Mental Health Policing

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On October 31, 1963, President John F. Kennedy signed the Community Mental Health Centers Act, which forced the transition of care for individuals with various mental illnesses from psychiatric institutions to poorly prepared community-based resources (Haigh et al., 2020). The majority of cities and counties lack the proper resources to adequately assist individuals that may be facing a mental health crisis. As a result of declining budgets and deficiencies in the local mental health systems, there has been an increase in the interactions between law enforcement officers and persons with mental illnesses and/or emotional/behavioral issues (Hassell, 2020). Individuals with mental illness (IMI) have 3-5 times more contact with law enforcement than individuals without mental illness (Haigh et al.,2020). There are roughly 18,000 police agencies within the United States, but only 2,700 agencies have received Crisis Intervention Team (CIT) Training (Rogers et al., 2019). A majority of the police agencies may be lacking any form of training for responding to crisis calls. Therefore, if trained officers and mental health professionals work alongside one another, then they can de-escalate crisis situations together and increase the individual's opportunity of receiving long-term care to potentially decrease the reoccurrence of police involvement.

I understand that a vast majority of people do not agree with actions of law enforcement. There were approximately 1,000 people in the United States fatally shot by police during 2018 and roughly 25 percent of those individuals were known to have a history of mental illness (Rogers et al., 2019). This statement alone should warrant the need for law enforcement to receive a form of crisis intervention training. As a social work major that is increased in working in the mental health field, I was originally upset at the thought of officers being in charge of what happens to individuals with mental illnesses that face law enforcement involvement. So many

individuals with mental illnesses end in the criminal justice system with no support to receive the mental health services they truly need. In today's times, it can be even harder to secure a bed in a psychiatric facility or a rehab program (if the individual is also facing drug abuse or drug dependency). The lack of resources may it more likely that the individual will end up in jail or have a negative interaction with law enforcement. After my research, it become more apparent that there is a plethora of options for law enforcement to receive forms of mental health training to interact with individuals with mental illnesses, behavioral issues, or emotional issues. Officers at minimal should be obligated to participate in mental health first aid training while they are in academy training.

There are three types of policing for mental health work. Some agencies prefer police-based specialized police response, which involves sworn officers obtaining specialized training to interacting with individuals with mental illness (Rogers et al., 2019). These officers usually coordinate with local mental health resources to assist the individual. The CIT program is a form of this response type. Another option is police-based specialized mental health response, which involves "non-sworn police department employees with mental health training providing on-site and remote consultation and advice to sworn officers in the field" (Rogers et al., 2019). The third option is mental-health-based specialized mental health response, which includes police departments coordinate with mental health professionals to provide emergency response in the field where the mental health professional is the primary responder. Mobile crisis units and the CAHOOT program fall into this category.

The availability of resources and the size of the police department are considered when determining which type of model should be implemented in a police agency. Rogers et al. (2019) stated that half of all police agencies have less than ten officers and about 75 percent of police

agencies have less than 25 officers. When agencies do not have a lot of officers, it makes it difficult for them to implement and follow the core elements of the CIT program closely. CIT is supposed to be self-selected police officers (at least 20% of the agency) volunteering to participate in a 40-hour training program that involves various topics to help officers better respond to mental health crisis calls (Watson et al., 2017). These officers will be separated on different shifts, so there will be a few trained CIT officers per shift. In cases where there are few officers, agencies have chosen to train every officer to be prepared to respond to a crisis situation. This can be controversial, because not ever officer has the repertoire to handle these calls. The program also involves training dispatch employees receiving coding and special training to guide these calls. The third component of CIT involves law enforcement developing and maintaining strong relationships with the local community mental health system to help link individuals with the most appropriate avenue for their needed care. It is preferred for agencies to have connection to a centralized drop-off mental health facility to cut down on the time law enforcement spends with each call, but this can be difficult to secure in some communities (Rogers et al., 2019). This aspect is becoming more difficult post-pandemic due to the increase of mental health concerns and the decrease in funding/staffing for mental health facilities. For example, there are five of Virginia's mental health institutions have currently halted their intakes due to staffing shortages.

The Mental Health First Aid for Public Safety training can be utilized in every police agency and police academy. The Department of Justice describes the training as a way for police officers, first responders, correctional officers, and other members of public safety to better understand mental illness and individuals with addiction. This approach is evidence-based and helps de-escalate situations without compromising safety (PMHC Toolkit). This is a 5-step plan

that gives public safety professionals the skills and knowledge to help connect individuals with professional and self-help care. Participants in this training gain the understanding of the importance of early intervention in mental health cases and develop empathy for those with mental health challenges (PMHC Toolkit). This option is a great way to incorporate multiple public safety officials in the support of individuals facing crisis, but it is merely a steppingstone in the right direction to provide adequate support for these individuals.

Stigma has been shown to effect how police officers interact with IMI. Therefore, a police officer's own attitude and beliefs towards certain individuals can dictate how they respond to crisis calls or confrontation with these individuals. Officers should experience a form of cultural awareness or diversity training within their mental health training program to help them become aware of their own stigma and bias towards various cultures. Individuals may not be aware of the stigma until the course helps them process through their actions and thoughts. Another good tactic for mental health training that the CIT program also covers is interacting with individuals that are apart of the population. CIT allots time throughout the training week for officers to interact with individuals affected by mental illness, whether they are personally experiencing a mental illness or they have family members that had an encounter with law enforcement during a mental health crisis. This is important so officers can develop an understanding of what mental illness may look like, so they are more prepared during a crisis call.

The skills and knowledge that officers gain from participating in a form of mental health training, whether it be CIT, Mental health First Aid or another model, can be beneficial for any call that an officer receives. These skills can help police officers with their everyday communication skills with their families, their colleagues, and individuals from their community.

These trainings will also help them develop a relationship with individuals within the local community to help strengthen the support of individuals with mental health if used correctly.

Another options for communities to look into include the CAHOOT program that was implemented in Eugene, Oregon over 30 years ago. This program involves two person teams, including a mental health professional and a medic of sorts. Some communities could utilize CIT training, develop comprehensive community outreach programs, and find ways to increase the number of beds in acute and long-term residential facilities.

In conclusion, it is evident that police officers have little choice to respond to mental health crisis calls, therefore, their academy and agencies should make sure they have the resources they need in the event of unknowingly entering a mental health crisis situation hen responding to a 911 call. Some cities have formulated alternatives for police response, but these options will require additional funding and support from the government and communities to be adequately implemented. While communities are researching alternative options for this problem, the officers within these communities should at least complete an 8-hour training course in Mental Health First Aid.

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