madison  
Staff Sergeant,  
Sequim (WA) Police Department

Ask a layperson to describe a person in crisis and “suicidal” will be high on the list. And in fact, many calls involving mentally ill persons do involve suicide threats or risks. But there are other common threads running through these incidents. People with mental illness are more likely to neglect their basic needs, leading to “welfare check” requests. They fail to adhere to social cues and appropriate behavior, so police may be called for someone “running in traffic” or simply someone “acting strangely.” Often, those with mental health issues self-medicate with drugs or alcohol, and signs of mental illness can mirror signs of inebriation, so officers may be called for disorderly conduct.

The influence of drugs or alcohol can exacerbate these reactions. Although traditional use of force tactics are often ineffective on individuals with mental illness or in mental health crisis, officers can be backed into situations where there is no other alternative. And that can produce a tragic outcome.

In 2015, the *Washington Post* released an analysis of 462 police shooting deaths that year. It found that 25% of those deaths involved people “in the throes of emotional or mental crisis ... The vast majority were armed, but in most cases, the police officers who shot them were not responding to reports of a crime.

## THE MOST COMMON TYPE OF CALL INVOLVING PEOPLE WITH MENTAL ILLNESS IS SUICIDE ATTEMPT OR THREAT

Another unifying aspect of calls involving people in crisis is the high risk they pose to officers and the subjects themselves. Most people with mental illness are not violent. But by the time law enforcement is called, the situation may be fraught with emotion. Mentally ill individuals often cannot describe their condition and may feel threatened by the presence of armed officers, especially if lights and sirens are used.

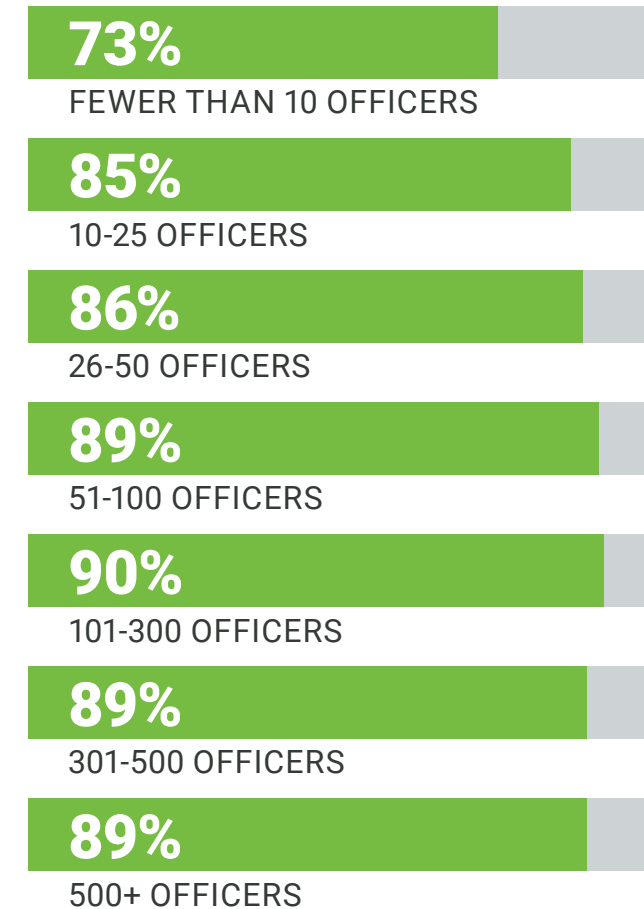
More often, the police officers were called by relatives, neighbors or other bystanders worried that a mentally fragile person was behaving erratically.”<sup>4</sup>

Even when the outcome of the call is not tragic, there is great risk of injury to officers or subjects whenever force is used.

**WHAT ARE THE TOP THREE TYPES OF CALLS YOU RESPOND TO THAT INVOLVE INDIVIDUALS WHO ARE MENTALLY ILL OR EXPERIENCING MENTAL HEALTH CRISIS?**



**RESPONDENTS IN AGENCIES WITH FEWER THAN 10 OFFICERS WERE LESS LIKELY TO HAVE USED FORCE ON A MENTALLY ILL PERSON THAN RESPONDENTS FROM ALL OTHER AGENCY SIZES.**



**87%**  
OF RESPONDENTS HAVE PERSONALLY RESPONDED TO A CALL WHERE FORCE WAS USED ON A MENTALLY ILL PERSON\*

\*Although a definition was not included in the survey, "use of force" in a police context can mean anything from grabbing an individual in order to restrain them, to the use of less-lethal methods such as the TASER® device, to lethal force such as firearms.


"Recently [we] had a mentally ill person who was off medication and had not eaten for a few days. The call initially was a suspicious person call, and during the call the subject stole food from a nearby restaurant. My officers handled the call well and did not pursue the misdemeanor crime. Instead [they] spoke with and explained the situation to the restaurant. The subject was transported by ambulance to receive a proper mental health evaluation. He initially denied being diagnosed or taking meds. No force was used, just verbal de-escalation."

Francois Obasi  
Sergeant, Las Vegas (NV) Metropolitan Police Department

"I remember entering the room knowing of the special needs of the [juvenile], attempting to de-escalate the situation until he threw a chair at the other children in the room. Due to the situation and location of the other children I knew that the use of my TASER [device] was out, so I had to go hands-on while trying not to harm him. As he was scratching at my face and eyes, I knew I just had to take it and get him subdued while trying my best to protect myself."

Mike Courtney  
Patrol Lieutenant,  
Madison County (ID) Sheriff's Office





# 32% OF RESPONDENTS HAVE BEEN INJURED DURING A CALL INVOLVING A MENTALLY ILL PERSON

The risk of injury rose with agency size: 23% of respondents from the smallest agencies (fewer than 10 officers) reported being injured during a call involving the mentally ill, compared with 35% of officers in agencies with more than 500 officers. This is likely because officers in larger agencies respond to more calls involving mentally ill people, as indicated on page 6 of this report.

## UP CLOSE

“On 6 July 2012 I responded to a disturbance call at a local housing development. On arrival I made contact with the complainant who was bed-bound ... Someone began yelling from the kitchen. A male exited the kitchen, approached me and would not comply with verbal commands to stop. When the male kept coming toward me, I raised my flashlight to block the male from getting any closer and pushed him back. The male then struck me in the face, at which point I struck him in the side of the neck (brachial area) in an attempt to stop his actions.

As the fight continued, blows were exchanged and at some point I was knocked down onto a couch. The suspect was able to obtain my flashlight and began striking me in the head with it. I attempted to radio for assistance, but my radio mic was ripped from my shirt and from its carrier.

Due to the confined space and blood running down my face I chose not to deploy my chemical spray. I thought about using my firearm, but the complainant was in line with the suspect. I went to draw my TASER [device] and the suspect began hitting me harder. I put my hands up to show the suspect I did not have my TASER [device] and attempted to get him to move off-line of the complainant. When he did not move and continued hitting me, I drew my TASER [device] with my support hand and deployed the cartridge. I could hear a high-pitched

noise, which indicated bad or no probe contact ... The suspect fell on top of me and I proceeded to drive stun the suspect ... The suspect rolled off me ... As I was attempting to stand and draw my firearm, the suspect tackled me, putting me face down on the sofa. I was able to push the suspect off me and roll him onto the couch.

I brought my firearm up to the ready position and was about to give verbal commands when I observed the suspect rising up from the couch and approaching me. I proceeded to fire two rounds toward the suspect; both rounds impacted his body. As I started to fire a third round my weapon malfunctioned. I was able to get my firearm back into battery and I could hear the suspect groaning. I gave verbal commands for him not to move and was able to locate my radio lying on the couch and call dispatch to advise of my situation and summon medical assistance.

