California Law Enforcement Agencies and the Mentally Ill Offender

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This article reviews the results of a survey of California law enforcement agencies, designed to assess the experience of these agencies with mentally ill offenders (MIOs) and the training of their officers to interact with this population. The results suggest that most law enforcement officers are given insufficient training to identify, manage, and appropriately refer the MIOs they are increasingly likely to encounter. The data indicate that, in contrast to their training and expectations, peace officers are as likely to be called to a mental illness crisis as to a robbery. The MIO is likely to be arrested for nonviolent misdemeanors and to be screened by officers with little of the training or knowledge needed to divert them to appropriate mental health treatment. Respondents report that increased communication and cooperation between law enforcement and mental health professionals is the single greatest improvement needed for handling mental illness crises.

Local and national studies have increasingly demonstrated that the criminalization of persons with mental illness is reaching crisis proportions. Since the Lanterman-Petris-Short Act in 1967 limited involuntary hospitalization in California, the number of mentally ill persons in California state hospitals has shrunk from 37,000 to 4,600. With other states passing similar involuntary commitment laws, state hospital populations nationally have decreased from 559,000 in 1955 to 68,000 in 1990.[1] The increasing difficulty in obtaining involuntary treatment for persons with severe mental illnesses seems to have resulted in a correlated increase in the number and proportion of mentally ill inmates found in our jails and prisons.[1–5]

The United States is reputed to have the highest incarceration rate in the world, with an estimated 1.1 million inmates in 1991.[6] California houses a large portion of these inmates. Statistics estimate the daily jail population in California to have been more than 67,576 in 1993 and 68,780 in 1994; the estimated daily prison population in 1995 was over 126,000, an increase from the 120,000 inmates incarcerated in our state prisons

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in 1994.[7,8]* Recent surveys indicate that at least 7 to 10 percent of jail inmates and at least 10 to 15 percent of prison inmates nationally suffer from major mental illnesses such as schizophrenia and bipolar disorder, a rate that is almost three times that of the general population.[4–10] At the conservative rate of 10 percent, an estimated 110,000 of these inmates across our nation suffer from serious mental illnesses, far more than the estimated 68,000 that are treated in our public hospitals.[1] Similar conservative rates applied to California prisons and jails would indicate that on any one day, at least 20,000 inmates in California are suffering from serious mental illnesses.

These inmates likely followed different pathways to incarceration. Many were never diagnosed or treated, and only when their neurobiological brain disorders disorganized their thinking, emotions, and behavior and resulted in psychotic behaviors that violated a law were they arrested. Other mentally ill offenders (MIOs) may have previously been treated briefly to stabilize their symptoms, but were inadequately followed after hospital discharge, stopped taking their prescribed medications, and with resultant decompensation joined either the homeless or the incarcerated mentally ill. Lamb and Lamb[11] evaluated a group of severely mentally ill homeless persons in Los Angeles and found that 74 percent of them were known to have been arrested at least once during their illness. Other studies have followed patients who were discharged after psychiatric hospitalization, and found that two-thirds of those with serious mental illness were arrested within six months of discharge.[12]

Many of the offenses of the homeless mentally ill population are misdemeanors that the Federal Task Force on Homelessness and Severe Mental Illness concluded were symptomatic of impaired reasoning and "crimes of survival." Thus with the increase in homeless mentally ill persons in large cities everywhere, we also see an increased number of MIOs in jails and prisons. For example, the Los Angeles County Jail estimates there has been a 66 percent increase since 1986 in the number of inmates in their mental health units.[3] These factors have given the Los Angeles County Jail the dubious distinction of being the largest mental health facility in the United States.

As a result of this "transinstitutionalization," law enforcement and corrections officers find themselves increasingly placed in the role of streetcorner psychiatrist or social worker, roles for which they have little preparation, training, or understanding. Some of the officers may resent the failures of the mental health system that caused them to be thrust into these roles; others may more readily accept these new service-oriented roles, but experience frustration in their attempts to handle their new responsibilities without adequate training.

As an initial step in correcting possible deficiencies, an effort was made by the Criminal Justice Advisory Committee of the California Alliance for the Mentally Ill to assess and analyze the prevalence of police encounters with the MIO in Cali-

*These statistics are based on data collected from all involved agencies on one designated sample day each year.

fornia, and to train peace officers to deal with this population. Such training in California is accomplished through a prescribed curriculum, established by state law for both Peace Officers Standards and Training (POST) and Standards and Training for Corrections (STC). A survey was developed for this assessment and sent to 405 California law enforcement agencies, including 58 county sheriff departments and 347 city police departments.[†] This article presents an overview of the survey results and their implications, and some recommendations for future action.

