Policing the Mentally Ill: Changes to Training and Best Practice

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Policing the Mentally Ill: Changes to Training and Best Practice

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Abstract

Purpose

Due to de-institutionalization, police officers are responding to more calls about people who have mental health issues. One of the biggest challenges for police officers when on these calls is being able to de-escalate a situation without it turning into a violent situation. Since police are not trained to interact with people who have mental health illnesses, and they are first of the scene, they should be required to attend a Crisis Intervention Training course during their pre-academy training to assist them in these situations. By attending trainings that have been developed and implemented in other law enforcement agencies, policers who arrive on the scene can utilize their skills instead of force.

The purpose of this paper is to provide recommendations to law enforcement agencies on how to respond to mental health crisis calls by providing officers, dispatch workers, probations officers, and other workers in the criminal justice field training in crisis intervention and de-escalation tactics to keep everyone safe.

Methods

The methods of approach utilized for this paper will consist of reviewing scholarly articles that have been peer-reviewed, websites, law enforcement agency policies for mental health situations, and any other secondary research and statistics pertinent to this subject matter. The information will be pulled from sources from 2017-2021 to have as much current

information as possible. A review of the Crisis Intervention Training (CIT) Program through Memphis, Tennessee, will be analyzed. The CIT program was first developed in Tennessee to coordinate efforts between law enforcement agencies, mental health facilities, city governments, and people who are in a mental health crisis (Bird & Schmilt, 2018). By analyzing this research, it will be determined if additional training and program implementation in mental health services will need to be provided to law enforcement agencies to better serve the mentally ill when out on calls.

Key findings

Police officers who were trained in Crisis Intervention Training (CIT) have been able to de-escalate mental health crises and get individuals resources and services to help them rather than arrest them and take them to jail. Research shows that 911 operators should be included in CIT because they are the ones relaying the information to the officers and giving them details on how to proceed. The 911 operator's directives can set the tone for how the officers will respond to the situation. By building partnerships with people in the community and the mental health profession, police officers have been able to implement successful programs to assist people with mental health illnesses.

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INTRODUCTION

Statement of the Problem

According to the National Institute of Mental Health (NIMH) (2020), mental health illnesses are more common than one might think. In the U.S., there are one in five adults living with a diagnosed mental health illness. That is about 51.1 million people in 2019 who had a mental health illness in the U.S. (NIMH, 2020). According to the NIMH (2020), a mental health illness is defined as "a mental, behavioral, or emotional disorder that can range from no impairment to mild, moderate, and even severe impairment" (Figure 1). Furthermore, the NIMH reported that in 2019, 23.0 million or 44.8% of Americans received services for their mental health needs.

As the number of mental health cases rises, so does the number of contacts individuals with mental health illnesses have with police (Lane, 2019). The deinstitutionalization of psychiatric hospitals in America is one of the significant reasons police are having more contact with people with mental health issues (White et al., 2019). People with mental health illnesses are frequenting bars, are homeless and in the streets, and are more often in the public eye since there are only some long-term psychiatric hospitals to assist individuals with mental health illnesses. White et al. (2019) mention that police officers are encountering more crisis calls from family members who are seeking help for their family members who are mentally ill because they do not know what to do to help them anymore. The police are usually the first to respond to these calls, even though they are not mental health professionals, because it is unknown how dangerous the situation is going to be, plus the police are available all the time. Even though

individuals with a mental health illness can have breaks and episodes at any given day and time, it seems that nights and weekends are the highest times for calls to the police department. This is because there are not many mental health resources available at those times (Lane, 2019). Many people in society stigmatize mental health disorders which leads to additional discrimination and prejudice against persons with such conditions. An individual with an untreated mental illness may be seen as having criminal intentions. This leads citizens to contact the police for people who are not acting by society's norms.

The training that officers are receiving deals with making sure an area is secure and safe for everyone involved and getting emergency situations under control by any means necessary (Puntis et al., 2018). This may include talking, arresting, or shooting an individual who is out of control or a threat to others. Unfortunately, police officers have been trained to shoot first and ask questions later, so people who have mental health issues that are aggressive, out of control, or deviant are being treated just like a criminal (Puntis et al., 2018). Puntis et al.'s (2018) research shows that when police encountered individuals with mental health issues, excessive force was used in 25% of cases, and some even led to death. By having police officers complete crisis intervention training and changing policies within the agency to have officers work more patiently with the mental health population, less force will be needed.

Purpose of the Research

The purpose of this research is to provide recommendations for how law enforcement can best respond to calls involving individuals experiencing a mental health crisis. By being able to address mental health issues efficiently and effectively when working with individuals, police officers will be able to lessen the use of physical force.

One of the biggest challenges for police officers is dealing with individuals who are mentally ill and in crisis. Relatives, friends, and concerned citizens often contact law enforcement when an individual is having a mental health issue, so police officers are the first on the scene. They do not know what they are walking into at that moment and are on high alert. Police are not trained to interact with people who are having a mental health crisis, and this can result in these situations having a deadly outcome. The individual who is having a mental health crisis may be displaying unpredictable and unsafe behaviors, and officers may feel that they must use excessive force instead of trying to de-escalate the situation another way. Many people with mental health issues are often incarcerated because of their behaviors, and what they really need is treatment to get them stabilized. Due to trainings and programs that have been developed and implemented in other law enforcement agencies, police officers who arrive on the scene to deal with a mental health crisis can utilize their skills instead of force. Several states require police officers to take a necessary amount of crisis intervention at the police academy, for in-service hours or as ongoing training. In Yavapai County, Arizona, Crisis Intervention Training (CIT) is presented twice a year to all law enforcement personnel, probation officers, dispatch workers, and detention staff ("Yavapai County Sheriff's Office," 2021). In Menasha, WI, officers are encouraged to take CIT, and only when the budget allows, but it is not a required training for the officers ("Crisis Intervention Team," 2017). In Portland, Maine, all officers are trained in crisis intervention ("Portland Police Department," 2021). Budget, size of the department, and area of the United States are some factors in determining who gets CIT or any type of mental health training. The purpose of this paper is to provide recommendations to law enforcement agencies on how to respond to mental health crisis calls by providing officers,

dispatch workers, probations officers, and other workers in the criminal justice field training in crisis intervention and de-escalation tactics to keep everyone safe.