I was transported to an area hospital where I received over 100 sutures to my face and head before being released. The suspect died at the scene. I was criticized on social media for not taking the time to evaluate and assist the person suffering from mental crisis ... To this date I suffer from post-concussion syndrome, memory issues, headaches and continuous ringing in my ears. It was later determined the suspect suffered from schizophrenia and had not been taking his medications for some time.”

Brian Leatherwood  
Investigator, Knoxville (TN)  
Police Department



# WHO RESPONDS TO THESE INCIDENTS—AND HOW?

Officers are not social workers, and interactions with mentally ill individuals have a much better chance for a positive outcome when specialized resources are on scene.

Across the United States, the models for how such specialized resources are deployed—and how quickly they are available—varies widely. A few agencies have the benefit of embedded licensed mental health practitioners. Others have specially trained officers ready to deploy at all times. Some provide basic training to all officers. And still others struggle with few available resources, forcing officers to wait on scene for long periods or to resolve the call on their own.

Even in agencies with specialized response teams, the first officers on scene are rarely part of those teams, and they must decide how to initially handle the call. Risk management expert Gordon Graham distinguishes between events that provide discretionary time—where officers may be able to use de-escalation techniques or even disengage completely while formulating a plan—and events that are non-discretionary time situations—when split-second decisions must be made.

Calls involving people in crisis can be either. Sometimes, however, officers unwittingly escalate an incident, perhaps not realizing the person is in crisis. Many signs of mental illness can masquerade as being under the influence, and individuals with mental illness often self-medicate with alcohol or drugs, compounding their symptoms—and making it even more difficult for officers to determine the root cause of their behavior.

Even if an officer is trained in crisis intervention, discretionary time can quickly disappear if the individual poses harm to himself or others.

**IN AGENCIES THAT HAVE CRISIS INTERVENTION TEAMS, THE MAJORITY (58%) OF RESPONDENTS SAID CIT-TRAINED OFFICERS RESPOND INDIVIDUALLY. ONLY 18% SAID THE MEMBERS OPERATE AS A TEAM AND ARE AVAILABLE AT ALL TIMES WITH REGIONAL MENTAL HEALTH PROVIDERS AVAILABLE IN SUPPORT.**

**“[Responded to] a suicidal subject with a gun in a car parked in a busy park. CIT officer communicated via PA, then a CIT-trained crisis negotiator made contact by phone. Negotiations ensued, and the subject subsequently surrendered. The subject was counseled, transported to mental health facility and set up with information and follow-up services prior to the officers leaving. The family was counseled on follow-up services. Having all of our crisis negotiators CIT-trained is highly beneficial and approximately 50% of our officers assigned to patrol are CIT-trained.”**

Erica Scott  
Sergeant, Quincy (IL) Police Department



**WHEN NEEDED, WHO IN YOUR AGENCY PROVIDES SPECIALIZED LAW ENFORCEMENT RESPONSE TO MENTALLY ILL SUBJECTS OR PEOPLE EXPERIENCING MENTAL HEALTH CRISIS?**

**NEARLY 40% OF OFFICERS & 50% OF CHIEFS AND SHERIFFS** REPORT THEIR AGENCIES DO NOT HAVE SPECIALIZED RESOURCES TO RESPOND TO CALLS INVOLVING MENTALLY ILL PEOPLE

“[Responded to] repeat [calls] with a female who was mentally affected and a user of street drugs. Her behavior led to her causing disturbances on buses and at times lying in the roadway in front of oncoming traffic. I used a calm voice and humor to develop a connection with her. She understood I was not there to harm her or, in most instances, arrest her. I understood her situation and over time would respond to calls when the description of the subject matched hers. Over time my arrival on a call had an immediate calming effect on her and she would call me by name and do whatever I asked of her.”

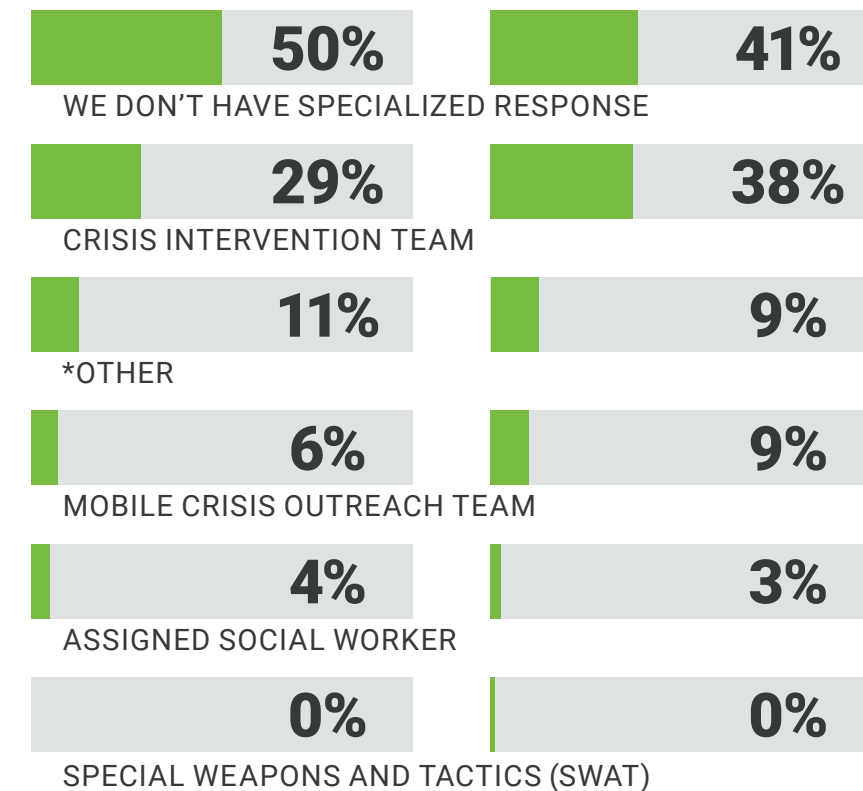
Clayton Powell  
Officer, Seattle (WA) Police Department



**CHIEFS/SHERIFFS**



**OFFICERS**



\*Most common "Other" responses were:

- All officers/deputies are CIT-trained
- Sworn members with specialized training (e.g., CIT)
- Mental health team or unit with sworn personnel and a clinician
- Psychiatric Emergency Response Team (PERT)
- Crisis negotiators
- County mental health professionals

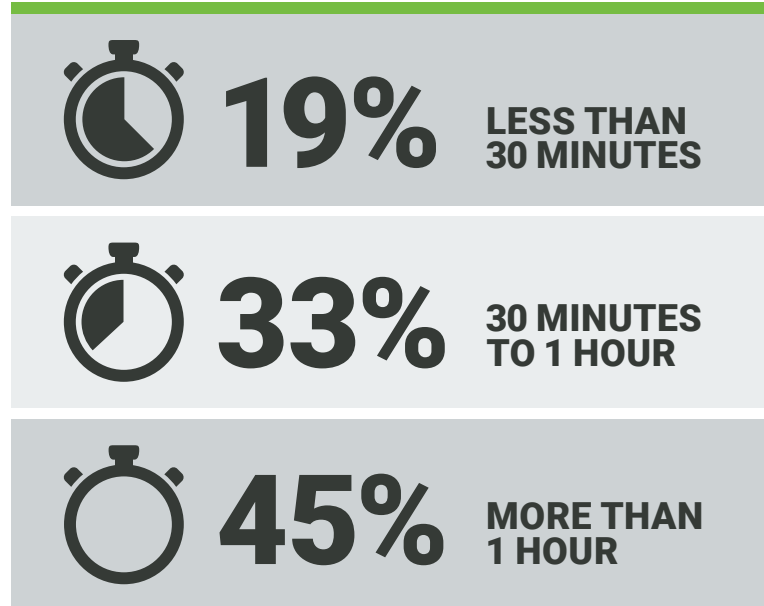


# 78% OF OFFICERS SAY IT TAKES AT LEAST 30 MINUTES TO GET PROFESSIONAL MENTAL HEALTH PROVIDERS ON SCENE

Agency size impacts ability to get specialized resources on scene. More than 50% of respondents from agencies with fewer than 50 officers