Results

A total of 158 agencies returned at least partially completed surveys, for a response rate of 39 percent. There was a higher return rate from police departments (41%) than from county sheriff departments (26%).

Most departments were small, with two-thirds of the responding agencies reporting fewer than 80 sworn staff each. The median number of sworn personnel for all departments was 43. Surprisingly, just two departments—the Los Angeles Police Department and the Los Angeles County Sheriff Department—comprised 47 percent of all personnel in the responding agencies, with a total of 15,650 sworn staff. Because these extremely large departments generally skew the statistics, which makes the average less meaningful, the median for the reported results will generally be used rather than the mean, or average, value.

Many departments reported they did not maintain the statistical data that was requested in the survey, which included such important information as the number of detainees who appeared to suffer from mental illness, the frequency of mental illness crises for which officers are called, the training of their staff to deal with these events, etc. In contrast, almost all respondents provided information on the problems they encountered in handling these crises and on their interactions with mental health professionals.

There was a statistically significant difference between police and sheriff estimates of the percentage of mentally ill suspects arrested (as opposed to those who were housed and in custody), with sheriff departments estimating higher proportions of mentally ill persons among their arrests than police agencies ($p = .002$). While most departments (56%) estimated less than 5 percent of arrested suspects were mentally ill, 36 percent of sheriff departments estimated that greater than 10 percent of offenders suffered from mental illness, while only 7 percent of police gave estimates above 10 percent. Both groups based this information primarily on records, and because research indicates 7 to 10 percent of detainees suffer from mental illness, the lower police estimates suggest that city police may be less likely to recognize the presence of mental illness in those they arrest, and therefore underestimate its presence.

Offenses of Mentally Ill Persons Information on the types of offenses for

[†]Mental illness was defined as "severely depressed, agitated, or acting bizarre consistent with traits of mental illness rather than intoxication." It is assumed that law enforcement officers can make only these global judgments, and would refer the offender to a mental health professional for specific diagnosis and treatment.

which MIOs are arrested is based primarily on estimates, since only 15 agencies reported having data on this information. The difficulty in measuring the data, of course, is that if the individual is not accurately identified as mentally ill by the arresting officer, the statistics will be inaccurate. With the limited assessment skills of most officers, only those MIOs who are most blatantly psychotic may be identified. Even if mental health professionals are consulted, confidentiality laws may prevent their giving feedback to the law enforcement officer on the accuracy of the assessments, thus limiting the officer's ability to recognize an MIO.

Nonetheless, the crimes that are reportedly committed by persons with mental illness are most often nonviolent minor misdemeanors, and likely to be a consequence of the impaired judgment and reasoning associated with mental illness. These offenses include misdemeanors such as loitering or suspected public intoxication, disturbing the peace or disorderly conduct, trespassing, petty theft, or vandalism. Both police and sheriff departments indicate that loitering and public intoxication are the most frequent charges, with disorderly conduct or disturbing the peace as the second most common charge. Assault and battery is also reported, although to a lesser extent. The assaults may also represent a disorganized and impulsive response to hallucinations rather than any organized intent to engage in criminal activity or felonious crime. An example would be a young man charged with assault with a deadly weapon, when he is arrested for throwing an ashtray at a customer in a gift shop. The predominance of nonviolent misdemeanors or low-level violence among MIOs is consistent with the findings of the national survey on Criminalizing the Mentally Ill.[5]

Frequency of Mental Health Emergencies The average percentage of emergency calls that were mental health crises was four percent (the median was 3%). However, the average estimate for police departments was four percent (3% median), while the average estimate for sheriff respondents was nine percent (with a median of 6%), a difference that is statistically significant ($p = .02$).

The estimates generally were not based on statistical data kept by the departments. As one large agency with a special unit for mental illness responses explained, they were able to identify four percent of their calls as mental health crises, based on information from the caller. But the presence of mental illness in calls identified as other emergencies (for example domestic disputes, assaults, disorderly conduct, etc.) was not known. Too often, the presence of mental illness is not recognized from these calls. A few departments explained that they did not arrest anyone who was mentally ill; those individuals were diverted to mental health treatment. Ideally this is what should be accomplished, but other survey responses suggest it is unlikely that so thorough an examination was held that the MIO who tried to hide his illness was nonetheless successfully identified.

