Police and the Mentally Ill: The McLean County Experience

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Over the last several years, increased attention has been given to the interaction between persons with mental illness and the police. In some incidents, persons suffering from mental illness have been killed by the police, and in other incidents, police officers have been killed by persons suffering from mental illness. The Federal Bureau of Investigation, in their study of *Law Enforcement Officers Feloniously Killed or Assaulted from 1991 to 2000*, found that 1.2% of the 644 officers killed were killed by assailants classified as "mentally deranged." Additionally, 1.5% of the 603,070 officers assaulted were assaulted by persons of the same category. There can be little doubt that persons with mental illness can lead to physical dangers for police officers. While police officers may be in danger from persons with mental illness, they are just as likely to be the victim of crime as the perpetrator of criminal acts.

The police are often called upon to assist with persons exhibiting mental illness or to control persons having psychotic episodes because of their mental illness. While citizens may believe persons suffering from mental illness are not going to receive the psychiatric help they desperately need from the police, they still call upon law enforcement to bring the situation under control as other options are often not available. The reliance upon the police to solve such problems is caused by a number of factors.

One factor that influences the public's call to the police is the fact that the police are the only government agency generally available 24 hours a day, seven days a week that will respond to complaints by the citizenry. The police have historically been the first government agency contacted for a variety of problems not just for crimes in progress, but any time citizens need assistance and they do not know who to call, mostly because the police are the most visible and accessible of all government agencies in American society. Secondly, the police are the only government agency that is vested with the authority to use force to restrain persons from hurting themselves, others, or property. When citizens become alarmed or are in fear of someone who is suffering from mental illness, they contact the police for assistance. Often, the public accepts the police are not the most therapeutic assistance they can call; however, they know the police will protect them from the person experiencing mental illness, and they have the authority to use all necessary force, including deadly force when required. Given the availability of the police 24 hours a day, seven days a week and their authority to use force, why does the number of calls to public safety agencies about persons with mental illness seem to be on the increase?

In November 2002, the Illinois Law Enforcement Standards and Training Board (ILETSB), through its Executive Institute, held a statewide summit to examine the nature and extent of police and mental health professional interaction and cooperation in finding solutions to dealing with persons having mental illness. During the three days of the summit, professionals from both the law enforcement and mental health fields came together to discuss common concerns, problems, and potential solutions. In the final report of that conference, it was reported that in 1955,

there were 560,000 persons hospitalized in psychiatric facilities in the United States. By 2001, the total number of persons institutionalized in psychiatric hospitals was reduced to approximately 60,000 persons.

What would explain such a reduction in the population of mental health facilities when the nation's population, the number of crimes reported, and prison population are all increasing? Several factors have influenced this dramatic reduction in hospitalized and institutionalized persons with mental illness. First, based on improved methods of research, there was a greater understanding and increased knowledge about mental illness and its causes. In the last half of the 20th century, there were tremendous strides in research conducted on persons with mental illnesses and understanding of the causes of mental illnesses. As late as the 1960s, persons with mental illnesses were routinely institutionalized with little thought towards their future or retuning them to mainstream society. Rather than a focus on treatment and returning them to the community, persons were placed in institutions and medicated to control their behavior. In short, they were removed from society and locked up for the rest of their lives. Secondly, as part of the improved knowledge base and understanding of the causes and extent of mental illness, there have been monumental improvements in medications and therapies to assist in the control of mental illness. Treatment for mental illness has evolved from the era of institutionalization and shutting society's doors to treating the behaviors associated with mental illness, providing therapy to improve coping skills, and providing medication to control those behaviors that cannot be controlled through other methods. The focus is now one of returning people with mental illness to society rather than locking them away. In addition, there is a concerted effort on the part of mental health professionals to return persons with mental illness to the community and allow them to become productive members of society rather than be dependent upon society. Part of the treatment plan includes bringing persons with mental illness out of the institutions and asylums and allowing them to learn how to cope with their condition and become productive members of society. Another final factor that has led to the increased number of persons with mental illness in society today is severe budget cuts and the closing of facilities where persons with mental illness were once hospitalized.

Despite the advances in the understanding, treatment, and medications for persons with mental illness, some persons were hospitalized in the best interest of the patient and society as a whole. Unfortunately, in recent years, many state facilities are being closed as a budget reduction measure. Regardless of how careful mental health professionals are in screening people before they are released, it is possible that persons who should continue their institutionalization are being released to communities unprepared or incapable of dealing with their problems. The question is how much of a problem for police are persons with mental illness being back on the streets?

