Commentary: A Multidisciplinary Approach to Developing Mental Health Training for Law Enforcement

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Vermette *et al.*[1] address a topic that affects many mental health clinicians and their patients. Policy changes, including deinstitutionalization, inadequate funding of outpatient treatment, and stringent commitment requirements, may have contributed to an increase in the frequency of police contacts with mentally ill citizens.[2] Law enforcement officers often act as paramedics for psychiatric emergencies in the community. In a survey of law enforcement professionals in three U.S. cities, officers reported that within the previous month they responded to an average of six calls that involved a person with mental illness who was in crisis.[3] Mentally ill patients report high rates of contact with the police. A survey of 360 psychiatric outpatients at an urban mental health clinic demonstrated that 48.6 percent of them had a history of arrest.[4] Officers working in jails and prisons also have contact with mentally ill citizens. It has been estimated that the prevalence of severe mental illness in jails and prisons is three to five times higher than that in the community.[5] Statistics have not been compiled regarding the frequency of police contacts with the mentally ill in the context of interviewing crime victims or witnesses.

Similar Responsibilities and Experiences

Mental health clinicians and law enforcement officers have similar responsibilities and experiences in their daily work with the mentally ill. Both professions engage in crisis management, risk assessment, and disposition of patients too dangerous or disabled to remain in the community. Both deal with a workload that is increased by inadequately funded systems of care. Both may be held liable for harm that they may not have been able to foresee or forestall. Despite these similarities of experience, tension and distrust may exist between the disciplines. For example, mental health clinicians typically do not respond in person to their patients who are imminently dangerous in the community (where weapons and intoxicants are available). Clinicians may also be fearful of the potential for force to be used against their patients if the police are called for assistance with management of the crisis. Similarly, law enforcement officers may be frustrated by repeated intervention with reportedly dangerous patients, only to have those patients released into the community by the evaluating emergency psychiatrist.

The need for the police to respond appropriately to the mentally ill creates a unique opportunity for collaboration between mental health clinicians and law enforcement professionals. To develop effective mental health training programs for law enforcement officers, members of both disciplines must learn something substantive about the other's professional and legal responsibilities. This increased awareness may ultimately lead to the delivery of improved clinical and law enforcement services to mentally ill citizens.

Working Together: A California Experience

In my experience, a multidisciplinary approach has been the most effective in creating training that

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best anticipates and responds to the needs of patrol officers. The development of the training program "Police Response to People with Mental Illness or Developmental Disability" by the California Commission on Peace Officer Standards and Training (POST) is an example of one such collaborative effort.

In response to several high profile cases in which mentally ill Californians had been shot and killed by police officers, the California State Legislature passed Assembly Bill (AB) 1718 in 2000, requiring that POST establish and keep updated a training curriculum relating to law enforcement contacts with mentally ill and developmentally disabled citizens. The underlying premise of the legislation was that improving law enforcement training in these areas would lead to improved outcomes in contacts between law enforcement and mentally ill citizens.

POST, overseen by 11 Commissioners and an Executive Director, carries out its mandate to "continually enhance the professionalism of California law enforcement in serving its communities" by researching nationwide trends in law enforcement, including crime statistics, legislative developments, tactical equipment, and training. POST uses this information to develop standards and training in the more than 600 subject matter areas in which all California law enforcement officers must develop and maintain proficiency. In 2000, the year AB 1718 was passed, 8 of the 11 POST Commissioners were career law enforcement officers. The others included the district attorney of a Bay Area county, a specialist in education and training, and a member of the public. The California Attorney General is an *ex officio* member of the Commission. POST's first task in fulfilling its responsibility under AB 1718 was to appoint a law enforcement officer with recent patrol and supervisory experience as Project Manager (PM). The PM then appointed members with experience in law enforcement contacts with mentally ill citizens to serve on an advisory committee that would develop the POST training.