The most surprising finding of the survey was the percentage of sworn personnel who were estimated to have responded to three major types of

emergencies in the past three months. With 80 percent of the agencies providing this information, the estimated percentages of field personnel that responded to the following crises are: robbery, 28 percent; assault, 62 percent; and mental health crisis, 29 percent. Thus the estimated percentage of mental health crisis calls (29%) was essentially equal to that of robbery calls (28%), yet officers are given less training on how to appropriately handle mental illness crises. More than one-third of the agencies reported that from 50 to 100 percent of their officers responded to such crises.

Training The survey asked for the amount of training on mental illness given to their law enforcement officers as well as the training topics covered. Although California state law requires that four hours of POST Academy training given to law enforcement officers cover serious mental illnesses and developmental disabilities, the estimated training time reported varied from 0 to 24 hours. Fifteen of the police departments reported from 10 to 24 hours of training on mental illness; two of the sheriff departments reported over 10 hours. The average number of reported training hours for all agencies was 6.3, which included procedural issues, such as involuntary commitment requirements and weapons confiscation, as well as problems with recognizing and handling the MIO. A breakdown of training topics is presented in Table 1, with estimates of the percentages of time spent by the agencies on each topic.

More than two-thirds of the agencies had no information on training. The percentages of estimated training time, if based on a required total of two hours, would represent a total of 17 minutes on description of mental illness, 19 minutes on symptom recognition, 22 minutes on handling mental illness crises, 15 minutes on handling suicidal patients, for a total of 1.5 hours; and 8 minutes each spent on community resources, and consultation and linkages with mental health departments. Such brief exposure to these topics probably explains why several respondents voiced frustration concerning their role. This is hardly sufficient training for a career that brings the officers into repeated contact with mental health emergencies.

Table 1
Mental Illness Training Topics and Approximate Time

Topic	Approximate %
Description of mental illness	13.8
Symptom recognition	16.0
Handling mentally ill persons in crisis	18.5
Handling suicide	12.1
Causes of mental illness	7.2
Involuntary commitment procedures	11.2
Resources and disposition alternatives	6.8
Consultation and linkage with mental health	6.5

In addition to POST Academy training, the survey results also revealed that the amount of in-service training received by the officers is limited. Only six sheriff departments and 77 police departments reported any in-service training on handling mentally ill persons, with a median of one hour for such training. When it was provided, the training was described

as consisting primarily of POST videotapes (27 agencies) and briefings on procedures and policy (19 agencies). Another 14 agencies report presentations by their mental health departments on mental illness issues. When the list of POST videotape titles that were available over the last 4.5 years were reviewed, however, only 1 video title out of 292 described the topic of mental illness and development disabilities.

Training of Custody Officers If the MIO is not identified and diverted into mental health treatment, then the likelihood that he/she will then be identified while in detention is not very great, according to research.[9] In her investigation of the presence of mental illness in a large metropolitan jail—one which routinely screens for mental illness—Teplin found that 62 percent of the actively psychotic inmates were not detected or treated. More alarming was the fact that only seven percent of inmates with severe depression were detected. A national survey demonstrated that larger facilities have higher estimated percentages of mentally ill inmates, perhaps because they are likely to have more staff available for identification of these inmates.[5] The percentage of undetected mentally ill persons in smaller facilities may thus be even greater.

This survey found that the majority of police detention facilities are small holding facilities, with a daily median population of six inmates; 90 percent of the agencies held fewer than 30 daily detainees. In contrast, the median number of detainees for the county jails is 500. Title 15 of California law describes the criteria that must be met in provision of mental health services for the various jail facilities.[13] For example, all facilities must insure that a physician is available for emergency response within 24 hours, and even the smaller (Type I, II, and III)[‡] facilities must insure emergency and basic health care. Often this is not provided on-site, leaving any assessment of need for evaluation or care up to the custodial personnel.

For the larger sheriff departments, jails may be staffed in part by deputies who have completed their basic Academy training and are completing their first several years of duty prior to patrol assignments. Senior officers may also elect to return to custodial assignments later in their careers. As a result, 58 percent of the sheriff departments report that sworn officers serve as the jail custodians. The majority of detention centers report that jailers and non-sworn personnel, including police security officers, jail security officers, dispatchers and even clerks, serve as custodians. Nine respondents reported that they provided no custody, but referred MIOs (assuming they recognized them) to their county mental health departments. Another 20 agencies reported that detainees are either transferred to the county jail, or if identified as mentally ill, to the Department of Mental Health or the

[‡]Per California Code of Regulations, Title 15, Crime Prevention and Corrections, the following definitions apply: (1) Type I facility—city jail or sheriff's substation jail, which holds a person for 48 hours or less while awaiting arraignment; (2) Type II facility—typically a county jail, holding the arrested person for whatever time necessary during trial and/or completion of a sentence; and (3) Type III facility—typically a local detention facility, housing only convicted and sentenced persons.