Significance of the Study

Police officers are trained to handle situations from domestic violence disturbances to robberies to traffic stops. Most of the interactions police officers have with citizens do not end in arrests or someone being shot because the officers are able to communicate with the individual and get control of the situation, but there are times when officers are not able to gain control and force is needed. Police officers have an abundance of training in how to handle aggressive, forceful citizens, but they do not have enough training when it comes to people who are mentally ill. Specifically, they do not have enough training on how to de-escalate a situation, be patient, and calmly work through a problem with someone who may need a few more minutes to feel safe. This paper will argue that by providing law enforcement officers with crisis intervention training and other mental health-related training, changing policy and procedures when interacting with the public, and offering other tactical methods, instead of force, police officers will be able to improve their interaction with the public, especially the mentally ill, and utilize less force in all situations. The mentally ill patients will also be less likely to be sent to jail and will get the treatment needed for their mental health illness.

Methods Used

The methods of approach utilized for this paper consisted of reviewing scholarly articles that have been peer-reviewed, websites, law enforcement agency policies for mental health situations, and any other secondary research and statistics pertinent to this subject matter. The information was pulled from sources from 2017-2021 to have as much current information as

possible. A review of the Crisis Intervention Training (CIT) Program through Memphis, Tennessee, will be analyzed. The CIT program was first developed in Tennessee to coordinate efforts between law enforcement agencies, mental health facilities, city governments, and people who are in a mental health crisis (Bird & Schmilt, 2018). By analyzing this research, it was determined that additional training and program implementation in mental health services will need to be provided to law enforcement agencies to better serve the mentally ill.

Limitations

The success of any training program or policy/procedure change comes with how supportive the upper management is with implementing everything and how willing the officers and the staff are with learning the new material. Dealing with people who have mental health issues is not for everyone, and when a person joins the police force, mental health encounters is not the first thing that comes to one's mind. Not every police encounter with a mentally ill individual can be successful by following the mental health training that is given to the officers and other staff members; however, the studies reviewed showed less force utilized by officers than necessary when officers were able to identify or were aware of an individual's mental health status.

Readers need to understand that there is not a one size fits all solution when police encounter a subject with mental health, so all the recommendations and suggestions in this paper have been tried by other police departments in other states and counties. Some of the trainings have worked, and some have failed; however, the police departments have recognized that their officers and staff have more encounters with individuals with mental health issues on a daily basis, and their staff needs to know how to handle the situation with less force.

LITERATURE REVIEW

The literature review section consists of five sections. The first section discusses a brief history of mental health hospitals. Section two talks about the deinstitutionalization of the mentally ill and then leads into the third section on court cases that contributed to deinstitutionalization. The fourth section discusses the consequences of deinstitutionalization and is broken into three sections; homelessness, increased police contact, and police using force against people with mental health issues. The fifth and final section talks about reinstitutionalizing people with mental health issues back into mental health facilities or into jail.

History of Mental Health Hospitals

The first mental health hospital, or "insane asylum," opened up on October 12, 1773, in Williamsburg, Virginia (Geloso & March, 2021). People in these asylums were used for entertainment purposes since everyone outside of the hospital thought they were unusual because of their strange thoughts and behaviors. Since some individuals were too violent or disruptive to live in their homes or to be out in the community, some hospitals started having separate wings for individuals with mental health issues. However, these facilities were expensive and could only be afforded by the wealthiest families (Geloso & March, 2021). By the 19th Century, the United States was following a structure from Europe where people with mental health issues were treated kindly, and their surroundings were peaceful, and if any restraints had to be used, it was for a short period of time (Geloso & March, 2021). Around the 1890s, elderly patients who were suffering from different ailments were sent to mental hospitals; however, the treatments and the environment were not making the elderly patients get better.

Most mental health facilities were overcrowded and housed way more patients than necessary, and the patients were not given proper mental health treatment. From the late 18th Century to the 1950s, the population of patients in mental health facilities was close to 600,000, and by 1977, the population of patients declined to about 160,000 (Yohanna, 2013). The decline in patients in mental health facilities in the United States was due to mental health budget cuts from the government, improved treatment through community resources, and the use of drugs, such as Chlorpromazine (Yohanna, 2013). Unfortunately, over 100,000 individuals with mental health illnesses are housed in prisons, and they are not receiving the treatment that they need to care for their mental health needs (Yohanna, 2013).

Deinstitutionalization of the Mentally Ill

According to Slate (2017), deinstitutionalization was developed to transition mentally ill individuals out of state hospitals and into community-based treatment facilities. This would lower the cost for families since the person would not be housed in a hospital forever, and the person would be integrated back into society. Mental health facilities were deemed to be cruel and inhumane places for people with mental health diagnoses, and by placing individuals with mental health diagnoses in the community, they would receive new medications, such as Chlorpromazine, to treat mental health illnesses (Slate, 2017). Many advocates were for mentally ill patients to be released into the community and placed on the new medication, and be treated by out-patient facilities because this would save money for the states. According to Slate (2017), some states did not transfer the savings from shutting down the psychiatric hospitals to improving the community out-patient facilities, so other problems occurred for the patients, such as homelessness, criminal activity, and being forgotten about altogether. Slate (2017) mentioned that President Kennedy signed the Community Mental Health Centers Act (CMHCA) in 1963 to

give monetary support to the deinstitutionalization movement so that community-based mental health treatment facilities can replace the failing, expensive state hospitals. The money from the CMHCA would have allowed the community-based mental health treatment facilities to flourish and provide the services needed to the mentally ill; however, President Kennedy was assassinated, and the money was allocated to the Vietnam War that was happening at that time (Slate, 2017). Patients were discharged out of the mental hospitals and sent out into the community without any guidance, money, or services available to them.

Court Cases that Led to Deinstitutionalization

States wanting to save money was one of the biggest reasons that led to deinstitutionalization, and court cases contributed to the deinstitutionalization movement too. Mental health patients were being committed to mental hospitals in their states and left there to suffer unspeakable treatment procedures. Some people with mental health illnesses did not need to be confined in a hospital setting for long periods of time or have their rights taken away from them, so cases were brought up to the courts to see if changes could be made (Perlin, 2018).

Several court cases, *Lake vs. Cameron, Lessard vs. Schmidt, Wyatt vs. Stickney, Olmstead v. L.C.*, and *O'Connor v. Donaldson,* paved the way in the judicial system for how long a person with mental health illness should have to stay in a facility, how they are treated, and how to integrate these individuals into the community by utilizing community services. In 1966, *Lake vs. Cameron* was brought to trial, and it was one of the first federal cases that limited the capability of states to commit mental health patients (Perlin, 2018) properly. States were ordered to use the least restrictive means necessary to treat patients in their facilities, so if the patients needed to be discharged to the community, then the hospital had to discharge the patient (Perlin, 2018).