During the ILETSB summit, it was stated that 5% of the nation's population is suffering from some form of severe mental illness. Other sources suggest that nearly 25% of the population of the United States has a diagnosable mental illness. Further supporting the position that police often are called upon to deal with the problems of the mentally ill is that 20% of persons who should be receiving treatment are arrested by the police before they are able to receive treatment. Data further suggests that 16% of the inmates in the nation's jails and prisons have some form of

diagnosable mental illness. It has also been demonstrated that the Cook County Jail holds more persons with mental illness than any other hospital. Consequently, the evidence suggests that rather than treating persons with mental illness as persons with an illness, they are secured in a different state facility—the jails and prisons of our nation. The criminal justice system is often utilized to deal with persons with mental illness. Equally problematic is the issue of police dispositions of persons they encounter, who are suffering from some form of mental illness. In a utopian society, police would be well-trained in dealing with mental health issues and be able to immediately spot mental illness in whatever form it may present itself. They would initiate services from the mental health system to provide treatment and services for the person suffering from mental illness. Of course, all this would be accomplished within minutes of arrival, and the officer could immediately return to patrol to respond to other calls for service. Unfortunately, police officers seldom have such advantages, and this simplistic solution is not realistic and seldom happens in a police officer's life.

Police have traditionally been trained in the traditional methods of policing. Their mission is the overall safety of the public and fighting crime by responding to crimes, identifying suspects, and locking them up. They have traditionally been trained to deter crime by identifying violators with criminal behaviors and placing them in the criminal justice system for punishment. Police, when necessary, can use the force necessary to control persons with mental illness and remove them from society. Interaction with the public is only when necessary and often brief in duration. Traditional policing methods, in addition to being questionable in their effectiveness in deterring crime, are far from efficient when dealing with the mentally ill.

Mental health professionals have the mission of diagnosing mental illness followed by establishing and implementing a treatment plan. Their main focus of attention is the person with mental illness, and their treatment plan would allow the person to be a productive member of society. Mental health professionals use medication in conjunction with therapy to help people learn how to control their illness and adapt to the community. In contrast to the brief interaction with police, mental health professionals spend many hours in working with their clients. Since the early 1980s, the law enforcement community has sought out new and better methods of deterring crime. Traditional policing methods have been found to be ineffective in dealing with crime, and new methods of dealing with criminal behavior had to be developed. Crime rates continued to increase; prison populations grew; and the public demanded more effective police protection.

Traditional police methods—that is those methods that embrace reactionary response to crimes, paramilitary organization, and "professionalism" of police—were not working. Two new concepts of policing were developed and implemented: (1) team policing (TP) and (2) problem-oriented policing (POP). Both methods of policing incorporated a team of officers working with the community to address problems in a specific area or with a specific problem. Under the TP concept, a group of officers would be assigned to a specific district or area and would be responsible for delivering police services to the community. This "team" would operate in addition to, and outside of, the patrol functions of the rest of the department. In the POP concept, officers and citizens would join together to identify problems or specific concerns, and a team of officers would then be assigned to specifically address those problems. In POP, the officers who participate in the problem-solving efforts are

a select few within the department, and they would operate in addition to other police patrols and functions.

There has been some discussion on both sides of the issue as to whether or not TP or POP would be successful where they were implemented. The controversy is based on whether the concepts were flawed, poorly organized and administered, or sabotaged by middle management as a way of protecting their positions within the department. Regardless of why TP and POP are no longer in practice, the concept of community-oriented policing (COP) evolved out of the era of TP and POP. In the COP model, police and the community unit attempt to find specific solutions to specific problems experienced by the community. Rather than being providers of services within traditional policing methods, the police become part of the process that finds long-term solutions to problems within the community. They work with the community to establish solutions to problems. Another one of the many characteristics of COP is that the model involves a department-wide philosophy of working with the community as a team. In both TP and POP, only specifically selected officers would interact and work with the community to address problems in a specific section of the community. In COP, the entire department is engaged in working with citizens to improve the community. Officers are trained to incorporate problem-solving strategies to work with the community and develop action plans for solving those problems. Initial evaluations of COP programs provide some support for the position that COP is effective. Even the staunchest detractors of COP have to acknowledge, at the very least, that COP has a direct impact on the attitudes of persons and their perception of safety in the community. COP has brought the police and the community together to address problems, which has a direct impact on the overall community.