Department of Health Services. Only one agency, which had a county forensic hospital, reported medical and mental health personnel served as custodians.

Only 40 (37%) of 108 respondents reported specific known training for custody officers on recognizing or intervening in mental health crises. Both sworn and non-sworn officers are required by California state law to receive special training prior to serving as jailers. STC consists of 116 hours of core training, with 40 hours of subsequent training tailored to the specific setting.[14] Despite the assumption of many respondents that custodians had received necessary training in STC, a review of the Core Training Manual for Corrections reveals that only one hour of training is focused on "Indicators of Psychological Problems."

Jail Screening All national standards rank intake screening in jails as an essential service, one of the most significant mental health services offered.[15, 16] In the responding California agencies, 27 percent of jail intake screening is done by jailers and non-sworn personnel, and 39 percent is done by the arresting officer, by the watch commander, or by other sworn law enforcement officers who have been given little or no training in performing this duty. While Title 15 of California law requires that screening on all inmates, including screening for mental health problems, be done at the time of intake by licensed health personnel or trained facility staff, the adequacy of screening is not supported by the survey results. The sample screening or booking forms were quite superficial in most cases and unlikely to identify and divert MIOs into the mental health system. The majority of mentally ill individuals are not likely to be detected by such screening.[9]

Nineteen percent of the agencies reported that screening was presumably done by the county sheriff, to whom the offender was transported. Only seven percent of the agencies reported that screening was done on-site by a mental health or medical professional; eight percent of the agencies reported the use of on-call mental health services. One large agency reported a specially trained Mental Evaluation Unit which provides this screening. In addition, the Los Angeles Sheriff Department now has an intensively trained Mental Evaluation Team, which pairs a sheriff deputy with a mental health professional to provide a compassionate response and professional evaluation to any suspected mentally ill person in crisis. The Los Angeles Police Department has similarly developed a System-wide Mobile Assessment Response Team to augment their city-wide response and diversion of mentally ill persons. Unfortunately, 44 percent of the responding agencies could not provide information on their screening process or stated that none existed, suggesting a limited or informal process is used for this important procedure.

The screening of incoming detainees to determine their need for treatment was generally done by interview and/or observation in 24 agencies, or by some form of medical questionnaire or screening (or "booking") form in 30 agencies. Most of these forms were developed years ago, before law enforcement had assumed such a central role in the identification of

MIOs, and the forms are rarely adequate. Except for one newly developed form, very little information is likely to be elicited from the inmate using the screening forms reviewed. Six sample forms reviewed were limited to questions such as: "Have you ever had depression or other psychiatric disorder?" or "Have you ever been treated by a psychiatrist or a psychologist?" Such close-ended questions are not adequate to uncover the impaired reasoning of most psychotic individuals, who may choose to hide their illness out of fear or stigma.

Mental Health Services Provided Fifty-three percent of all responding agencies, including most city jails, reported no mental health services provided in the jails, and no on-site mental health staff, a source of complaints from some respondents. As noted earlier, Title 15, Section 1200 requires that all type I, II, and III facilities make available a physician for the purposes of evaluation, emergency health care, segregation from the general jail population, and the transfer to a treatment facility for any inmate who cannot be adequately cared for in the jail. The custody officers must be able to recognize this need for such services. All sheriff respondents reported that mental health services are available through either referral to county mental health departments, the Department of Health Services, or to contract agencies. The on-site mental health staff appears to be minimal for most of these agencies, however, and symptoms may have to be very blatant to elicit a referral for mental health services.

Suicide Prevention Training Despite the legal duty of custodians to provide care and protection to persons they incarcerate, only seven percent of the agencies in this survey reported specific training on suicide prevention for custody officers, ranging from one to eight hours. Eighteen agencies (11%) assumed it was given in Academy training, 21 agencies (13%) assumed it was taught in STC certified training or Core Jail Operations Training. In fact, suicide prevention training is not a basic part of training. Only eight agencies (5%) indicated they specifically provided suicide watch training or crisis intervention training, and five other agencies (3%) reported inservice training on suicide prevention was given to "new hires." Screening forms for detection of potential inmate suicide have been developed, and are available along with guidelines for suicide prevention.[17, 18] After limited training, these can be used to increase these detection rates and implement a successful suicide prevention program.[9, 19] Given the liability and risk involved, better training for mental health screening of detainees is essential.