There were two court cases in 1972; one in Wisconsin and one in Alabama. The case of *Lessard vs. Schmidt* in Wisconsin was a federal case that constricted the states' ability to commit people with mental health illnesses into facilities on an involuntary basis without meeting the standards of commitment (Perlin, 2018). Mental health professionals must find less restrictive ways to find someone mental health services before seeing if a person qualifies for a Chapter 51. Most states have the same requirements when it comes to placing individuals with mental health illnesses involuntarily in-patient or chaptering them. According to Chapter 51 Wisconsin State Legislature (2021), a person has to meet specific criteria to be committed to a mental health facility on a non-voluntary basis. The person has to be mentally ill or developmentally disabled, proven to be treatable with proper treatment, a danger to self or others, or danger to self due to neglecting self because of improper nourishment, shelter, or impaired judgment ("Chapter 51," 2021). In Florida, Statute 394.467 states that in order to involuntary place a person at a treatment facility, the person has to have a mental health illness, be incapable of living on their own, and sometime in the future he may harm himself due to his most recent behaviors ("The 2021 Florida Statutes," 2021). They need to show proof to the courts that other alternatives were explored and would not be appropriate for the patient before placing a person with mental health issues into a facility involuntarily (Perlin, 2018).

The second court case from 1972 is *Wyatt vs. Stickney* from Alabama. This court case determined that most people with mental health illnesses did not need long-term institutionalization because treatment would be successful (Perlin, 2018). It was found that the patients were not receiving adequate treatment, and their rights were being violated because they were being held behind the walls of the facility when they did not need to be (Perlin, 2018). The main purpose of this court case was to help the patients assimilate back to their community and

live as normal a life as they could. The Wyatt Standards were developed from this case, and this consisted of three standards that all mental health facilities needed to follow for their patients. The facilities needed to have a humane and safe environment, qualified staff and enough workers per patient, and individualized treatment plans for all patients (Perlin, 2018).

O'Connor vs. Donaldson was tried in 1975 by the Supreme Court. This case helped define what is required for a commitment order. Just because a person has a mental health illness does not mean he should be confined in a facility against his will (Perlin, 2018). A person has to be in immediate danger to himself or others or is not capable of living on his own without the assistance of family, friends, or other live-in help (Perlin, 2018). In 1999, the Supreme Court ruled in the case of *Olmstead vs. L.C.* Mental health was being looked at as more of a disability, and people with a mental health illness were being given more rights under the Americans with Disabilities Act (Perlin, 2018). By giving individuals with mental health issues more control of their treatment options and more rights, police officers are not able to force people into going into treatment that they do not want to do. Unfortunately, if a person is not a danger to themselves or others, and they choose not to receive services at the time of interaction with the police officer, then that is their choice, even if it is clear that they need some kind of treatment (Perlin, 2018). These are the patients who will have more contact with the police because they are not stable on their medication or any other treatment.

Consequences of Deinstitutionalization

Homelessness

Once mental health facilities that were run by the state started to decrease, patients were expected to enter treatment in community-based programs; however, these programs were not

structured enough for some of the patients, and this led to a large number of individuals becoming homeless because they had nowhere to go. Family members were not equipped to deal with the angry outbursts or unpredictability of their loved one's behaviors or moods, so they would give up and push their relatives out of the home and out into the streets. Since there is a lack of shelters in many cities, many homeless people have to live on the streets, and then this is when they start interacting with police officers. Police officers encounter homeless people with mental health issues in many different situations. A concerned citizen may contact the police because the individual is not making sense or acting erratic, and the citizen is concerned for the person's safety and the public's safety. The individual may be a victim of a crime or a suspect of a crime, or an officer might want to just talk to the person with the mental health issue to offer some shelter, food, or supplies since the person is homeless (Batko et al., 2020).

According to the United States Interagency Council on Homelessness (2020), in Wisconsin, 22% of the homeless population had some type of mental health illness. When an individual has symptomatic behaviors due to their mental health issues, such as screaming at nothing in particular, talking to oneself, or causing a scene, the police will be the first agency called to check on the person due to safety concerns (Batko et al., 2020). If the person has harmed someone or committed a crime, then officers will have to enforce the law by taking the person to jail; however, if an officer is trained in noticing an individual may be having a mental health crisis, then the officer can take the individual to a crisis center or emergency room for an evaluation and possible in-patient/voluntary services.

With the closure of the state-run facilities, there are fewer psychiatric beds for individuals who want to go in-patient voluntarily, so if the person does not meet the requirements to be admitted, then he will be on the streets again. If a person with mental health needs is able to get a

bed, their stay at the facility is normally short because there is a quick turnaround since there are so few beds available for everyone who needs assistance (Batko et al., 2020). The person is normally not fully stabilized if the stay at the facility is only for a few days, and they are back on the streets where they will most likely have contact with police officers again. Chaptering an individual with mental health issues is the last resort, and this can only be done if the person meets the statutes put forth by a state. If there are no facilities available to take the individual, and the police believe that a crime was committed, then the person will be arrested and spend time in jail.

Most of the time, the offenses are minor, but eventually, the person begins to realize what they can do to get arrested so that they do not have to spend another night on the streets (Batko et al., 2020). This begins the cycle of more police contact.

Increased Police Contacts

After deinstitutionalization, police contacts with individuals who are mentally ill increased over 200% (Wood et al., 2017). Mental health-related calls for officers are called non-law enforcement-related calls when no arrests are made or officers are not enforcing some law. Mental health calls take officers off of the streets and into hospital settings where they spend a lot of time waiting on mental health professionals to perform evaluations, to get the person to calm down, or to transport for a chapter (Wood et al., 2017). These calls take officers away from criminal matters and other services that officers are used to doing. According to a survey conducted by Wood et al. (2017), police officers like to go where the action is instead of sitting around seeing if a person is going to be sent home, go in-patient, or be chaptered.

First and foremost, officers are not mental health professionals. They are trained to handle crisis and stabilized situations, but they are not equipped to offer specific services to individuals or conduct assessments for a person's mental health needs. Since people with mental health issues are unpredictable, police officers must be a lot more careful at these calls because they are more likely to be injured (Wood et al., 2017). Family and friends do not want their loved ones to get hurt, so they do not tell dispatch exactly what is happening on the scene, so officers are walking into a situation blindly. This is why officers need to proceed with caution when going out on mental health calls. Administration does not want any injured officers or injured or killed civilians. Extra force is not needed if proper training is put into place when out on mental health calls (Wood et al., 2017).