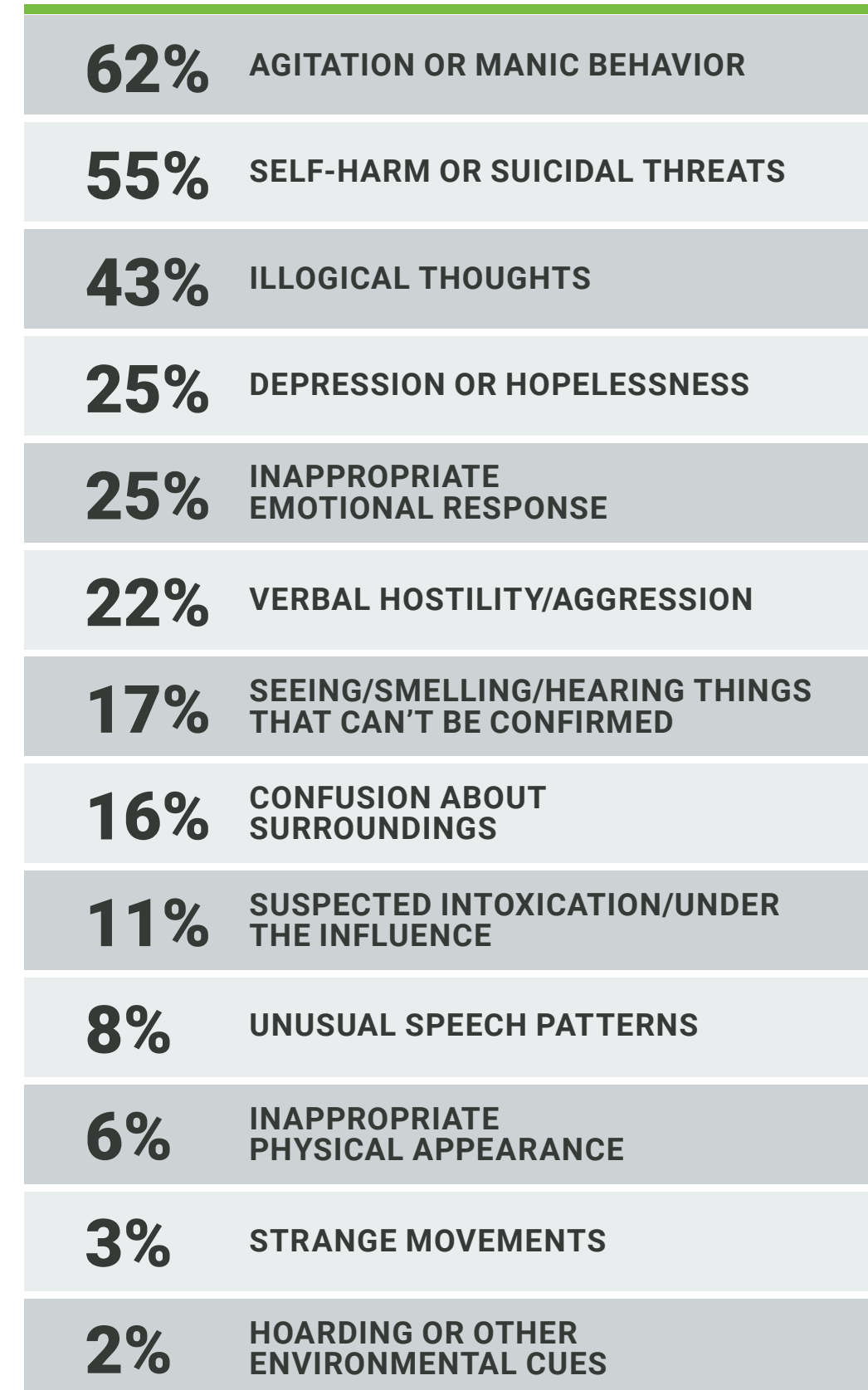
said it took more than an hour to get resources on scene. That figure fell to 39% for agencies with more than 500 officers.

## PROFESSIONAL MENTAL HEALTH PROVIDERS CAN BE ON SCENE IN:



**TO IDENTIFY THE POTENTIAL FOR MENTAL ILLNESS OR MENTAL HEALTH CRISIS IN A SUBJECT,** OFFICERS ARE MOST LIKELY TO RELY ON AGITATION OR MANIC BEHAVIOR, SELF-HARM OR SUICIDAL THREATS, AND ILLOGICAL THOUGHTS

## WHAT ARE THE TOP THREE SYMPTOMS YOU RELY ON MOST TO INDICATE POTENTIAL MENTAL ILLNESS OR MENTAL HEALTH CRISIS IN A SUBJECT?







“The man was experiencing delusions, he was manic, exhibiting signs of psychosis, and was malnourished. He got upset at the clinic and left on foot ... The man was very confused and resistant. I got him to return to the crisis center with me and again speak with his clinician. They engaged again but that quickly turned south. I could see the clinician was stuck and had lost her rapport with him. I made small conversation [with him] and eventually found some common ground. I asked them to get him food, which seemed to be a big help. After gaining his trust I was eventually able to convince him that he needed to be evaluated. This call lasted for over 1.5 hours, but the outcome was positive. We had been getting 3 to 5 calls a week about him or from him but now he’s been placed in a more conducive environment and we haven’t had a service call in several months.”

Gregory Shore  
Patrol Officer, Norwood (MA) Police Department

## 64% OF OFFICERS SAID DE-ESCALATION TACTICS ARE ONE OF THE TOP THREE STRATEGIES THEY USE ON CALLS INVOLVING PEOPLE EXPERIENCING MENTAL HEALTH CRISIS

WHAT ARE THE TOP THREE ACTIONS YOU MOST OFTEN TAKE OR ARE MOST EFFECTIVE WHEN ENCOUNTERING A PERSON YOU SUSPECT IS MENTALLY ILL?



Supervisors were more likely to call for specialized resources (41%) vs. officers (32%). Officers rely more on counsel-and-release and counseling family and friends. There was almost no difference across

ranks, however, in use of de-escalation tactics and encouraging individuals to be transported to a mental health facility.

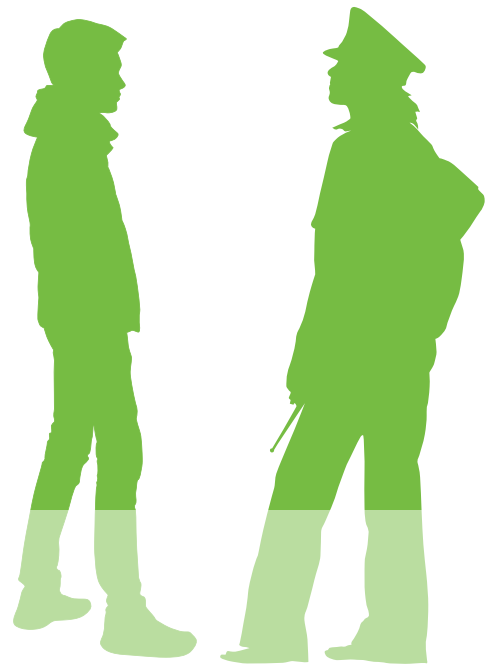


# HOW DO OFFICERS FEEL ABOUT THESE INTERACTIONS?

Law enforcement officers are generally people of action. They respond to requests for service or to unfolding situations they observe, take steps to address the situation, document as necessary, clear the call and move on. Their role is one of problem-solver; indeed, many people call 911 because they are unable to solve a problem on their own, whether or not it's a true emergency.