Satisfaction with Mental Health/Law Enforcement Interactions The majority of law enforcement agencies were dissatisfied with the interaction of law enforcement and mental health agencies in handling the MIO in the community. Sixty percent of the respondents felt that there was a need for improved liaison between the two departments. There was a statistically significant relationship between law enforcement agencies reporting no cross-training with mental health personnel and those reporting a need for improved liaison and communication be-

tween the two agencies ($p = .021$). This indicates that the availability of cross-training between law enforcement agencies and mental health agencies appears to foster improved working relationships and satisfaction with communication and cooperation between the departments. Respondents were vocal in expressing the needed improvements in such cooperation. To quote one police chief in response to the need for improved liaison, "A big yes! Law Enforcement has a history of sticking its head in the sand on this one. We are long overdue."

For those agencies who felt improved liaison was needed, the improvements that were desired fell into four main categories:

1. Nineteen percent felt that more available services and resources were needed, including 24-hour response capability from mental health, more field teams for involuntary placements, and more mental health professionals at the jail. They wanted the Department of Mental Health to take more responsibility for mentally ill persons, especially for those who are potentially violent, and to be available for observation and evaluation of these individuals.

2. Seventeen percent expressed a need for improved access and response time from Psychiatric Emergency Teams (PET) and crisis teams, at times expressing regret at budget cuts that reduced the availability of these vital services.

3. Eighteen percent expressed a desire for more training by mental health agencies on mental illness and resources.

4. The greatest number of responses, 46 percent of responding agencies, voiced a need for improved communication and cooperation between law enforcement and mental health agencies. They want a clear description of the needs, duties, resources, and services of each agency for the MIO, clarification as to which agencies to contact for dispositions, and more cooperation and consistency between the two agencies.

Cross-Training Of 145 agencies responding to this item, only 35 percent report that cross-training between mental health professionals and their law enforcement agency is available. Such training is provided through in-service presentations from mental health agencies, ride-alongs for mental health personnel on police response to crisis calls, briefings, roll-call training and other methods. When such training is available, studies have shown improved attitudes of law enforcement officers toward persons with mental illness, as well as toward mental health professionals; and police referrals have been more readily accepted by the mental health agencies.[20]

Emergency Field Responses Law enforcement agencies are largely unaware of any emergency field responses other than arrest or involuntary hospitalization, except for crisis teams such as PET. Unfortunately, 40 percent of the respondents reported that no emergency mental health intervention was available, and only one-third of the 86 agencies that were aware of emergency mental health intervention felt that this intervention was provided in a timely manner.

Police departments seem to be at a critical disadvantage when seeking mental health assistance for emergency calls.

The responses of police agencies and sheriff agencies showed a statistically significant difference in distribution of their responses ($p < .05$), with 86 percent of sheriff departments reporting a knowledge of emergency mental health interventions available to them, and only 57 percent of city police reporting that such emergency interventions were available to them.

Finally, while 83 percent of completed responses to this item stated that their emergency teams had involuntary commitment powers, 86 of 151 respondents were not able to answer this question and presumably did not know whether the mental health emergency teams had such commitment power.

Role of Law Enforcement in Handling Mentally Ill Persons While law enforcement officers may have assumed the role of streetcorner psychiatrist by default, it is apparent that, at least in California, the majority of officers have grown accustomed to the role and have adopted it as one of their duties. When asked what they considered their main role to be in handling this population, the greatest number of respondents (38%) saw themselves as responsible for recognizing the need for treatment, evaluating the situation, and getting the ill person to the proper treatment resources. These responses were given even more frequently than the role of "peacekeeper," responsible for the safety of the individual and the public, which 36 percent of the respondents cited. Another 15 percent of the agencies saw themselves as providing primary crisis response and evaluation, and three percent reported their role as taking custody of the individual for 72-hour evaluation. Only six percent of respondents appeared to resent their role in handling this population, and saw themselves as a "dumping ground," or needing to fill in where mental health had failed.