Force Used Against the Mentally Ill (Arrest or Chapter)

According to Crissman (2019), police do not feel that they are trained or experienced enough to handle calls that include people with severe mental health disorders. Since people with mental health disorders can be unpredictable and hostile towards officers and others around them, this can cause fear, anxiety, and uneasiness in the officers on the scene. The situation may become unsafe due to the person not complying with an officer's orders or the person's behaviors escalating to violence towards others, sometimes requiring the officer to use force. This may be in the form of pepper-spraying an individual, taking the person to the ground, or shooting the individual (Crissman, 2019).

According to the research of Frederick et al. (2018), police are interacting with people with mental health disorders about 37% more than before deinstitutionalization occurred. Police officers are dealing with citizens who are suffering from panic attacks, depression, suicide attempts, schizophrenia, bipolar disorder, and visual and auditory hallucinations. Police officers

are trained to assess the situation, make sure everyone is safe, and use the least level of force as possible; however, a person with mental health issues can have erratic behaviors from the start, this can put the officers, the individual, and anyone around them in a dangerous situation (Frederick et al., 2018). Being trained to use de-escalation skills whenever possible would decrease the chance of unnecessary force having to be utilized; however, Frederick et al. (2018) determined that police are 18 times more likely to shoot at a person with a mental health illness due to the person's unpredictability, erratic behaviors, and the officer not having the proper training to handle a person with a mental health disorder.

When an officer encounters a person with mental health issues, they have to determine if the situation calls for an arrest, a chapter, or services for the individual. This all depends on what the individual is going through at the time of the encounter. As stated previously, a person's rights cannot be taken away just because one has a mental health illness. There are policies and procedures put into place, so no one abuses their authority over another human being (Roy et al., 2020). Roy et al. (2020) reported that police officers need to learn to recognize when someone with a mental health illness is homeless and not necessarily trying to be a nuisance or disturbance to the public. The officers need to take a little more time to figure out what the individual needs instead of just assuming that this person is intentionally causing a disturbance and then arresting the person. People who are mentally ill may not receive any mental health services if they are arrested a placed in jail. They might get a warm place to lay their head and some food in their bellies, but this is not going to help them after they get out.

Reinstitutionalization of the Mentally Ill

One of the main goals of deinstitutionalization was to get patients with mental health issues out of mental health facilities and into community-oriented treatments; however, without

proper mental health care or proper police training, people with mental health issues are being reinstitutionalized into jail or other mental health facilities, if there are open beds (Frederick et al., 2018). According to Yang et al. (2018), the L.A. County Jail, the Cook County Department of Corrections, and Rikers Island in New York contain more people with mental health illnesses than any of the mental health facilities that are still opened in the United States. By placing people with mental health issues in jails or prisons, they are not receiving adequate treatment for their mental health, and this can lead to more aggressive behaviors and higher rates of recidivism (Frederick et al., 2018). As previously stated, the goal of getting these individuals out of confined places and into community-oriented treatment services is not working when the individuals are being placed into a jail cell which is another confined space.

Another goal of deinstitutionalization was to save money by closing down some of the psychiatric hospitals and using community-oriented treatment services; however, by housing people with mental health issues in jails and prisons, the money is being moved from the mental health system to the criminal justice system instead (Frederick et al., 2018). Clinicians, crisis workers, psychiatrists, and other mental health professionals are not able to provide recently released inmates who have mental health diagnoses with proper services because there are not enough funds to disburse to community treatment centers, resources, and housing programs in the area (Frederick et al., 2018). Police officers encounter individuals with mental health disorders on a routine basis and are able to get to know what is needed or not, eventually.

Each county and state is different with who can chapter a person. In Kenosha, WI, a police officer, and a crisis worker can chapter an individual who meets the criteria put forth by the state. Both parties have to be in agreement to move forward with the chapter, or another form of plan will need to be figured out. When a person knows that he may be getting arrested, he may

start yelling that he wants to kill himself. The officers have to take this statement seriously, even though the individual may only be doing this to prolong the inevitable jail time. The police officers will have to spend more time with this individual to make sure that he is not suicidal and does not require more intensive mental health treatment, such as being chaptered (Roy et al., 2020). If an officer just ignored the suicidal statements by an individual and that person killed himself while in jail, then there would be a lot of questions that would need to be answered. Police officers have an obligation to ensure that people who are mentally unstable get the care that they need so that the individual does not harm himself while in police custody (Roy et al., 2020).

Police officers are usually the first on the scene and spend the least amount of time with someone, and they have to make decisions in a timely manner. Officers have limited background information on individuals when they meet them, and sometimes the information they do have is not correct. The officers have to decide on whether the person needs mental health or medical assistance or should be arrested for a crime. This is a lot of responsibility for police officers who are on the streets.

Yang et al. (2018) found that even if police officers know the individual they are dealing with needs mental health assistance, there is only so much they can do for the person due to the mental health system and the way that it is run. Sometimes the emergency rooms are backed up, and there are long waiting times or no beds available for people who want to go in-patient. If a person does not meet the requirements to be chaptered, then a mental health professional or crisis worker has to come up with a safety plan with the person, and most of the time, this means the person is going back on the streets (Yang et al., 2018).

METHODOLOGY

The methods of approach utilized for this paper consisted of reviewing scholarly articles that have been peer-reviewed, websites, law enforcement agency policies for mental health situations, and any other secondary research and statistics pertinent to this subject matter. The information was pulled from sources from 2017-2021 to have as much current information as possible. Statistical information from the National Alliance of Mental Illness (NAMI) and the National Institute of Mental Health (NIMH) about the interactions between individuals with mental health illnesses and law enforcement was analyzed. Studies on officer training were looked at to see what is being offered on mental health and what should be offered to officers to provide them with the tools and strategies to work with people with mental health illnesses and in crisis situations. Qualitative studies and data were searched to gather the information that pertained to the significance of police officers using de-escalation strategies with individuals with mental health illnesses instead of force when approaching them on calls. Peer-reviewed papers and websites were reviewed to gather research on the history of mental health deinstitutionalization and how to get people with mental health illnesses into treatment instead of incarcerated.

