Improving Police Mental Health Response

Officers trained in crisis intervention and psychological first aid can work with mentally ill subjects and prevent tragedies.

Officer John Jones of the Miami-Dade Police Department was the first to arrive at the dilapidated house in a poverty-stricken section of the city. He and his fellow officers had been summoned to the address by a caller who had alerted police that a depressed 18-year-old mom was threatening to hurt her 3-month-old son.
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Jones remembers it was a strange scene. Though police and sirens were blaring as backup arrived, a young man stood in the front yard on his phone, looking unfazed. Jones took out his TASER when the man seemed hostile at the unfolding scene. But the man was more antagonistic and sarcastic than violent, and he eventually pointed officers to a walled-off efficiency apartment.

Jones peered into the room.

"I saw the mom on the bed, with the child in her arms. But she was rocking the baby very aggressively," the 18-year law enforcement veteran says. "I could see she had been crying, but she was almost in a trance."

Jones holstered his TASER.

"I sat down on the bed, next to her, not too close, just like we were going to have a conversation," he says.

With other officers now on the scene, including one who was with the young man, he knew he had backup. There were no weapons, so Jones could work to defuse the situation.

"And then I just started talking to her about the child," he recalls.

What a beautiful baby.
What's his name?
How old is he?
Look, he's smiling!

Within minutes, the woman smiled through her tears when the baby smiled—and she handed him to Jones.

"She calmed down, and she was able to make a call to her family to take the baby. And we took her to a hospital," he says.

"She just didn't want the baby to grow up with what she had to deal with growing up," Jones says she later confided.

She was thankful. "This was not a violent criminal. When she realized she was getting help, she was at ease," Jones says.

Jones isn't an expert in post-partum depression or a licensed mental health professional. He's an experienced police officer who has been trained in crisis intervention, and that night his training as a Crisis Intervention Team member kicked in. He says before his CIT training, he may have ordered her to put the baby down, which would have been a big mistake.

In 2010, there were 45.9 million adults in the U.S. with mental illness, according to the Substance Abuse and Mental Health Services Administration. With 20% (5% with a serious mental illness) or one in five Americans dealing with anything from depression and anxiety to psychosis, it’s a significant population. And while mass shootings are most prominent in the nation’s mind, mental illness is often part of the common calls officers face, including domestics, substance abuse, emotional distress, armed persons, and suicide by cop.

THE MEMPHIS MODEL

Crisis Intervention training has become a critical tool for law enforcement agencies. The program teaches first responders strategies to safely maneuver through situations involving the mentally ill and then compassionately direct individuals—often the subjects of the calls—into treatment. The training and the actual crisis intervention teams have been shown to reduce injuries and use of force by officers, and lower arrest rates.

"CIT brings clarity in a crisis," explains Sam Cochran, a retired officer who served with the Memphis Police Department and now works as project coordinator of the University of Memphis CIT Center. Cochran was one of the founding members of the Memphis CIT, which was created in 1988. After a 1987 shooting, the mayor convened a task force, which eventually became the long-standing "Memphis Model" now in use by some 2,800 agencies nationwide.

CIT is designed as training for uniform patrol officers who respond to calls about emotionally disturbed persons. But the team members also work as specialists that respond to calls for support from other officers who are dealing with people experiencing mental health crises.

Standard CIT training is a 40-hour program that covers everything from psychotropic medications and cognitive and personality disorders to substance abuse. Trainers run their students through scenarios teaching de-escalation techniques such as slowing things down; opening up communications; lowering your voice; moving people away; addressing the fear emanating from the person, family members, and fellow officers; and reassuring all involved. Your confidence—"I got this"—is critical, says Cochran.

Crisis Intervention Teams work with a city’s mental health professionals, Cochran stresses. The community component, partnerships with nonprofits like National Alliance for the Mentally Ill (NAMI), is imperative because an officer needs to know
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whether help is available for someone at 3 a.m. on a Sunday.

“We have chiefs and sheriffs sitting on NAMI panels to talk about homelessness or help for veterans, so it’s way more than just training,” Cochran says. “It’s the community coming together to talk about this. What do these officers need? What back-door services do the hospitals have? Will someone in crisis get a piece of paper and be told to come back for their appointment next week?”

Different levels of illnesses are also taught such as mild or severe psychosis, says Steve Wickelgren, counselor, lead trainer for Minnesota CIT, and a recently retired Minneapolis police officer.

Wickelgren recalls how the training helped one Rochester officer who arrived at a scene where other officers were talking quietly to the person, with no effect. He recognized that the man was experiencing severe psychosis, which he felt called for loud clapping to get the subject’s attention. It worked. He quietly to the person, with no effect. He recognized that the man was experiencing severe psychosis, which he felt called for loud clapping to get the subject’s attention. It worked. He reported to Wickelgren, “I clapped him half a block to my squad car, and then found him some help.”

“We want officers to be safe first, to be suspicious. We are [in the end] talking about public safety, not ‘care’ for the mentally ill.”
—Steve Wickelgren, Minnesota CIT

“Mental health issues are physical, medical problems, no different from diabetes. It’s not a bad attitude; it’s an illness we’re dealing with,” says Wickelgren. “I ask the cops, when a drunk driver is swerving and they pull him over and see a diabetes bracelet, do they charge him? They say no, they get help. I say this is the same thing.”

No statistics are kept on police shootings involving mentally ill subjects. It is known, however, that such deadly force encounters are common. Which is why one of the goals of CIT programs is to reduce the number of such tragedies.

But mental health trainers also want law enforcement to know that CIT strategies for dealing with the mentally ill without using force never trump officer safety.