As Sir Robert Peel, the father of modern policing initially proposed in the 19th century, "the police are the community and the community are the police." COP may take on a variety of forms and have a multitude of shapes, all being dependent upon the specific makeup of the community. In dealing with persons having mental illness, COP is a truly effective mechanism to deal with problems of the mentally ill. The full resources of the community can be focused on the issues associated with persons having mental illness, whether that be as victims or perpetrators. During the summit held in November 2002, the participants identified five goals which law enforcement and mental health professionals have identified: (1) Prevent tragedy or physical harm to person with mental illness; (2) Prevent tragedy or physical harm to law enforcement personnel as well as inappropriate release of persons who subsequently harm themselves or others; (3) Encourage referral for long-term intervention and treatment; (4) Maintain the dignity of the person suffering from mental illness; (5) Serve as a government role model for the rest of society, and treat mental illness as an illness. While collaboration is the most efficient use of the resources both in the law enforcement and mental health fields, there are a number of obstacles that have been identified for law enforcement.

The first obstacle is the "revolving door" approach to persons with mental illness. The cycle of detention and release followed by detention again appears to most officers as non-ending. Not only has the person with mental illness not received necessary treatment but also the repeated interactions with the police deplete valuable police resources quickly. A second obstacle is the personal risk to police officers in dealing with violent persons suffering from mental illness. The

unfortunate truth is that persons suffering from mental illness are often treated like anyone else with whom law enforcement officers have contact. Those persons with mental illness may not comprehend that the police are there to help them and may perceive the police as threats to their safety. The police may not fully understand the actions of the persons suffering from mental illness and often misinterpret their actions as threatening. Often, police officers perceive hesitation to directions as threatening, when in some mental illnesses the person needs to process what they are being told to do, and therefore do not respond to the officer's directions. This is not to minimize the constantly present danger that anyone, with or without a mental illness, poses to police officers. Officers must respond to the behaviors exhibited by persons with whom they have contact. A thorough understanding of the basics of mental illness may assist the officer in making more accurate judgments about the threat a person with mental illness presents, thereby increasing the officer's safety in dealing with the public. A third obstacle that has been identified is the tendency in traditional policing practices towards short periods of interaction with the public. Officers must often go from assignment to assignment, and many times, they are not allowed to provide a more time-consuming intervention. This lack of adequate time to fully implement the emergency psychiatric services of the community may lead to less-than-effective intervention by the police. These obstacles are universal and may affect police intervention in any community in the nation.

In central Illinois, however, a unique collaboration between mental health and police professionals has been in place since before COP was the new trend in policing. The McLean County Center for Human Services and the law enforcement agencies within McLean County have built a unique working relationship that has lasted for years. The McLean County Experience–The McLean County Center for Human Services is the community mental health center for McLean County. The office is located in downtown Bloomington and is funded by the State of Illinois Department of Human Services, Office of Mental Health in addition to local community funding (e.g., United Way, local health department, local contracts) to serve individuals who experience mental illness. The center's mission statement indicates that the agency exists to assist persons in McLean County who are in need of mental health services. The agency provides services to children, adolescents, and adults through a variety of programs and services. In addition, it provides intensive services to adults with serious and persistent mental illnesses utilizing both case management services and residential programs.

These services are designed to fill the gap created by the deinstitutionalization process that began in the 1950s, as described previously, with the implementation of antipsychotic medication. Due to this process, long-term hospitalization is not a viable option for many clients, and crisis intervention services are increasingly in demand. Individuals having serious and persistent mental illness are now treated so as to function in communities and are expected to lead independent lives as much as possible. Case management and residential programs in particular help individuals with mental illness maintain their independence within the community. Unfortunately, mental illness is like any other illness in which symptoms ebb and flow between functional and non-functional.

The Emergency Crisis Intervention Team (ECI) treats the current symptoms (in contrast to long-term therapy) of persons with mental illness and assures their safety and well-being. In essence, ECI functions as a mobile psychiatric rescue

squad for persons suffering from psychotic episodes. ECI is a seven-member unit of mental health professionals who are available 24 hours a day, seven days a week, 365 days a year. For each activation of the ECI, the team is represented by two professionals available to respond to any psychiatric emergency within McLean County. These mental health professionals are well-versed in responding to mental health emergencies and the Illinois State mental health code (laws) in addition to various mental illnesses and their treatment. It has been found to be very advantageous to have two mental health professionals responding to each psychiatric emergency. One individual can gather information, and the other can work with the individual in crisis to help promote a safe and therapeutic disposition as efficiently as possible. This team approach creates an environment in which the mental health professionals can consult with each other and assess a situation to promote the most effective disposition for the individual experiencing a crisis. This two-person ECI team approach is unique to McLean County and has been found to be beneficial to both the ECI members and the client. ECI is also unique in the variety and depth of connections to available resources it has within the community. ECI dedicates daily staff time to providing services for both the local mental health in-patient unit and within the McLean County Detention Facility. This is a priority service in that it allows ECI team members to assess and link individuals with mental illness to the appropriate services in an attempt to decrease the involvement of the legal system and local or state psychiatric hospitals. This positioning within the detention facility and local mental health unit provides ECI with the opportunity to develop relationships with the individuals we serve so that we might be better able to assist them in times of crisis.