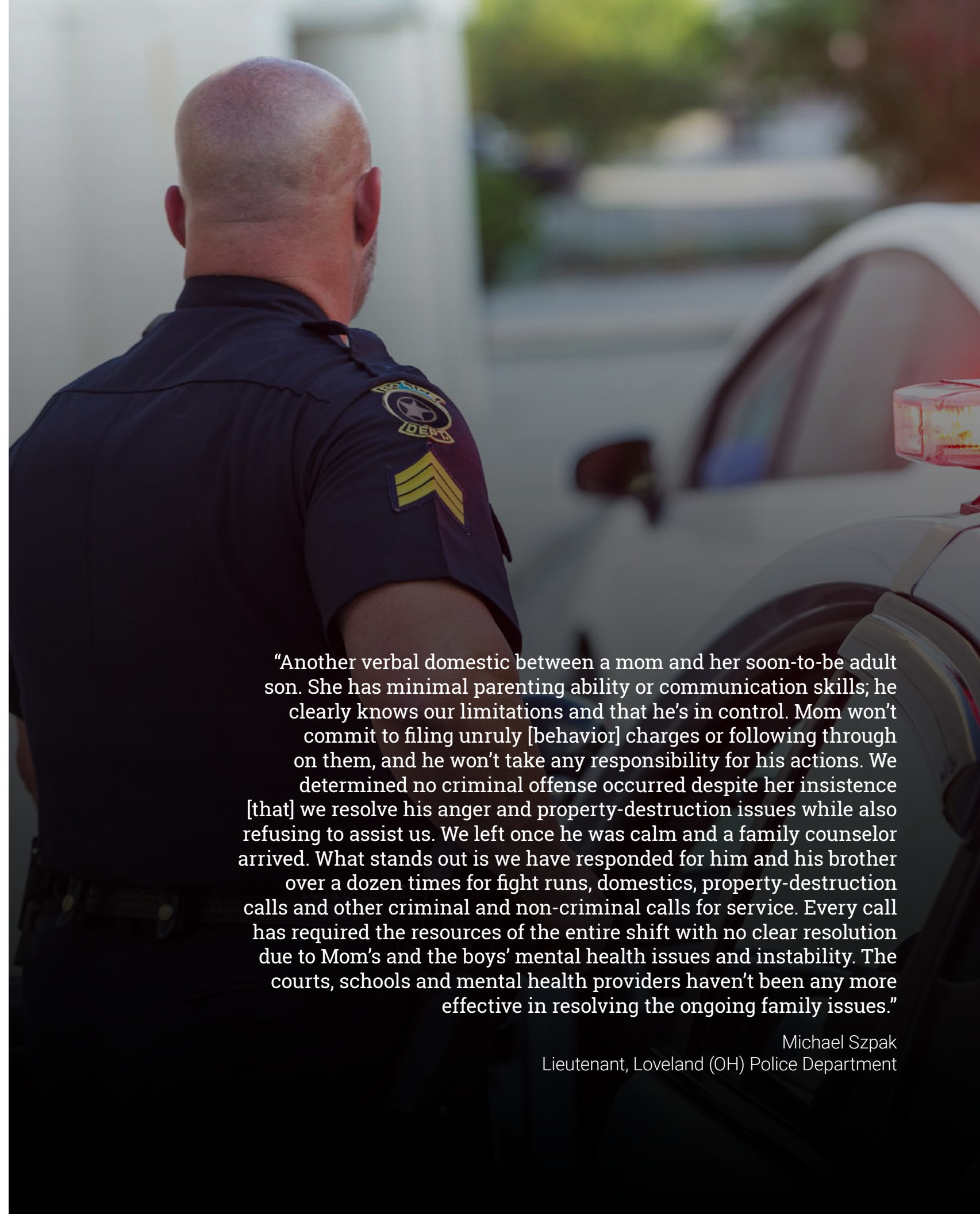
It's no surprise, then, that incidents involving individuals who are mentally ill or in mental crisis are frustrating to officers. Often, there's little that can be done within the realm of law enforcement. An officer may be called because someone is out of control

emotionally, but if there's no active threat or evidence of criminal activity, there's no reason to arrest. And meeting the involuntary commitment threshold is often difficult. So the officer does what he or she can, documents the incident, clears the call ... and waits to be called back. The process is time-consuming, even more so because calls involving mentally ill individuals sometimes involve lengthy transports to psychiatric facilities or waiting for hours in the hospital.



**78%** RATE THE OUTCOME OF THEIR INTERACTIONS WITH THE MENTALLY ILL AS FAVORABLE OR IDEAL

**22%** RATE THE OUTCOME AS LESS THAN FAVORABLE OR POOR



“Another verbal domestic between a mom and her soon-to-be adult son. She has minimal parenting ability or communication skills; he clearly knows our limitations and that he’s in control. Mom won’t commit to filing unruly [behavior] charges or following through on them, and he won’t take any responsibility for his actions. We determined no criminal offense occurred despite her insistence [that] we resolve his anger and property-destruction issues while also refusing to assist us. We left once he was calm and a family counselor arrived. What stands out is we have responded for him and his brother over a dozen times for fight runs, domestics, property-destruction calls and other criminal and non-criminal calls for service. Every call has required the resources of the entire shift with no clear resolution due to Mom’s and the boys’ mental health issues and instability. The courts, schools and mental health providers haven’t been any more effective in resolving the ongoing family issues.”

Michael Szpak  
Lieutenant, Loveland (OH) Police Department

**NEARLY 60% OF OFFICERS SAY THEY FEEL PREPARED TO MEET THE CHALLENGES OF RESPONDING TO MENTALLY ILL PERSONS OR PERSONS IN MENTAL HEALTH CRISIS. BUT 23% SAY THEY DO NOT FEEL PREPARED, AND 17% SAID THEY'RE UNSURE.**



**60%** FEEL PREPARED

**23%** DO NOT FEEL PREPARED

**17%** UNSURE

Interestingly, chiefs and sheriffs ranked their preparedness the lowest, with just 50% of chiefs and sheriffs saying they feel prepared to meet the challenge of responding to the mentally ill and 31% percent saying they do not feel prepared.

Confidence in the ability to respond was linked to respondents' opinions of their agency's policies. More than 70% of those who rated their agency's policy on responding

to people with mental illness as adequate said they felt prepared to respond to incidents involving people in crisis, while just 36% of those who rated their agency's policy as inadequate said they felt prepared. Agency size was also a factor, with just 52% of officers at the smallest agencies saying they felt prepared, compared with 63% of officers at the largest agencies.

"We have multiple cases where people having a mental health crisis are taken on a 5150 hold and transported to the County Emergency Psych Department. In most cases they are released almost immediately, provided transportation back to our city and dropped off. The crisis continues, and we take them again on a 5150 hold. Sometimes twice in the same day. Huge waste of resources."

Scot Smithee  
Chief, Gilroy (CA) Police Department

**WHAT ARE THE THREE TOP CHALLENGES YOU FACE ON CALLS INVOLVING PEOPLE WHO ARE MENTALLY ILL OR IN A MENTAL HEALTH CRISIS?**

**80%** REPEAT CONTACTS WITH SAME PERSON WHO DOES NOT OR CANNOT SEEK HELP

**76%** CALLS TAKE MORE TIME AND REQUIRE MORE RESOURCES

**40%** CITIZEN/MEDIA SCRUTINY AND/OR MISUNDERSTANDING ABOUT THE CHALLENGES OF THESE CALLS

**19%** DIFFICULTY DISTINGUISHING MENTAL ILLNESS FROM INTOXICATION/UNDER THE INFLUENCE

**14%** LACK OF KNOWLEDGE ABOUT LOCAL MENTAL HEALTH RESOURCES

**13%** CONFUSION ABOUT LEGAL DUTY TO RESPOND

**11%** NO INFORMATION OR INADEQUATE INFORMATION FROM DISPATCH

**9%** HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONCERNS

**7%** LACK OF POLICY DIRECTION

**80% OF RESPONDENTS CITED RESPONDING TO REPEAT OFFENDERS AS A TOP CONCERN**

Supervisors and officers differed slightly in identifying the top challenges involving incidents with mentally ill people. While both groups selected the same top three challenges, officers weighted citizen and media scrutiny heavier than supervisors, who were more focused on the time

and resources the calls require. Supervisors were also more likely than officers to select "difficulty distinguishing mental illness from intoxication" and "confusion about legal duty to respond."