Major Problems in Handling Mentally Ill Persons Although this was an open-ended question on the questionnaire and allowed a wide-range of answers, the responses fell into three main categories. The most prevalent complaint reflects the consequences of reduced spending on mental illness: the lack of alternative and necessary mental health resources. This includes not only a lack of clinics or treatment programs, but basic needs such as housing, placement for the intoxicated mentally ill person, or for the indigent mentally ill person with no insurance. Thirty-nine percent felt this lack of resources was the greatest problem. Twenty-three percent felt they lacked adequate training to deal with this population, honestly admitting to concerns about officer safety in handling the unpredictable behavior and possible violence or dangerousness of persons with mental illness. Without training, peace officers are likely to hold the same stereotypes of dangerousness that the general public does, and may respond more strongly than is necessary to handle perceived threats. They also report a lack of training and knowledge about community resources that are available to them.

The third major category of problems encompasses procedural issues, an outgrowth of restrictive commitment laws and lack of intensive follow-up treatment

for the MIO. Respondents find that the commitment procedures are not only time-consuming, but frustrating. MIOs need help, but cannot be given it involuntarily; MIOs are discharged after 72 hours and repeat their offenses; MIOs don't reveal their severe symptoms to the examining physician, so they cannot be hospitalized.

Discussion and Recommendations

These survey results from 158 California law enforcement agencies suggest that most law enforcement officers are given insufficient training to cope with the need to identify, manage, and refer the MIOs that they are increasingly likely to encounter both in the community and in their jails. With the increase in homeless and untreated mentally ill persons on the streets of most cities, peace officers are as likely to be called to a mental illness crisis as to a robbery, but need a different set of skills for the two situations. There are wide differences in the training on mental illness provided to peace officers and custody officers throughout the state. Some of this training is excellent and intensive; more often it is perfunctory or even nonexistent.

Documented Training on Recognition of Mental Illness, Crisis Intervention, and Prevention of Suicide Should Be Required for All Officers, Sworn and Nonsworn Programs developed by the Police Executive Research Forum generally recommend 16 to 20 hours of training to increase the understanding and improve the attitudes of officers toward persons with mental disabilities.[18] Providing only one hour of such training could create a potential crisis, and is certainly inadequate, in view of the large numbers of untreated mentally ill individuals who enter the criminal justice system as a result of a psychotic illness. This lack of training for law enforcement officers is especially unfortunate, considering that an estimated 40 percent of persons suffering from serious mental illness will be arrested at least once in their lifetimes.[5] Torrey's national survey indicates that the presence of mentally ill inmates in the jail creates disturbances among inmates, requires additional staffing, and subjects the MIO to potential abuse, rape, and exploitation. Insufficient training leaves the custodians unprepared to meet the challenges and intensive care needs of these inmates. Manuals and training programs are available to assist agencies in the development of better training. Given the preponderance of mental illness crisis calls and the rapid changes in our knowledge about mental illness, this is an area open to much improvement, especially because the officer on the street is likely to be the first point for diversion of the MIO into the mental health system.

Many differences were revealed in response rates of police and sheriff departments, which require further analysis. Factors influencing these differences may include the size of the agency, community responsiveness, fragmentation, or population served. Police departments may be more responsive to perceived community needs and trends, because they must answer to city councils. Sheriff departments, in contrast, are mandated by law and are perhaps more resistant to

external community demands. The county sheriff department may be more fragmented, with multiple stations in many cities throughout their county, while the police department serves its local community. The county sheriff deputies serving rural communities may come in contact with a variety of isolated and reclusive individuals who might never be seen until their bizarre behaviors elicit an emergency call or citizen complaint. Additionally, the sheriff is mandated to maintain the county jail and custody facilities to which the local police agencies may bring their mentally ill detainees, thus serving as the ultimate custodian of the MIO. The sheriff deputies initially may look more carefully for any problems, knowing they will have to manage the difficult mentally ill person while he/she is in their custody. Finally, differences may relate to differences in training or experiences of the two agencies, or differences in their relationships with the local department of mental health.

Local Mental Health Centers and City Police Should Collaborate to Improve Their Cooperation in Handling Mental Illness Emergencies This survey confirms that most MIOs are charged with nonviolent misdemeanors, crimes that may be symptomatic of their illnesses. When compared with sheriff deputies, police officers identify a smaller percentage of these suspects as mentally ill. Police agencies also identify a lower percentage of mental illness crises in their emergency calls than sheriff agencies, which may reflect less interagency cooperation between police and mental health agencies. This may be due to the fact that both mental health and sheriff agencies are often county departments, funded from the same county budget and interacting in more areas. Given the demonstrated presence of mental illness nationally among those who are arrested, it is likely that police are under-identifying the MIO. Nonetheless, the lack of interaction and collaboration between city police and county mental health departments seems to be a problem area for police responding to mental health crisis calls, and limits corrective learning.