A review of the Crisis Intervention Training (CIT) Program through Memphis, Tennessee, was analyzed. The CIT program was first developed in Tennessee to coordinate efforts between law enforcement agencies, mental health facilities, city governments, and people who are in a mental health crisis (Schucan & Schemilt, 2018). Crisis Intervention Teams from different cities, Menasha, WI and Portland, Maine, and others, were reviewed to see how other cities and states handled mental health situations. By analyzing this research, it was determined

that additional training and program implementation in mental health services is needed by law enforcement agencies to provide better service to the mentally ill when out on calls.

PROGRAM EVALUATION RESULTS: CURRENT EXAMPLES OF LAW ENFORCEMENT

Mental Health Interventions and Programs

Mental health calls are more frequent for police officers these days, and police administrators have recognized that there is significant room for growth when it comes to responding out to calls with individuals with mental health illnesses. In the past, police officers did not know how to de-escalate situations when responding to a person with a mental health crisis, and they did not know how to differentiate between someone who needed treatment or needed to be arrested. Police officers have always been trained to use force and then ask questions later, but in more recent years, police officers have been using training and skills to be more proactive and problem-solve with the help of mental health professionals. Properly addressing immediate concerns and dealing with issues with people who have a mental health illness before they get out of control is one way for police administrators to start moving forward in their agency. The way that this can be accomplished is by implementing Crisis Intervention Training for all law enforcement staff, developing crisis intervention teams with mental health professionals, social workers, and psychologists/psychiatrists, and offering more thorough trainings in the pre and post-police academy trainings.

Crisis Intervention Training (CIT)

Crisis Intervention Training (CIT) was developed in 1988 in Memphis, Tennessee, with a collaboration between the Memphis Chapter of the National Alliance on Mental Illness (NAMI),

the University of Memphis, and the University of Tennessee (Barrus, 2019). CIT was developed and implemented after police killed a mentally ill man who had a knife and was attempting to kill himself, but when police arrived, he charged at the officers while still holding the knife, and officers did what they are trained to do, they opened fire on the man. If officers were trained in de-escalation tactics and how to engage with individuals with mental health illnesses, the situation may have ended differently (Barrus, 2019). The CIT is a 40-hour course taken by police officers, dispatchers, administration, emergency room staff, and others in law enforcement who might be in contact with individuals who are mentally ill. Officers are taught how to effectively respond and interact with people who are in a mental health crisis and how to use de-escalation techniques (Barrus, 2019). CIT provides safety to police officers, citizens, family members, and individuals with mental illnesses when officers are called out on a scene. The training also provides officers with problem-solving skills when interacting with individuals with mental health illnesses (Barrus, 2019).

According to the University of Memphis CIT Center (2019), the main goal of CIT is to de-escalate the mental health crisis so the person does not end up being arrested and sent to jail. Participants are not just given techniques on how to de-escalate mental health crises during the training; they are also provided with instruction on cultural awareness, psychotropic medications and side effects, suicide intervention, community resources, and understanding some mental health diagnoses (University of Memphis CIT Center, 2019). According to Perez (2018), participants are taught the skills in a lecture-based format except in two sessions where there are role-playing exercises and scenarios played out by veteran CIT officers. The scenarios start out easy and then get more complicated so that the participants can see a variety of situations that they may be in when out on calls. Some of the scenarios show the participants what happens

even if the techniques are utilized and do not work with the person. The training was designed for the participants to learn from the successes and failures since not every situation is a success in real life.

CIT uses more of a compassionate approach when working with individuals who are in a mental health crisis or who have a mental health illness. This component of the training is huge in its success because it makes the person calmer and less stressed out in the situation. Most people are afraid when interacting with the police, so when an officer is more understanding and compassionate, it shows in their actions and the way they speak (Perez, 2018). The training allows officers to develop rapport with people who have mental health issues, and this can lead to shorter de-escalation times, more positive connections, smoother transitions to treatment programs, and to a safer environment for all involved (Perez, 2018). By utilizing the techniques properly, officers who are trained in CIT have been able to offer more resources and get individuals the mental health services that are needed instead resorting to arrest. In some circumstances, officers will have to arrest an individual who has mental health issues if any laws had been broken.

A study conducted by Ortiz et al. (2021) about officers who were trained in CIT and how they interacted with individuals who had mental health illnesses compared to officers who were not trained in CIT showed some positive results. Ortiz et al. (2021) found out that the trained CIT officers spent an average of 82 minutes with individuals with mental health issues and asked three times as many questions compared to officers who were not CIT trained. During the study, all of the calls dealing with a person with a mental health crisis were resolved on the scene or transported to the hospital for treatment. No one was arrested or taken to jail (Ortiet al., 2021). Throughout the duration of the study, Ortiz et al. (2021) were able to see that CIT officers have

been able to keep individuals with mental health illnesses out of jail and into treatment, and the collaboration between the police and mental health staff has opened up tremendously and the community has started to feel safer and supported.

Perez's (2018) research showed that CIT-trained officers utilized the de-escalation techniques that they learned, and this, in turn, decreased the amount of physical force or use of weapons needed on a call with individuals with mental health illnesses. From the Chicago Police Department to the Los Angeles Police Department, there has been documented proof that officers who have gone through CIT are less likely to draw their weapons, use restraints on a subject with mental health illness, or cause injury (Barrus, 2019). Police officers are trained to use force when necessary to always keep everyone safe - including themselves. When they are able to de-escalate the situation with words and assess that the person is not a danger to himself or others, then force is not needed to control the situation. Unfortunately, there are some circumstances where force is necessary when all other measures have been utilized.

Crisis Intervention Teams

Crisis intervention teams have been developed in law enforcement agencies around the United States. Law enforcement officers are teaming up with mental health workers, social workers, and psychologists/psychiatrists to serve the mental health population better. By going out on calls together and collaborating on cases, police officers and individuals working with the mentally ill are able to get the person the care and treatment that they need.

Mental Health Workers and Police Officers

Perez (2018) mentioned that the Watsonville Police Department in California developed a position in their department called a mental health liaison who works alongside one full-time

police officer in the Crisis Assessment Response Engagement Team (CARE Team). This team responds to calls regarding individuals who are having a mental health crisis. The mental health worker can assess or evaluate the individual on the scene and determine if the person needs to be provided resources or actually needs to go to the emergency room to find a bed at a treatment facility (Perez, 2018). Having the mental health liaison with the officer on the scene frees up other officers for other calls and unnecessary trips to the emergency room, especially if all the person needs is resources. Perez (2018) stated that another component of the CARE Team is that they provide follow-up to the individual and the family. The team makes sure the person is receiving food, shelter, medication, therapy, and other services needed to do well in their life.