“Our biggest problem is once a person is deemed an involuntary committal to the state facility, the facility has no beds available and we (police) are forced to maintain 24-7 security for the person until a bed becomes available. [This causes] major problems for resources and manpower.”

Donald Poore  
Chief, Paola (KS) Police Department

## UP CLOSE

Yakima County, WA, is testing out a model becoming more popular throughout the country: embedding mental health professionals with officers. “The Yakima County Sheriff’s Office, Yakima City Police Department and the Union Gap Police Departments are involved in an area program with Central Washington Comprehensive Healthcare,” says Yakima County Sheriff’s Office Lieutenant Max James. “The Sheriff’s Office and the Police Department have embedded with them designated crisis responders, or DCRs, who work out of our buildings and respond to calls for service and ride along with law enforcement officers. They conduct follow up interviews and screenings of members of the community that might need their assistance.”

Although dispatchers can access a 24-hour call center to help people in crisis, having the DCRs embedded means the difference between an officer waiting on scene for hours with a mentally ill person versus having someone respond immediately. “This is an aid for our officers, a resource that can help them when they encounter people with mental health issues,” Lt. James says. “Embedded health professionals can only do what they can do, but it’s more than we can do.”

It’s a start, but the six DCRs are hardly enough to provide 24/7 support across Yakima County, which Lt. James says has a large homeless population in the city as well as issues with illegal drugs—issues he says are getting worse. “Every year we see more and more homeless, and a large percentage of them have mental health issues, either naturally or self-induced through drugs,” he says. “This has always been a part of police work; I remember learning about it in the academy. A certain percentage of the population has always suffered from mental illness. But I think the drugs and current events have made it more pervasive.”

And Lt. James sees a direct connection to officer safety. “Our guys are working a very large area, more often than not alone,” he says. “That’s always the way it’s been, but when you add in mental illness and drugs, there’s a lot more people who are going to snap a lot quicker, and we’re having to deal with that. I don’t know what the answer is. I’m apprehensive for the future. I want my guys safe, everyone going home. Part of that comes from our policies and training, but another part is our social values, how we address this issue as a society.”



# HOW ARE WE PREPARING OFFICERS TO DEAL WITH THE MENTALLY ILL?

For officers to successfully navigate encounters with mentally ill individuals or those in mental health crisis, the agency must provide both comprehensive policies and frequent training. Policies and training work together—policies form the guiding principles for officers; training helps officers apply those principles to real-world situations.

Policies prescribe the *what* and *why* of how an agency operates; *how* to carry out these rules and guidelines is best captured in the agency's procedures and training materials.<sup>5</sup>

We can see the intersection of policy and training when we explore an issue such as the use of force on mentally ill persons. If you ask a civilian whether police officers should use force on unarmed, noncriminal mentally ill subjects, most will say no—and that the agency's policies should reflect that. But such an answer doesn't address the realities of policing, where a person in crisis may be

endangering themselves or others without committing a crime, and force may be the only way to control them. (Force, of course, involves a range of options, from grabbing a subject's arm to using firearms.)

For this reason, agencies may choose not to prohibit officers from using force on unarmed, mentally ill subjects. To limit the chance such force will be used, however, agencies train officers to use discretionary time, take into account a person's mental state when possible, and incorporate de-escalation techniques.

Think of policies as the backbone of the agency, and training as the nervous system. Both are essential for helping officers successfully navigate calls involving people in crisis.

"I responded to a suicidal veteran suffering from PTSD and depression. He was threatening himself with a knife but asking for us to shoot him. I was able to talk him out of the knife, and ultimately into voluntarily going for a mental health evaluation on a police officer hold. What stands out was that the training provided helped me work through it, keep it slow, and ultimately not only was no force used, but I was able to build and maintain his trust by gaining a voluntary response to help. It was a huge win for me."

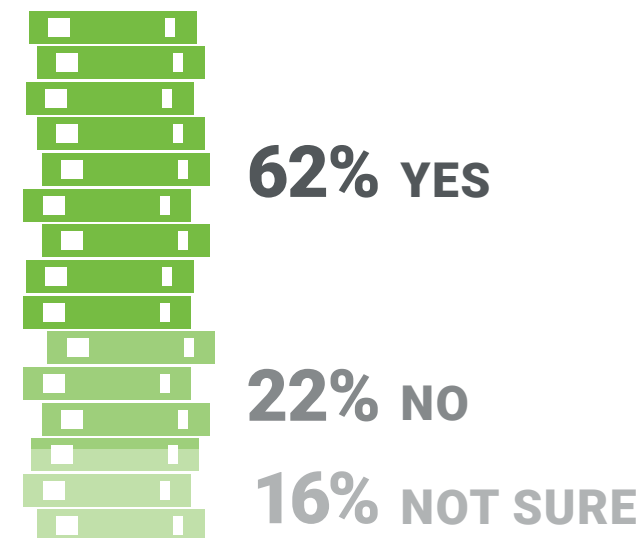
Richard A. Lewis  
Patrol Sergeant, Springfield (OR) Police Department

## 79% OF AGENCIES HAVE A POLICY ON INTERACTIONS WITH MENTALLY ILL PERSONS OR PERSONS EXPERIENCING MENTAL HEALTH CRISIS

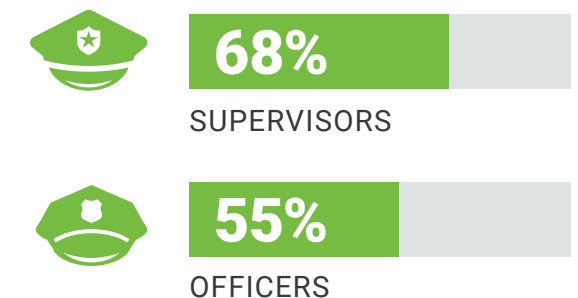
Respondents from larger agencies were more likely to report having a policy on interactions with the mentally ill. Just 61% of respondents in agencies with fewer than 10 officers and 73% of respondents

in agencies with 10-25 officers said their agency has such a policy. That number rises to more than 81% for all other agency size brackets.

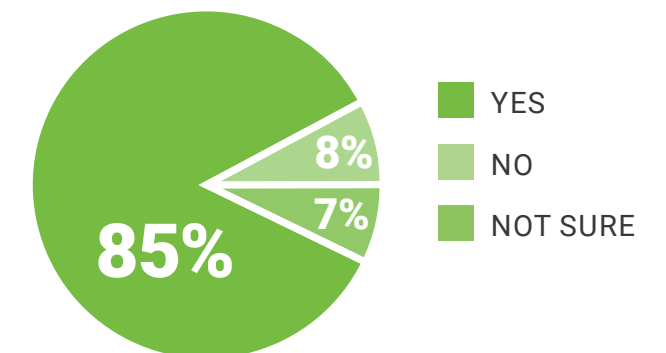
## DO YOU FEEL YOUR AGENCY'S POLICIES ADEQUATELY ADDRESS MENTAL HEALTH RESPONSE?



### THE POSITIVE RESPONSES DIFFERED SLIGHTLY BASED ON RANK.

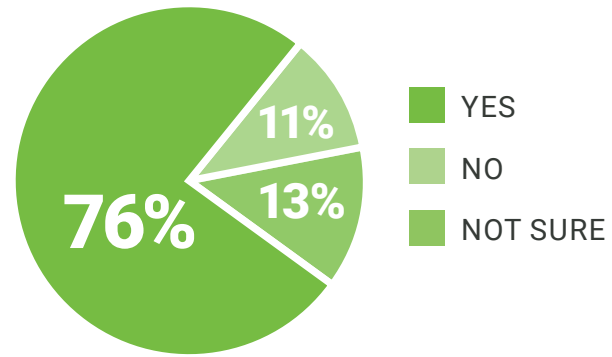


## DOES YOUR POLICY/TRAINING ENCOURAGE TAKING A PERSON'S MENTAL STATE INTO CONSIDERATION PRIOR TO USING FORCE WHEN YOU HAVE DISCRETIONARY TIME?