It Is Essential that Compassionate Response Teams Be Developed in Communities Served by City Police, as well as Within County Areas Served by the Sheriff Departments The MIO has generally come to the attention of law enforcement because of a failure to receive needed mental health services; both law enforcement and mental health agencies need to insure those services are provided.

The development of special teams comprising representatives from both law enforcement and mental health agencies has been successful in improving the diversion of MIOs to appropriate treatment programs. The use of such teams has been shown to improve identification of mental illness in suspects, to insure better use of appropriate community resources, to increase the acceptance rate of involuntary patients by hospitals, and to improve the communication and collaboration of the two agencies.[21]

Mental Health and Law Enforcement Professionals Need To Collaborate to Develop and Implement Effective Screening Forms and Methods and To

Provide Training in Ongoing Monitoring of Suicide Risk for MIOs in Jails and Detention Centers Mental health professionals need to work with their local law enforcement agencies to develop effective screening methods. The MIO is very likely to be an individual who denies his illness, refuses medication, and lacks the insight to seek mental health treatment.[2, 11] Someone has to be well qualified to make that initial assessment, and to insure such an inmate is identified. Otherwise, a "catch-22" situation is created, because without the training and assistance in identification from mental health professionals, law enforcement may be unable to recognize the symptoms of mental illness that indicate an inmate needs mental health services. The Supreme Court, as well as state courts, have determined that MIOs have a right to treatment to prevent needless suffering, avoidable deterioration, and possible death.[7, 16] Identification of the MIO is clearly required. It is important that this screening be effectively structured and taught to all officers or custodians likely to be responsible for the care of an MIO.

Suicide prevention remains a key concern for all jails. Suicide is the leading cause of inmate death, and the suicide rate of inmates is approximately nine times that of the general population.[22] A study for the National Center for Institutions and Alternatives that reviewed suicides for the years 1985 and 1986 found that 73 percent of suicides occurred in county jail facilities, and 27 percent of these suicides occurred in municipal jails and lockups; thus screening for suicide potential is an essential procedure for all jail facilities. Hayes[22] cites a South Carolina study indicating that the suicide rate of inmates in police department holding facilities was approximately 250 times greater than the rate for that state's general population, and thereby indicating that these facilities must be especially sensitive to clues of possible suicide. Hayes notes that the majority of suicide victims had no screening. Other research found that 89 percent of jail suicides and 97 percent of suicides in holding facilities had not been screened.[23] Collaboration between mental health professionals and the criminal justice system in developing suicide prevention programs will benefit all involved persons.

Cross-Training Between Mental Health and Law Enforcement Agencies Should Be Accomplished Through In-Service Training Programs, Ride-Alongs, Briefings, Joint Conferences, and Problem-Solving Meetings According to our respondents, increased communication between the two agencies is the single greatest improvement needed in law enforcement/mental health liaison. As a result of this lack of communication, almost half of the police departments reported they were unaware of the availability of mental health interventions in their community. Cross-training between mental health and law enforcement agencies is shown to improve communication and interagency satisfaction.

Case Management and Treatment Dollars Should Follow the MIO into and out of Jails and Prisons to Insure Continuity of Care, Including Involuntary Outpatient Treatment When Needed The lack of alternative mental health re-

sources is another frequently voiced problem for law enforcement officers in dealing with persons with mental illness. For example, there are no placements for intoxicated mentally ill persons or for indigent uninsured mentally ill persons; there is no emergency housing; and there are no 24-hour emergency services. These resources are certainly essential, yet Steadman[24] notes that while inadequate resources may be a problem, the greater issue is often the poor use of existing resources and the lack of integration of mental health and criminal justice programs. An excellent example of this is seen in the numerous arrests in a southern California city of one substance-abusing mentally ill woman, who through the years cycled repeatedly through the courts and back to the streets without treatment. The local judge who presided over many of her court appearances estimated that she cost the criminal justice system and the courts at least $500,000 (Judge P. J. Mirich, Los Angeles Justice Department, personal communication, 1992). Intensive case management, costing an estimated $17,000 annually, would have been far less expensive, both in dollars and in human suffering. Incarceration in jails and prisons is estimated to cost from $20,000 to $60,000 a year.[6] These costs are often not calculated when mental health resources are subjected to budget cuts.