The working relationship between ECI and law enforcement has been a long-standing positive experience when working with individuals who may be suffering from mental illness. The relationship is simple; ECI depends on law enforcement professionals to thoroughly and safely do their job, and law enforcement professionals have learned to utilize ECI to deal with individuals who may be suffering from mental illness. This working relationship is based on professional respect and positive working interactions. ECI relies on law enforcement to provide a quick response and to secure a scene. Law enforcement depends on ECI to advocate for the individual, and if need be, navigate the officers through the mental health system to meet the client's needs. This approach has worked effectively in McLean County for several decades and will continue to do so in the future as long as law enforcement and the mental health system do not lose sight of the mutual interests they share.

The easiest way to demonstrate this collaboration is through an example. This is a fictitious example based upon many experiences, but it demonstrates the strengths of the relationship between law enforcement and the mental health system in our community. In our example, we will involve the police, ECI, the local hospital emergency department, the in-patient mental health unit, and the Center for Human Services. We will follow the individual from first contact with the police to discharge from the mental health center and follow up with the community mental health center.

Police are dispatched to respond to a white male ("Billy") in his early 20s who is chasing cars in a local grocery store parking lot and screaming bible verses. Upon arrival at the scene, officers see Billy yelling and chasing after cars, and at one point, Billy attempts to jump on the trunk of a moving vehicle. When police approach Billy, he is cooperative but continues to recite bible verses. At this point, the officer notifies dispatch to contact ECI. Within thirty minutes, ECI is on the scene and are meeting with the police. Prior to the arrival of ECI, the police are able to identify Billy and verify that there are no active warrants for his arrest. There are no current criminal charges against Billy. ECI has had previous contacts with Billy and is aware of Billy's condition and knows that he has not been on his mood stabilizing medication for the past three weeks. After talking with Billy, ECI finds him agreeable to go to the emergency department. Police transport Billy to the emergency department where ECI continues to conduct their evaluation. After evaluating Billy and having him medically cleared, ECI suggested to Billy that he be psychiatrically hospitalized to stabilize his mood. Although reluctant at first, Billy becomes agreeable to hospitalization, and ECI makes the necessary arrangements. Because Billy has agreed to be hospitalized, there is no need for the police officers to prepare a petition for involuntary admission. If Billy had refused to be admitted, the ECI team would assist the patrol officers with the completion of the petition, and the emergency room physician would have made a decision, based on the personal observations of the officers and the doctor, on whether or not to involuntarily admit Billy.

During his course of treatment on the mental health unit, Billy is restarted on his medication and screened by the ECI worker on the unit for case management services. Within two days, Billy shows great improvement with his mood, and the religious preoccupation is diminished significantly. He is agreeable to receive case management services from the Center for Human Services. Prior to his discharge from the mental health unit, the ECI worker on the mental health unit makes arrangements for Billy to meet his case manager and set up a time to meet after discharge. Billy and the case manager agree to meet the day of discharge, and Billy is willing to allow the case manager to transport him home upon leaving the mental health unit. Billy is discharged from the mental health unit after five days. After six months, Billy remains medication compliant and has remained out of the hospital since this hospitalization.

This example demonstrates a good interaction between law enforcement and the mental health system. In this example, law enforcement is dispatched to meet with an individual with a probable mental illness. Rather than being placed in a situation in which they are forced to be mental health professionals, the officers contacted ECI to evaluate the subject. It is this resource, having a mobile mental health team to respond to psychiatric emergencies, that allows law enforcement to remain available for other calls for service and not be tied to one call for an extended period of time. In addition, this example demonstrates the appropriate treatment plan for the individual based on individual needs. ECI was aware of Billy's condition and instability and was able to facilitate appropriate treatment in the least restrictive environment. By initiating an appropriate treatment plan, the ECI members were able to prevent an additional burden on the criminal justice system. This example also demonstrates the necessity of mental health professionals linking the individual to the necessary and appropriate services. The ability of the ECI worker on the inpatient mental health unit to facilitate the connection to appropriate services has allowed Billy to remain in the community without any further inpatient hospitalizations or interactions with law enforcement.