**DOES YOUR POLICY ALLOW FOR THE USE OF FORCE ON UNARMED, NONCRIMINAL MENTALLY ILL SUBJECTS?**



Officers from agencies with fewer than 10 officers were much more likely to report being unsure whether their policy allowed for use of force (22%) than officers in all other agency size brackets.

**85% OF AGENCIES HAVE PROVIDED TRAINING ON INTERACTIONS WITH MENTALLY ILL PEOPLE OR PEOPLE EXPERIENCING A MENTAL HEALTH CRISIS**

**65% OF OFFICERS HAVE RECEIVED SUCH TRAINING WITHIN THE LAST YEAR**

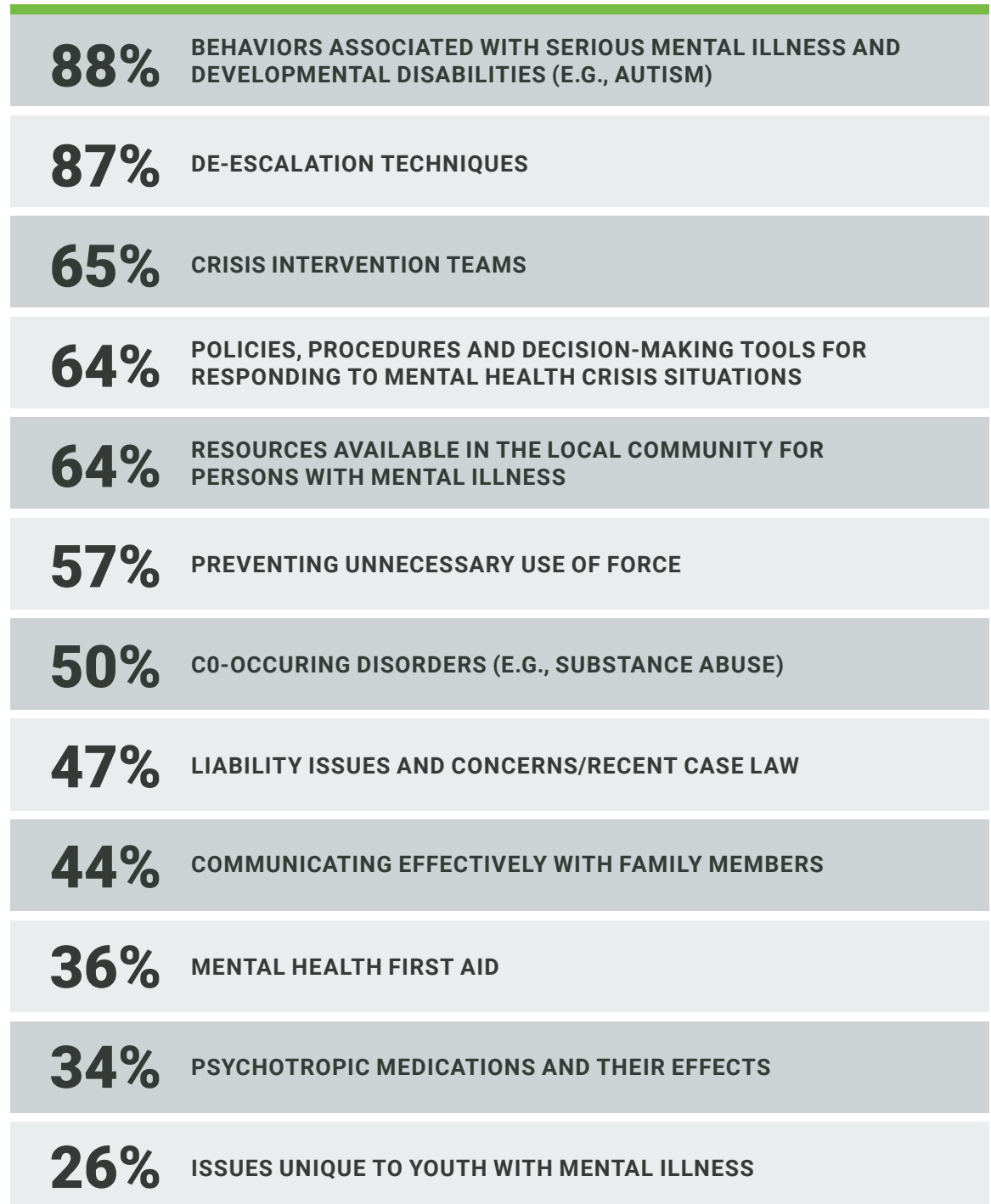


Training on dealing with mentally ill subjects varied depending on agency size. Just 66% of respondents from agencies with fewer than 10

officers had received such training, compared with around 90% of respondents from officers in agencies with more than 100 officers.

**IDENTIFYING BEHAVIORS ASSOCIATED WITH SERIOUS MENTAL ILLNESS AND THE USE OF DE-ESCALATION TECHNIQUES WERE THE TOP TOPICS FOR AGENCY MENTAL HEALTH CRISIS TRAINING**

**TOPICS COVERED BY AGENCY MENTAL HEALTH CRISIS TRAINING:**



## UP CLOSE

"[Responded to a] very large-framed teenage male (high-school football player and wrestler) who was expressing suicidal thoughts while holding a large kitchen knife inside a relatively small apartment with [his] mother and younger sister. Subject initially refused to cooperate with any verbal direction to drop the knife, which he kept rubbing up and down his neck. Eventually, with the assistance of the School Resource Officer familiar with the subject, he was convinced to walk outside to an awaiting ambulance for transport to a hospital for evaluation per the request of his mother.

While walking out to the ambulance, an officer placed a hand on the subject's arm. The subject reacted to this action by turning rapidly and pulling his arms violently away from the officer. Due to the size and agitation level of the subject, a second officer deployed his TASER [device] in probe mode, striking the subject in the back. The subject was then handcuffed and placed on the ambulance gurney without further incident.

Ultimately two internal complaints were investigated related to the initial officer placing his hand on the subject and the second officer using his TASER [device]. In review of this incident with regard to the reasonableness of the use of force, it became very apparent two of the three prongs [of the] *Graham vs. Connor* [test to determine the objective reasonableness of police use of force] are not available when dealing with a mental health issue."

—Anonymous

*Editor's note: A 2017 6th Circuit decision came to a similar conclusion. Although the case involved use of force on someone experiencing a diabetic emergency rather than a mental health crisis, the parallels are striking. In Hill v. Miracle, the Court concluded, "Applying the Graham factors to the situation that [the officer] faced is equivalent to a baseball player entering the batter's box with two strikes already against him. In other words, because Hill had not committed a crime and was not resisting arrest, two of the three Graham factors automatically weighed against [the officer]."*<sup>6</sup>

**65%**  
OF AGENCIES MANDATE CRISIS  
INTERVENTION TRAINING

**35%**  
LEAVE IT VOLUNTARY

"Subject was making death threats via social media. My partner and I went to interview and learned the subject suffers from bipolar, ADD and depression. During the interview, the subject exhibited a wide range of emotional responses to our questions and began acting agitated. Noticing his increased agitation, we informed him we were both CIT-trained in dealing with mental health issues. The subject immediately relaxed and thanked us for our wanting to learn about persons with mental illness. From that point forward, our interview turned for the better. We contacted the local crisis team, who responded immediately, and got the subject someone to talk with. The crisis team thanked us as well because the subject was out of his meds and likely falling into another manic episode."