According to Morabito et al. (2018), in 2017, the Boston Police Department received a total of 681,546 calls for service, and 5,953 of those calls specifically involved people with mental illnesses. The Boston Police Department developed a Crisis Intervention Team due to these high mental health calls. There is a master's level clinician who rides along with a police officer, and they respond to mental health calls during the shift (Morabito et al., 2018). Before the Boston Police Department implemented the Crisis Intervention Team, there were three outcomes that would happen when officers would encounter a person with a mental health illness. The first solution was very costly to the patient, and this was to take the patient to the emergency room to be checked out, but most patients do not need medical care at all, only mental health services. A second solution was to offer the person mental health services that the person was to follow up on, and the person never did, so officers were called to the home on other occasions. And a third solution was arresting the person and involving the individual in the criminal justice system (Morabito et al., 2018). None of these solutions seemed to work, so this is when having a mental health professional on the team was developed. The clinicians can

evaluate, assess, intervene, and stabilize an individual in a mental health crisis right at the scene instead of moving the person to an alternate place (Morabito et al., 2018). If a clinician feels that the person needs in-patient treatment, out-patient treatment, or a safety plan with the family, then the clinician will be able to discuss the options with the person on the scene without anyone having to wait for the clinician to arrive. According to Morabito et al. (2018), not all officers on the force buy into having the crisis intervention team and have clinicians riding along with them on calls because this is one more person they have to protect during a call, but by having the clinicians on the scene, the situations have ended peacefully and calmly, and no one has been hurt.

Social Workers and Police Officers

Police officers and social workers have been working together for years to ensure the safety of children and others in the community. When it comes to people who have a mental health illness, police officers do not normally rely on social workers. They rely on their training and if they should arrest or not arrest a person. Nowadays, things are different, and police officers and social workers are collaborating more on keeping the community safe, especially when it comes to opioid and other drug use (White et al., 2021). Mental health illnesses and drug or alcohol use go hand in hand. Social workers have been trained in stabilization and de-escalation techniques, interviewing skills with abused children and mentally ill victims, stress management, and identifying resources in the community compared to most police officers (White et al., 2021). By working with social workers on a case, whether in a hospital, mental health, or a child protective services settings, police officers will be able to learn some of the skills the social workers use to communicate with individuals who are mentally ill, homeless, drug users, or all three (White et al., 2021).

In Lumberton, North Carolina, a program called Social Work and Police Partnership (SWAPP) was developed by the Lumberton Police Department. Like many programs where officers have to work with outsiders, there were many officers who were resistant to work with social workers on substance abuse treatment for victims and suspects, but once officers realized that by working with the social workers and helping the underserviced population, there were not a lot of repeat calls due to the resources that were offered (White et al., 2021). By working with social workers, officers have been able to cut their call times shorter when working with people with mental health illnesses and drug and alcohol issues because the social workers are able to step in and take over. Once the threat of danger has been cleared, the officer is allowed to leave the scene, and the case can be taken care of by the social worker.

Psychologists/Psychiatrists and Police Officers

Some law enforcement agencies utilize psychologists and psychiatrists when dealing with people who are mentally ill. If there is funding in the budget, some police departments will have a psychologist or psychiatrist on staff to evaluate inmates who are suicidal or have a mental health diagnosis when booked into jail (Rosenbaum et al., 2017). Most psychologists or psychiatrists are utilized during tactical situations when they are needed with the crisis negotiation team, though. According to Rosenbaum et al. (2017), 52% of all hostage situations are started by someone with a mental health illness. As stated in the previous section, police officers have a hard time accepting outsiders into their circle, so working with psychologists and psychiatrists is even harder for some police officers because they often do not trust someone higher up in the mental health profession (Rosenbaum et al., 2017). Rosenbaum et al. ‘s (2017) research shows that there needs to be a mutual acceptance between both professions and an understanding of each other’s roles during the situation. Often psychologists or psychiatrists act

as consultants for the police instead of being out in the field with them. By being a consultant, the psychologist or psychiatrist can offer his point of view on mental health issues, behavioral patterns, strategies, and negotiations (Rosenbaum et al., 2017). A psychologist or psychiatrist can assess suspects while they are on scene, provide training to officers on negotiating techniques, and provide treatment to the officers after a serious event (Rosenbaum et al., 2017). By utilizing psychologists or psychiatrists during negotiations or for evaluations on mental health, inmate shows that police officers are willing to let others into their community so that others can be helped.

Use of Technology in the Field

Technology has helped police officers when they are in the field working with people with mental health illnesses. Strom (2017) stated that body-worn cameras are able to be viewed by mental health professionals when they are not on the scene experiencing the person's mental health crisis from the start. Police officers have been able to show social workers, case managers, and other professionals exactly how the person was acting or what the person was saying before the professional arrived on the scene. This evidence could be crucial in what happens next. When officers were first asked to start wearing body-worn cameras, there was some pushback from some of the officers because they felt like they were not being trusted to do their job in the field (Strom, 2017). Actually, the opposite is true; the people the officers are stopping cannot be trusted to tell the truth most of the time. When there are no cameras around, what happens becomes a "he said she said" situation, and this does not always end well for one of the parties.

The use of computers and tablets in the field has become popular in some police departments, especially the ones that have crisis intervention teams or work closely with mental health professionals. In several of the police departments in New York, police officers are able to

connect with a mental health clinician by accessing the person via a computer or tablet while in the field (Bauer, 2020). By using this technology, officers do not have to wait for a person to come to the scene. A clinician can talk to the individual who is in the middle of a mental health crisis and can conduct an evaluation or assessment and offer resources right on the spot. Officers are all equipped with cell phones, too. If a person with a mental health illness does not want to go to the hospital or anywhere else but he is willing to speak to a clinician or crisis worker over the phone, officers can use their cell phones to make that call (Bauer, 2020).

Medical apps are now able to be downloaded onto cell phones, so this is another technology tool that assists people with mental health issues (Bauer, 2020). These apps allow the person with the mental health illness to develop a profile with information about their disorder, add in what triggers worsen their situation, how they can approach the situation, and what coping skills or de-escalation tools can be utilized in the moment (Bauer, 2020). If this information is in the app, then police officers will be able to access it and review the information before talking to the person. By having this information, the officers can effectively communicate and de-escalate a situation that is occurring and keep everyone safe at the scene.