Despite the fact that mental health issues comprise just one of more than 600 subject matter areas covered by POST, the work the Commission does in carefully monitoring developments in all areas meant that POST already had good relationships with several professionals working at the interface of law enforcement and mental health care. The final advisory committee comprised 28 members: 3 current law enforcement officers with doctoral degrees in psychology, 7 police officers assigned to either patrol or supervisory positions, 1 police officer with previous experience in developing a successful mental health training curriculum, 11 mental health clinicians with experience in subjects involving law enforcement, 3 citizens who worked in patient advocacy, 2 attorneys with experience in defending law enforcement officers and agencies in wrongful death and inadequate training suits, and 1 expert in developing training programs for law enforcement agencies.

Problems in Curriculum Development

AB 1718 did not specify the training's content, format, length, or faculty, nor did it require POST to collect data on those officers who underwent this training and their subsequent interactions with the mentally ill. The committee as a whole met three times, with various subcommittees convening separately to develop and finalize various aspects of the training.

To develop familiarity with the approach other agencies have taken, the committee surveyed the mental health training programs of law enforcement departments throughout the United States. Committee members attended classroom and field training at law enforcement agencies in New York City; Memphis, Tennessee; and Phoenix, Arizona. Written materials and other training aids from several other agencies were reviewed as well. Members of the committee found a two-day training program developed by New York State to be particularly well designed, as it presented the mental health material simply and effectively.

Committee members without a law enforcement background quickly became familiar with factors that shape the development of a training program that could be used by all law enforcement agencies in California. The training had to be long enough to be substantive, but short enough that it would not create a hardship in small departments to allow officers leave time to attend it. It had to be relevant to officers in urban Los Angeles and the nearly deserted county of Siskiyou. It had to be realistic in what it offered and what it recommended across a wide range of populations, geography, and mental health resources. To that end, the committee decided to offer an eight-hour program. The program consists of six lessons, covering introductory concepts that emphasize destigmatization and the biological basis of men-

tal illness, developmental disabilities, major mental illnesses, verbal intervention strategies, alternatives to lethal force, and community and state resources.

Each discipline contributed to the curriculum and worked with the others to refine their priorities for final inclusion. Law enforcement professionals emphasized the importance of providing material that would be immediately transferable to the street. Mental health clinicians explained the importance of including California Welfare and Institutions Code sections governing involuntary commitment, to help officers understand clinical decision-making and improve their report-writing when requesting commitment of a citizen. Advocates for the mentally ill helped the committee to understand the sometimes frightening experience of family members in their interactions with the police. Material was incorporated to respond to this concept. The attorneys supported the inclusion of relevant California case law in written materials provided during the training, as well as broadening the material to include areas that were often cited in lawsuits brought against a law enforcement agency alleging inadequate mental health training.

Law enforcement professionals told the clinicians the training had to be "action-oriented," "hands-on," and "portable." The committee incorporated videotape simulations and role-play into the training materials. Excellent suggestions, such as providing the virtual-reality hallucination experience offered by a pharmaceutical company or bringing a human brain to the training to emphasize the medical nature of mental illness were ultimately rejected as impractical. However, in my experience, both techniques have been very successful in other training formats.

Conclusion

The final product of the committee, the training entitled, "Police Response to People with Mental Illness or Developmental Disability" consists of an Instructor's Guide, a DVD of the videotaped simulations, a field guide for officers attending the training, a laminated wallet card containing principles of communicating with the mentally ill and suicidal individuals, and a second card with the names of common psychotropic medications. The training is designed to be co-taught by a law enforcement professional and a mental health clinician, as the committee felt strongly that both disciplines should be present to provide appropriate answers to participants' questions.

Committee members agreed that having different disciplines work together resulted in a more thoughtful and complete training program. They also felt they would take knowledge gained in working with other disciplines back to their communities to initiate new relationships and opportunities for collaboration.

The content and format of effective mental health training will vary to some extent with the characteristics of an individual law enforcement agency. Vermette *et al.*[1] provide a useful starting point for officers and mental health clinicians who develop or update training curricula. Assessing the mental health training priorities and preferred teaching formats of their target audience would allow them to create more effective and relevant training.

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