We could modify this scenario to exemplify a few other concepts. Assume that Billy refuses to cooperate with the police and/or ECI. According to the Illinois Mental Health and Developmental Disabilities Code (5/3-606), "a peace officer may take a person into custody and transport him to a mental health facility when, as a result of his personal observation, the peace officer has reasonable grounds to believe that the person is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm."

In this scenario, the officers witnessed Billy attempting to jump on the trunk of a moving vehicle, thus demonstrating a potential risk to himself and others. The act of trying to jump on the vehicle, Billy's refusal to cooperate with the police and/or ECI, and his religious preoccupation led the police to believe that they had reasonable grounds to take him into custody and transport him to the local emergency department at the hospital. Upon arrival to the emergency department, ECI would assist the police in accurately and correctly completing the petition for involuntary admission. ECI would list themselves on the petition as witnesses to the events that are described on the petition (witness to any events that occurred once ECI arrived on scene). It will be at this point that law enforcement personnel are able to back out of the call, and ECI will either complete the first certificate or assist the emergency department physician to complete the first certificate for involuntary, psychiatric hospitalization. If the scenario continues to be complicated and Billy remains uncooperative and meets the criteria for involuntary hospitalization, the psychiatrist will complete a second certificate. The certificates will be filed with the circuit court, and a court hearing will be set within five days (excluding weekends and holidays). The advantage in this situation is that the police officers are not required to attend the commitment hearing. The State's Attorney's office uses the testimony of ECI members for the hearing leaving law enforcement out of the scenario and focusing on law enforcement duties rather than mental health issues. If Billy is found to meet criteria for court commitment to mental health treatment, Billy will be transferred to a state hospital for further treatment.

Once stabilized at the state hospital, Billy will return to the community with the appropriate services in place, including something as intensive as court-ordered medication compliance. Another twist that can be added to this scenario would be the exclusion of ECI at the scene and the police officers arresting Billy and transporting him to the McLean County Detention Facility. Once at the detention facility, the ECI jail counselor would attempt to assess Billy and determine the level of care he requires. If Billy is willing to accept treatment, the detention facility has a contract with one of the psychiatrists at the McLean County Center for Human Services, who can restart his medication, and the ECI jail counselor can reestablish the necessary services for him. If Billy were to remain uncooperative, the ECI jail counselor would have several options. The jail counselor could petition Billy for involuntary hospitalization. The detention facility could issue an I-bond for the charges. Another option is to wait for Billy to appear in front of the judge and have the State's Attorney request a personnel recognizance bond on the criminal charges from the judge release in order to involuntarily hospitalize Billy in the local inpatient mental health unit.

The difficulty with charging Billy with a crime is assessing whether or not this is the best approach to treat his mental illness. Another complicating factor is the charges that may be filed against Billy. If felony charges are pending, it is not possible to civilly commit a person for inpatient psychiatric treatment. If the charges are felony charges, the ECI jail counselor would contact the State's Attorney's office to review the case in an attempt to reduce the charges to misdemeanors so that ECI could proceed with an involuntary hospitalization on the inpatient mental health unit to stabilize Billy's symptoms. This would not only relieve the already overcrowded criminal justice system, but would allow Billy to receive the treatment necessary to rejoin society as a productive member. We are hoping to use this article as a demonstration of why it is imperative for law enforcement to work jointly with mental health professionals when dealing with individuals who are suffering from severe symptoms related to a mental illness. Police are not trained to deal with mental health issues, and mental health professionals are not trained to deal with matters involving police intervention. As is demonstrated above through the collaboration in the "McLean County Experience," it is the responsibility of the mental health arena, not law enforcement to provide the appropriate services for individuals who are in some sort of mental health crisis. This working relationship in McLean County is enhanced by the commitment of law enforcement and mental health to do the right thing for the client and the community as a whole.

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Captain Gehrand currently holds a bachelor's degree from Illinois State University and is currently completing his master thesis in criminal justice sciences. He is a graduate of Northwestern University's School of Police Staff and Command. He is also a member of the Advisory Board for Mobile Training Unit 8, Law and Justice Commission, Illinois Law Enforcement Standards and Training Board. In addition, Captain Gehrand is an instructor in Police Response to Persons with Mental Illness.