Chuck Rowland  
Senior Inspector, United States Marshals Service



# RECOMMENDATIONS TO GUIDE OFFICERS AND AGENCIES

This survey was designed to be descriptive—to shed light on the problem of law enforcement interaction with mentally ill subjects and people in crisis so we better understand how often these interactions occur, what the interactions look like and how officers feel about them. Developing a robust set of tactics for addressing the problem is beyond the scope of this project. But in the course of gathering and analyzing the data (including open-ended responses) and conducting follow-up interviews with select respondents, some patterns emerge. These patterns point toward five steps law enforcement agencies and community stakeholders should explore as we develop long-term solutions.

## STEP 1 LOOK AT MENTAL HEALTH AS A RISK MANAGEMENT PROBLEM

In many communities, the problem of mental illness is so pervasive that it's

tempting to accept calls involving people in crisis as “just part of the job.” While we may not be able to make such interactions go away, leaders should not be complacent about the risks these interactions pose. Taking a risk management approach to the problem is helpful, because it changes the focus from resolving the issue to minimizing the harm that comes from it.

The Tucson Police Department has taken this approach through Crisis Intervention Team (CIT) training and developing a crisis response center where police can take mentally ill people who don't belong in jail. The center strives to process offenders in 10 minutes so officers can quickly get back on patrol.

In a recent *Virginian-Pilot* article highlighting innovative strategies to reduce the number of mentally ill people in jail, Tucson Sgt. Jason Winsky said, “If you ask our chief of police, he will tell you there

“The old method of bringing them in for a psych eval so they can be kicked back out does not work. An LICSW [licensed independent clinical social worker] working with the police department has been our best approach so far. The vast majority of contacts involve harmless low-level chronic offenders. The method of dealing with them is very similar: Build trust, get the release signed, collaborate with community partners on a plan. Then track and monitor that person for accountability on all involved.”

Kelly Greenwalt  
Sergeant, Community Policing/Mental Health Unit  
Duluth (MN) Police Department

**60% OF OFFICERS SAY THE ABILITY TO GET SPECIALIZED RESOURCES ON THE SCENE MORE QUICKLY WOULD HELP THEM FEEL BETTER EQUIPPED TO DEAL WITH CALLS INVOLVING PEOPLE IN CRISIS. 16% SAY MORE OR BETTER TRAINING IS KEY.**

are all the reasons in the world to do this stuff. Because it's the right thing to do. But on the other side of it, he views it as a risk management program. Because if you are training and you have the right policies and procedures in place, you can stand on that. Nobody is saying that doing these things is going to guarantee you an outcome. You are still going to have critical incidents. You are still going to have use of force. The idea is to minimize them.”<sup>7</sup>

## STEP 2 REDUCE THE TIME OFFICERS NEED TO DEVOTE TO CALLS

Tucson's efforts to achieve 10-minute processing point to another important area of focus—reducing the time officers must spend on calls involving the mentally ill. Law enforcement is a first response function. In their open-ended responses and in follow-up interviews, survey respondents did not exhibit a reluctance to respond to incidents involving mentally ill people; they exhibited frustration because officers alone can't appropriately resolve these calls, so they often wait long periods for specialized resources. It's a little like an officer showing up to a house fire and being expected to deal with the situation for 60 minutes or more until the fire department finally arrives.

Getting specialized resources on scene—embedded social workers, mental health

officers or on-call personnel from county crisis response programs—is one way to alleviate this problem. But it's also possible to do without specialized resources.

Sergeant Robert Nelms of the Guadalupe County (TX) Sheriff's Office says before his agency took steps to develop a streamlined procedure for mental health calls, officers sometimes avoided processing subjects through the mental health system because it was time-consuming and complicated. “If the procedure is not a simple, clean procedure, if it's burdensome and ties them up for a day, they will avoid it,” Sgt. Nelms says. “No one wants to say it, but it's realistic. If it's going to turn into driving to five different hospitals, and the person just gets released again without getting help, officers are going to avoid it. So you see officers try to find a way to say things are OK, this person doesn't need help.”

Guadalupe County reduced the amount of time officers spend on scene by training them in the Texas Mental Health Peace Officers Course and the Texas Mental Health Code. The agency then developed a streamlined process that emphasizes officer empowerment. Officers don't have to wait for a specialist to arrive on scene; they make the call on the appropriate intervention and, if necessary, transport the person to a mental health facility—none of which requires reams of paperwork.

“The state of Texas gave us a great tool,” Sgt. Helms says. “It’s legislated that an officer can never be forced to fill out more than one piece of paper to get a psych commitment started.”

When officers operate with embedded social workers or have a place where they can take people in crisis and not be turned away, they are more likely to pursue the needed resources and not resort to arresting someone for a minor offense when jail is likely only to exacerbate the problem.

### **STEP 3 DON'T GO IT ALONE**

Most agencies work with a tight budget for mental health response. Collaboration across agencies and county programs is essential, not only to extend resources but to make intervention more effective. The Duluth (MN) Police Department Mental Health Unit (MHU) includes two licensed independent clinical social workers (LICSW) who work out of the same location as the sworn officers assigned to the mental health unit; they respond to requests for service alongside officers or

on their own—a model the agency calls “the Duluth Response.”

“One of the unique things about our program is the collaborative approach,” says LICSW Patty Whelan. “Around 2015, the MHU expanded their participation with a community intervention group. We participate with about 25 agencies in Duluth who provide services to people with mental illness—private providers, detox, counseling, etc.” The local shelter developed a release form that when signed, allows all agencies to coordinate the individual’s care using a consistent approach. “Any one of the agencies can obtain the release, so it expedites everything,” Whelan says. “Someone can show up in the ER in crisis and previously they would just be discharged; now the ER personnel can reach out to any of the community partners. It’s gone from a tool the department and local shelter used to one all 25 agencies are using.”

The collaboration extends beyond emergency response to longer term planning. “Each month all the partner agencies come together and look at the chronic calls for service,” Whelan says. “As

“85% of our patrol force is trained in Crisis Intervention. We call it Emotionally Disturbed Persons Response. The training is voluntary and is 40 hours long. Our dispatch center knows who is trained and makes every effort to send trained officers on these types of calls. Our officers have intimate knowledge of local resources available to make referrals. Every effort is made to avoid incarceration and hospital admittances. We meet monthly with local providers, hospital staff, and [mental health] professionals to discuss barriers, achievements and chronic cases. We have a local wellness center comprised of peers to which we make referrals and a Mobile Crisis Response team comprised of local providers to respond to scenes during evening hours.”

David Guerrero  
Lieutenant, Cortland (NY) Police Department

## **68% OF RESPONDENTS WHO INDICATED THEIR AGENCY HAS A CRISIS INTERVENTION TEAM REPORTED FEELING PREPARED TO MEET THE CHALLENGES OF RESPONDING TO THE MENTALLY ILL, COMPARED WITH 54% AT AGENCIES THAT DON'T HAVE CRISIS INTERVENTION TEAMS.**

a team, we talk about community response. The case manager might try to set them up with psychiatric appointments, the outreach staff might explore options for housing. There’s an aligned agreement on working with the person.” Such collaborative approaches build trust, cut down on repeat calls and reduce the chances someone will fall through cracks in the mental health system.

### **STEP 4 INCREASE CRISIS INTERVENTION TRAINING**

Risk management expert Gordon Graham stresses that every law enforcement officer has a set of “core critical tasks” they must train on constantly.<sup>8</sup> These tasks represent situations where if the wrong actions are taken, tragedy can result. Calls involving mentally ill individuals or those in crisis certainly fall into the realm of core critical tasks. And that means training is imperative. Yet nearly 30% of respondents said their last training on interaction with mentally ill people was 2 years ago or longer, with another 6% saying they can’t recall. Together that’s more than one-third of respondents who haven’t received recent training.

Much of the crisis intervention training in law enforcement today dates back

the “Memphis Model” of crisis response started by the Memphis (TN) Police Department more than 30 years ago.<sup>9</sup> It involves training officers in empathy, listening skills and related de-escalation techniques, with a focus on connecting the individual to psychiatric resources rather than arresting them. Such training is typically about a week long (32-40 hours).