Use-of-force rules still apply: If the subject is attempting harm, save your life and others.

Training is not a magic wand for every scenario. “We want officers to be safe first, to be suspicious. It’s still a public safety goal. And we are [in the end] talking about public safety, not ‘care’ for the mentally ill,” says Wickelgren.

He adds, “Our goal can’t be to end officer shootings of the mentally ill because that is unrealistic. Our goal should be to reduce them. We can’t control mental health crises. People will display behaviors that could endanger officers’ lives [where] no de-escalation techniques will work.”

For example, Wickelgren says, “If someone wants to do suicide by cop, they will do that.” Like with medicine, he adds, doctors can’t keep all people from dying.

Yet with many cities’ public safety budgets being cut and a lack of psychiatric beds, law enforcement is looking at a critical problem: how to get officers training, and at the same time find a bed—not a cell block—for someone who needs one.

Budget cuts also make it difficult for agencies to provide CIT training for their officers. In addition, taking officers off the street for training can be a tough sell at many agencies because it can mean an increase in overtime costs. That wreaks havoc for even the savviest of fiscal planners, as they hope for local tax increases, appropriations, re-allotment of budgets, and grants to augment their budgets.

Still, some cities are finding the money to increase crisis intervention training. Sometimes they do so looking down the barrel of a federal consent decree. The Albuquerque Police Department, under fire for a number of incidents that the Justice Department has found to be “excessive” force, will try to certify all field officers and add 10 crisis intervention classes this year.

STREET PSYCHOLOGY

CIT programs have had many documented successes in defusing dangerous and even deadly situations. But some law enforcement and mental health professionals believe such programs may be asking cops to be street psychologists, to diagnose complex illnesses of the mind like those with doctorate degrees and physicians with psychiatric training do. And they say that’s stretching the concept too far.
"I wonder if we're asking too much, but don't know if we're going that far as expecting them to be social workers or psychologists," Wickelgren says.

Retired Memphis officer Cochran agrees. "No one expects them to be psychologists," he says. But he stresses that only some officers are suited for CIT. "It takes a special person to go into this...I never wanted to be vice squad; there were other things I had a passion for. So when you get that call, you want that officer who has the most understanding of this."

Besides, both men rhetorically state, is it ever detrimental to learn?

"We don't want them to be social workers. The goal is to provide the officers with tools they need to work with different populations, just like a specialized unit."
—Habsi Kaba, CIT liaison, Miami-Dade County

Capt. Coffey co-authored in 2009 a basic 8-hour public safety training module for Mental Health First Aid that was piloted in cities like Philadelphia, New York City, and Washington, D.C. More than 25,000 public safety officers (police, corrections, probations) and 4,400 instructors have been trained in Mental Health First Aid (MHFA) in 50 states.

"It’s important for officers and agencies to realize there is more to mental health response training than the expansive CIT programs. Officers can be trained in what has been dubbed "Mental Health First Aid."

"It's like regular first aid; you can apply it anywhere, even off-duty," Coffey says.

He should know. Off duty while taking his daughter on an errand, he noticed a car in a pond, just off an embankment. He could see movement, so he quickly pulled over. He climbed into the partially submerged car through the back window. The woman showed a blank stare, and he thought, why is she not trying to get out?

What is your name? I'm Joe. I want to help you.

She pushed the door open and did not fight the water rushing in. He dove in after her as she tried to go under.
He stayed calm, rescued her, and kept right on talking.  
I want to help you.  
We’re going to get through this, together.

Coffey says that before the training, he wouldn’t have known what to do. “I never would’ve thought to say, ‘I’m here to help. And I never would’ve thought it was a suicide,” he says.

MHFA public safety curriculum does not compete with CIT; it complements the 40-hour CIT program, says Bryan Gibb of National Council for Behavioral Health in Washington, DC. While traditionally 25% of a department is trained in CIT, he hopes the rest of the street officers get a minimum of MHFA training. “Every officer should have some training in how to recognize signs and symptoms, how to respond safely and effectively,” Gibbs says.

Coffey believes that early mental health response by officers can prevent future critical incidents. “I’d rather deal with someone who has depression and get them help, than deal with them as a barricaded crisis situation... Now the officer can talk to the clinician, and say, ‘Here are the behavioral signs I observed.’ And then the clinician can better serve that person.”

Of course it can be difficult to prove why something didn’t happen. So success of law enforcement mental health response programs can be difficult to quantify.

“A lot of our work can’t be measured, how we’re responding differently,” Coffey says. “But we’re confident people are getting help. And we’re getting great comments from family members [of the mentally ill].”

“Our fundamental goal is to avoid crises,” Gibb says. “We position our course as another tool in the officers’ tool belts that can be helpful.”

He offers the example of a traffic stop. If officers can recognize the driver is hearing voices, they may avoid putting their hands on him and get him help.

Mental health response trainers say they remind officers that when answering calls involving the mentally ill, it’s not an us vs. them situation. “Mental health is not about the other guy. It’s our mothers, fathers, daughters, sons. It’s even us,” says Cochran.

Coffey agrees: “I’ve seen it first-hand, in my own community, and in my own family.” A 28-year veteran in police, military, and corrections, he was surprised “no one was talking about [officer mental health].”

That’s not the case anymore, according to Coffey. “An officer wants to help a fellow officer, who’s maybe a victim of a traumatic brain injury, or exposed to things [like PTSD] which may create an onset. So it’s not a ‘them’, it’s a ‘we.’ We have officers exposed to 100 people dying in the nightclub fire. Would you not want to help them?”

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