Increased Pre-Academy and Post-Academy Training

Police officers today are required to wear more equipment and tools on their bodies than ever. Body cameras, tasers, and guns all require in-depth training from qualified instructors, so when officers are sent out into the field, they know how to keep themselves and everyone else safe. Due to the increase of mental health calls that officers have to respond to on a daily basis, police officers are required to be trained in mental illness strategies, such as de-escalation techniques, problem-solving, and how to work collaboratively with other agencies. Providing the

skills needed to work with the mentally ill population during pre-and post- academy training is necessary for officers to engage with individuals who are mentally ill and to keep everyone safe.

Pre-Academy Training

Police academy training is where police officers learn how to become successful in their job duties, especially when they go out in the field. Blumberg et al. (2019) found out that pre-academy training was more like military-style training with physical demands, a high standard of discipline, and building up camaraderie. Most of the focus of the training is on tactile skills and situations and how to fire weapons and be on the defense. The authors also determined that the recruits were not being fully trained in how to work with people in the community and how to communicate efficiently and effectively (Blumberg et al., 2019). This makes sense since officers need the tactical skills to keep themselves and others safe when they are on the field, but being able to de-escalate situations and communicate effectively with others can also help keep people safe. Blumberg et al. (2019) determined that during pre-academy training, recruits are only receiving 10 hours of mental illness training compared to 168 hours of firearms, self-defense, and use of force training. Depending on the police department, this may be the only mental health training officers receive in their career. Because officers are dealing more with mental health calls, there is a need for them to take continuing training on mental health by attending the 40 Crisis Prevention Training.

Post-Academy Training

Law enforcement agencies in the United States have noticed that there is a lack of mental health training in their pre-academy training, so this is being addressed after officers have been hired by having them take extra courses and trainings on mental health and dealing with people

with mental health issues. According to Fiske et al. (2021), when officers participate in the mental health training that is offered by their department, they learn to understand better mental illnesses and the impact that mental health has on the individual, family, and community. Officers also learn to identify signs and symptoms of mental illnesses, how to utilize a range of stabilization and de-escalation techniques, and what resources are available in the community for the individual and family (Fiske et al., 2021). The Crisis Intervention Training that is utilized by most of the law enforcement agencies has a role-play component to the training. This section engages the officers in true-to-life situations in dealing with people who are in a mental health crisis and how to utilize the skills that they used without having to use force.

Several states have mandated their officers to take Crisis Intervention Training due to several cases where excessive use of force has been used on a subject who was mentally ill. In Minnesota, in July of 2018, all law enforcement officers are required to complete a 16-hour course in crisis response and conflict management within their first three years of employment (Crisis Intervention Training, 2021). According to the Minnesota Department of Public Safety (2021), all officers will be trained in Crisis Intervention Training along with the crisis response and conflict management course. In California, officers are required to take a mental health training course every two years to stay up to date with working with people with mental health issues (Mental Health Training in Law Enforcement, 2021). Every state has its own requirements for how many hours a training is supposed to be, what training it is going to be and who is required to take it. Police departments should not wait for their officers to kill a person who is mentally ill before implementing training that can save a life.

RECOMMENDATIONS FOR LAW ENFORCEMENT AGENCIES

Mental Health Programs in Law Enforcement

Crisis Intervention Training (CIT) should be required for all staff in law enforcement and a refresher course should be given every two years. By making CIT a mandated training, all officers will be educated on techniques on how to de-escalate situations with people with mental health issues, and they will be able to understand some mental health disorders. Officers will have a better understanding on how to approach an individual who may have schizophrenia and may be having visual hallucinations (Roger et al., 2019). For police officers who want to be more involved in mental health calls, then a Crisis Intervention Team can be developed. These officers will be utilized to manage the majority of mental health calls and be called upon when their fellow officers need assistance with de-escalating a situation.

The Crisis Intervention Team would not just consist of only police officers. There would be mental health professionals, crisis workers, nurses, and doctors who are all trained in CIT to assist with the person. With the combination of CIT and all of the other skills the professionals bring, the Crisis Intervention Team will be able to manage situations that arise and keep the person with the mental health illness safe and everyone around him safe, too. With medical staff on the team, officers will spend less time in the hospitals and more time back on the streets.

Crisis Prevention Training for all Law Enforcement Staff

To make a successful mental health program within a police department, all staff working with the public should complete Crisis Intervention Training - especially 911 operators. Police officers are the first people on the scene dealing with people with mental health illnesses face to face; however, 911 operators are talking to the person or family member of the person with the

mental health issues on the phone, trying to get information on what is happening before an officer goes out. It is important for the 911 operator to gather as much accurate information as possible, so the officers know what kind of situation they are responding out to at any given moment. If the 911 operators are not adequately trained to recognize mental health calls before sending out officers, someone might get harmed. Without proper training, 911 operators may get the person with mental health illness more aggravated and upset, so when officers arrive on the scene, the situation may be more heated than it needs to be. When officers respond to mental health individuals who are agitated, problems may arise, and negative outcomes may arise (Shulski, 2020). 911 operators and police officers should go through the Crisis Intervention Training before they start their first shift, and the training should be geared towards their specific positions since each role is completely different (Shulski, 2020). The Crisis Intervention Training can assist 911 operators and police officers de-escalate situations with individuals who are in a mental health crisis, so no one gets harmed.

Any staff member in law enforcement who is dealing with a person who has mental health concern should have CIT. This way everyone in the department is using the same language and same skills when managing a mental health situation.

Challenges With These Programs

With any kind of program, there are challenges. The Crisis Intervention Training is not always offered when law enforcement agencies need their staff to be trained. Unless law enforcement agencies have someone on staff who is certified as a trainer for CIT, then administration will have a challenging time training their officers during the academy, and their other staff members as they are hired (Wood & Watson, 2017). Another challenge is that law enforcement agencies and 911 operator communication centers are understaffed and busy, so

pulling officers and staff members to take a 40-hour training is time consuming and causes more staffing issues. One more challenge is getting officers, mental health professionals, doctors, and nurses together to develop a Crisis Intervention Team. Once everyone is on board, then there can be a successful program. Until then, doctors, nurses, mental health professionals, and police officers will be disagreeing on the best action to take for a person with mental health issues (Wood & Watson, 2017).