Appropriate Statistics Should Be Kept to Reveal the Accurate Percentage of MIO Inmates and Their Follow-Up Treatment The information that is not provided in the surveys is also revealing, given the high number of mentally ill persons known to be incarcerated in California jails on any given day. Because no statistics are kept on the number of mental illness-related crises or arrests, local resources are not known by law enforcement agencies, and the fact that agencies do not know how screening for mental illness is accomplished in their agencies clearly suggests where improvements are needed.

The magnitude of this problem calls for collaborative efforts of all involved agencies to provide necessary treatment, and not punishment, to MIOs.

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References

1. Torrey EF, Erdman K, Wolfe MD, Flynn LM: Care of the Seriously Mentally Ill: A Rating of State Programs (ed 3). Arlington, VA: Public Citizen Health Research Group and National Alliance for the Mentally Ill, 1990
2. Whitmer GE: From hospitals to jails: the fate of California's deinstitutionalized mentally ill. Am J Orthopsychiatry 50:65–75, 1980
3. Tobar H: A dumping place for the mentally ill. The Los Angeles Times. August 25, 1991
4. Jemelka R, Trupin E, Chiles J: The mentally ill in prisons: a review. Hosp Community Psychiatry 40:481–91, 1989
5. Torrey EF, Stieber J, Ezekiel J, Wolfe SM, Sharfstein J, Noble JH, Flynn LM: Criminalizing the Mentally Ill. Washington, DC: Public Citizen's Health Research Group and the National Alliance for the Mentally Ill, 1992
6. Jemelka R, Rahman S, Trupin E: Prison mental health: an overview, in Mental Illness in America's Prisons. Edited by Steadman H, Cocozza JJ. Seattle, WA: The National Coa-

lition for the Mentally Ill in the Criminal Justice System, 1993, pp 9–23
7. Coleman v. Wilson, No. CIV S-90-0520 LKK (E.D. Cal 1994)
8. Hill EG: Who is in prison?: crime in California. Report to the Legislative Analyst Office, California Legislature, 1994
9. Teplin LA: The Prevalence of severe mental disorder among male urban jail detainees. Am J Public Health 80:663–9, 1990
10. Steadman JH, Fabisiak S, Dvoskin J, Holohean EJ Jr: A survey of mental disability among state prison inmates. Hosp Community Psychiatry 38:1086–90, 1987
11. Lamb HR, Lamb D: Factors contributing to homelessness among the chronically and severely mentally ill. Hosp Community Psychiatry 41:301–5, 1990
12. Belcher JR: Are jails replacing the mental health system for the homeless mentally ill? Community Ment Health J 24:185–95, 1988
13. California Administrative Code, Title 15: Minimum jail standards. California Board of Corrections, 1988
14. State of California: Standards and training for corrections: CORE training manual. California Department of Corrections, 1990
15. Steadman HJ, McCarty DW, Morrissey JP: The Mentally Ill in Jail: Planning for Essential Services. New York: Guilford Press, 1989
16. Cohen F: The legal context for mental health services, in Mental Illness in America's Prisons. Edited by Steadman HJ, Cocozza JJ. Seattle, WA, National Coalition for the Mentally Ill in the Criminal Justice System, pp 25–90, 1993
17. Hayes LM: Training Curriculum on Suicide Detention and Prevention in Jails and Lockups. Alexandria, VA: National Center for Institutions and Alternatives, 1988
18. Murphy GR: Managing Persons with Mental Disabilities: A Curriculum Guide for Police Trainers. Washington, DC: Police Executive Research Forum, 1989
19. Sherman LG, Morschauer PC: Screening for suicide risk in inmates. Psychiatr Q 60:119–38, 1989
20. Murphy GR: Special Care: Improving the Police Response to the Mentally Disabled. Washington, DC: Police Executive Research Forum, 1986
21. Dvoskin JA: Jail-based mental health services. in Breaking Through the Barriers: Jail Diversion for the Mentally Ill. Edited by Steadman HJ. Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System, 1993 pp 64–89
22. Hayes LM: National study of jail suicides: seven years later. Psychiatr Q 60:7–30, 1989
23. O'Leary WD: Custodial suicide: evolving liability considerations. Psychiatr Q 60:31–71, 1989
24. Steadman HJ (editor): Breaking Through the Barriers: Jail Diversion for the Mentally Ill. Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System. 1993