Another approach is called Mental Health First Aid, an 8-hour course that teaches officers how to identify, understand and respond to signs of addiction and mental illness and apply a 5-step action plan to help.<sup>10</sup> The International Association of Chiefs of Police launched the “One Mind Campaign” in 2016 with a goal of training 100% of sworn officers and selected non-sworn staff, including dispatchers, in Mental Health First Aid. The program also challenges agencies to train at least 20% of their sworn officers in the CIT model.<sup>11</sup>

Providing CIT or Mental Health First Aid to all officers is an admirable goal. But the focus should go beyond one-time training. Training is most effective in small, frequent doses and based on real-world examples. In the survey, the longer respondents had gone without training, the less confidence they reported in being prepared to respond: 73% of those who reported receiving training in



## 63% OF OFFICERS WHO REPORTED

THEIR AGENCY HAS A POLICY ON INTERACTIONS WITH MENTALLY ILL PERSONS SAID THEY FELT PREPARED TO MEET THE CHALLENGES OF SUCH INTERACTIONS. THAT NUMBER DROPPED TO 42% FOR OFFICERS WHO SAID THEIR AGENCIES DIDN'T HAVE A POLICY.

the last six months were confident in their ability to respond to incidents involving mentally ill persons. That number fell to 59% for those who had gone more than 2 years since receiving training.

Fortunately, brief, frequent training is also cheaper and easier to deliver than all-day or full-week programs. Supervisors can use roll call or briefing to review parts of a policy or pose a scenario to officers, using it as a basis for discussion that helps officers recall and retain the more comprehensive CIT training. This approach can also provide valuable direction for officers in agencies where funding for formal CIT training is not available.


### STEP 5 MAKE SURE POLICY IS UPDATED AND PERSONNEL KNOW THE POLICY

Only 14% of respondents said they don't have a policy that addresses responding to people in crisis, but 22% said their policies don't adequately prepare them. In addition, 7% said they didn't know whether their agency had policies addressing these interactions and an equal percentage was unsure about the content of the policy.

These responses underscore what Lexipol, the nationwide leader in public safety policy solutions, sees over and over again

working with thousands of agencies across the country: Agencies often lack critical policies. And even when an agency does have an applicable policy, it is frequently old, inconsistent with common practice or rarely referenced.

In the area of mental health response as well as in all operational areas, law enforcement agencies can benefit from a robust policy management system that keeps policies up to date, tracks and documents officer acknowledgment of policies, and provides training to enhance officer understanding of policies.



"We recently had a 'repeat' subject who abuses narcotics and was 'hearing and seeing' people who he believed were trying to injure or kill him. He is known to always be carrying some type of bladed weapon, and he was actively trying to defend himself against those he was hearing and seeing yet were not there. Due to the training that our officers have had, we were able to de-escalate the encounter and take him into custody and transport him to the county hospital's mental ward where he could receive help, rather than use force on him, arrest him, and place him in jail, where he would not get the same type of treatment for his problem. Our chief was very proactive in getting all our sworn personnel to be certified mental health officers, several years prior to the state requiring officers to go through the training. He had the foresight to do something to help before it was mandated."

Robert Cantu  
Warrant Officer/Mental Health Liaison,  
River Oaks (TX) Police Department



# CONCLUSION

A couple concerned about their schizophrenic son's recent deterioration. A convenience store owner confronting an elderly homeless woman talking to people who aren't visible. A colleague held hostage by an employee wielding a gun and threatening suicide. A security guard reporting trespassing by two young people who get extremely aggressive when he asks them to leave.

Each of these people turns to 9-1-1 for assistance. And in the time it takes to make a call, mental illness and emotional crisis become a law enforcement issue—even when many times, there is no criminal behavior involved. Sometimes, officers draw on training and instincts to defuse these potentially volatile situations and get the individuals the help they need. But despite the best intentions and efforts of

law enforcement officers and agencies, many of these encounters continue to be frustrating, demoralizing and dangerous—to the officers and those experiencing mental health crises.

This survey provides just a glimpse into the nature of law enforcement interaction with the mentally ill. There is much more work to be done to fully understand the problem and to develop, test and refine best practices for mental health response. But the complexity and scope of a challenge should never stop us from trying to minimize the risk it brings. We hope this study provides a foundation for how the public safety community can better understand the issue of responding to persons exhibiting mental illness—and in turn, create resources to help officers across the country.

“We have several bridges that sit high above a river and often get people threatening to jump off the bridge. Most times we are able to get the person to come back over the railing. The one that stands out was the one I couldn't save. We talked for what seemed like a long time. He had just been released from a nearby hospital after a psych evaluation. After talking with him, he simply pushed back and fell to his death. That one haunts me still and it was probably 15 years ago.”

Cheryl Fridley  
Lieutenant, Rochester (NY) Police Department

# ABOUT LEXIPOL

Lexipol is the nation's leading content, policy and training platform for public safety and local government, with a suite of services dedicated to reducing risk and improving personnel safety. These mission-critical services are offered through the PoliceOne, FireRescue1, EMS1, CorrectionsOne and EfficientGov digital communities. Delivered via an online platform and mobile policy app, Lexipol's content is continuously updated to address legislative changes and evolving best practices, allowing leaders and first responders to focus on serving their communities. With principal offices in Dallas, Texas, and Irvine, California, Lexipol services more than 2 million public safety professionals in 6,300 agencies and municipalities across the United States.

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# SOURCES

1. National Alliance on Mental Illness. Mental health by the numbers. Retrieved 1/28/19 from <https://www.nami.org/learn-more/mental-health-by-the-numbers>.
2. Centers for Disease Control and Prevention. Suicide rising across the US: More than a mental health concern. Retrieved 1/28/19 from <https://www.cdc.gov/vitalsigns/suicide/index.html>.
3. National Alliance on Mental Illness. Jailing people with mental illness. Retrieved 1/28/19 from <https://www.nami.org/learn-more/public-policy/jailing-people-with-mental-illness>.
4. Lowery W, Kindy K, Alexander K et al. (2015) Distraught people, deadly results. *Washington Post*. Retrieved 1/28/19 from <https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results>.
5. Pieper S. (6/28/17) Policy vs. procedure: In public safety, what's the difference? Lexipol. Retrieved 1/28/19 from <https://www.lexipol.com/resources/blog/policy-vs-procedure-public-safety-whats-difference>.
6. Wallentine K. 6th Circuit outlines new guidelines for police use of force during medical emergencies. Lexipol. Retrieved 1/28/19 from <https://www.lexipol.com/resources/blog/6th-circuit-outlines-use-force-standard-medical-emergencies>.
7. Harki G. (12/6/18) Jailing people with mental illness is a national problem. The solutions are local. *Virginian-Pilot*. Retrieved 1/28/19 from [https://pilotonline.com/news/local/projects/jail-crisis/article\\_001fb1f6-f418-11e8-af61-0739dc1083e5.html](https://pilotonline.com/news/local/projects/jail-crisis/article_001fb1f6-f418-11e8-af61-0739dc1083e5.html).
8. Graham G. (12/5/18) Thinking critically about public safety training. Lexipol. Retrieved 1/28/19 from <https://www.lexipol.com/resources/blog/thinking-critically-about-public-safety-policy-training>.
9. University of Memphis Crisis Intervention Team Center. Memphis Model. Retrieved 1/28/19 from <http://www.cit.memphis.edu/overview.php?page=2>.
10. National Council for Behavioral Health. Mental Health First Aid. Retrieved 1/28/19 from <https://www.mentalhealthfirstaid.org/about/>.
11. International Association of Chiefs of Police. One Mind Campaign: Improving police response to persons affected by mental illness. Retrieved 1/28/19 from <https://www.theiacp.org/projects/one-mind-campaign>.