According to Wood and Watson (2017), geographic location is another problem for law enforcement agencies when it comes to implementing a Crisis Intervention Team and having their officers take the Crisis Intervention Training. Smaller departments do not have the resources to send their officers to the larger cities for the trainings or to sacrifice the officers since the department is so small. Even if a police officer, in a small town, deals with a person with mental health crisis, that person will have to travel outside of the town, and probably a fair distance, to receive the help that is needed (Wood & Watson, 2017). In this situation, it is better for the officers in the rural areas to be trained in crisis intervention so that when they are dealing with a person with a mental health crisis, then the person is receiving care that is beneficial to him instead of being arrested or harmed.

Building Partnerships With Citizens who are Mentally Ill

The most important part in developing any mental health program is getting the citizens involved, especially the mentally ill, because these are the people the police are going to be encountering. There has to be a level of trust among police officers and the public when it comes to mental health. Because of the media showing video after video of officers shooting people with mental health disorders instead of de-escalating a situation, citizens do not want to contact dispatch to have officers come out to their homes but at times it is necessary. With 911 operators

asking the right questions and relaying pertinent mental health related information to the officers, everyone can be safe, and the person with the mental health crisis can get the help that is needed. Officers collaborating with the families of the person who is mentally ill and the citizen who is mentally ill makes everyone more comfortable when in a stressful situation. When a situation is managed successfully, the family and the patient will remember the experience and be more inclined to contact the police before the situation escalates to an emergency situation where someone gets hurt. When the situation is managed poorly because of untrained officers or staff members gathering information, then citizens are more likely to take matters into their own hands and the situation could become deadly. By building partnerships with the citizens in their community, officers are able to know how to de-escalate individuals when a call comes through their department and make sure everyone is safe and gets the services they need.

Choosing Officers

Having police officers and staff who are not interested in participating in CIT and being on the Crisis Intervention Team can be detrimental to the force. Any officer who has reservation about being trained in how to de-escalate a situation with a mental health subject or learn about mental health disorders should re-evaluate being an officer in this day and age since officers are the first ones on the scene when a person is having a mental health crisis and pulling out a gun and threatening this person is not the best response. During the police academy, officers are trained to keep everyone safe at all costs and this means if they have to shoot someone, then they have to shoot someone (Wood & Watson, 2017). When dealing with a person with mental health illness, there are a lot of unknowns and impulsivity, so officers need to be alert, but not necessarily use up to lethal force. Officers can be trained on how to de-escalate the person and keep everyone safe without even having to draw their weapon.

Research has shown that officers who decide to volunteer to be a part of CIT and the Crisis Intervention Team have experienced someone in their life dealing with mental health issues or have dealt with these issues personally (Wood & Watson, 2017). These officers are the ones who will go out of their way to find services for the individual and even follow up with the person to make sure that everything is fine. When an officer is forced to take the training and do something they do not believe in, they will not spend extra time with the person with mental health needs and want to get out where the action is. Every call is important, even if it is just assisting an individual with determining if they need to go in-patient or need more support. Rogers et al. (2019) determined that people who volunteered their time to train and become a part of the Crisis Intervention Team had better jail diversion outcomes when they were in contact with individuals with mental health illnesses. These officers are better at de-escalation techniques, have more resources for the families, and have a better attitude towards the person because they want to help and are willing to take the time to help (Rogers et. al., 2019). Sending all officers to CIT is beneficial; however, when it comes to assigning officers to the crisis intervention team, it is best to have officers who are willing to collaborate with people who are mentally ill instead of assigning officers.

CONCLUSION

Due to deinstitutionalization to remove mental health patients from mental health facilities, police have had an increased number of contacts with individuals who have mental health illnesses. Deinstitutionalization was supposed to have patients receive community-based treatment and go in-patient in facilities that were not long term, but funding was low, and the programs were underdeveloped, so people with mental health issues were displaced and became homeless since their family and friends did not want to or could not help. The lack of structure

and treatment for some of the people with mental health illness caused increased contact with the police.

Police officers are first responders and are now called out to homes and other areas around town to deal with people with mental health issues. If a police officer has improper training to deal with mental health issues, then there can be negative outcomes, such as the person being sent to jail or lethal force being used. Administrators have noticed that people with mental health issues do not need to be incarcerated, they need mental health services. Unfortunately, a crisis or horrible situation had to happen before change is implemented. In Memphis, TN in 1988, an African American male, who was mentally ill, was fatally shot, and this opened up the eyes of some law enforcement administrators, and they sought out a training that had been developed to assist officers and others when managing people with mental health illnesses. This training is called Crisis Intervention Training (CIT). When CIT is utilized as it was written and developed, police officers who are trained have shown the ability to reduce the use of deadly force, reduce taking people with mental health illness to jail and de-escalate situations before they become worse.

The lack of mental health training that law enforcement officers receive in the police academy has been noted by administrators. The states do not require police officers to have an abundance amount of training on mental health. Each individual law enforcement agency will need to implement a program for their officers that has classroom instruction and real-life scenarios. Then, the officers can practice what it will be like when encountering an individual with a mental health crisis or just a mental health illness. These scenarios are really important when it comes to officers implementing the trainings in the field. Post-training for officers should include more CIT so that they keep up with their de-escalating skills, basic knowledge of

common mental health diagnoses, and how to keep everyone safe in situation without having to use force.

According to Rogers et al. (2019), there are over 2,000 law enforcement agencies in the United States that have made the CIT mandatory for all officers and other staff members. But requiring officers to take CIT is not enough, each department should develop a mental health crisis unit where officers respond out on calls with mental health professionals so that they can be more productive and work for the person with the mental health illness instead of against. Officers should volunteer to be a part of this unit and not be told that they have to do it because then the program will not succeed. Rogers et al. (2019) found that officers who were told that they had to join the mental health crisis unit did not work well with the mental health professionals and tried to rush through their calls with the people who had a mental health crisis. Due to funding, most departments are not able to develop and implement a Crisis Intervention Team because there just is not any money to do so.

A positive of having a crisis intervention team is the officers can start developing positive relationships with the people who have mental health illnesses. 911 operators will have a better understanding of the individual's needs if the person is a frequent caller and better information can be relayed to the officers. By having a Crisis Intervention Team, a person with mental health issues may start taking his medication because the team will be asking if he has taken his medication, and if he has not, they will make sure he does. Officers will be able to develop a better sense of what services and resources are in their county for people with mental health needs.

Police officers have hard enough jobs as it is by trying to keep the citizens of their city safe from the criminals all around. Most officers say they do not have time to deal with people

who have mental health issues unless they are committing a crime, but by developing an understanding of mental health services in their city and being able to de-escalate a situation so it does not get out of hand, a police officer can really make the city a safer place for the person with the mental health illness and everyone else.

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