Commentary: The Challenge of Training Police Officers

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Vermette *et al.*[1] offer significant observations about the training of police officers working with individuals who have a mental illness. The need to have effective training that meets the expectations of line officers as well as supervisors and police chiefs is readily apparent. Law enforcement officers are routinely the first responders in situations involving mentally ill persons in crisis. The findings provide guidance in crafting a training program that will address areas that officers regard as the most relevant to their work. Considering the needs and requests of officers is an essential step in developing a partnership with law enforcement to support training efforts. Training programs are needed to provide officers with the information and skills to interact more effectively with persons suffering from mental illness.[2,3]

Need for Training

With the advent of deinstitutionalization, tightening of civil commitment statutes, and cutbacks in psychiatric treatment programs, a greater number of individuals with mental illness are living in the community. These changes have resulted in an increase in the number of contacts between individuals with mental illness and the police.[4,5] There have been estimates by medium and large police departments that seven percent of their contacts, including both investigations and complaints, concern persons believed to have mental illness.[2] Police are a major source of referrals for psychiatric emergency services. Redondo and Currier found that 26 percent of patients evaluated by the psychiatric emergency service of the University of Rochester Medical Center were brought in by police.[3]

Police are usually the first and often the only community resource called on to respond to crisis situations involving persons with mental illness[4] and have been termed "*de facto* mental health providers."[5] Officers are expected to act as the primary gatekeepers for the criminal justice and mental health systems. They must either recognize an individual's need for treatment and divert that person to an appropriate mental health facility or make the determination that the individual's illegal activity is the primary concern and that the person should be arrested.[5,6] The task is typically accomplished with little training.

The good news is that the survey by Vermette *et al.*[1] suggests that police officers are interested in learning more about interacting with the mentally ill, and officers consider it an important aspect of the job. Over 90 percent of respondents reported that mental health training was either fairly or very important, and 68 percent preferred yearly training. Over half of the police officers had volunteered to attend, indicating an appreciation of the importance of the subject.[1] Similarly, Cotton[7] found that most of the Canadian police officers in her study were not, in fact, averse to accepting a significant role in working with individuals with mental illness. Rather, officers viewed their involvement as an integral part of community policing, as part of their jobs, and as an area in which they should receive specialized training. These encouraging findings are consistent with the shift from the traditional enforcement model to a community-policing model that embraces a problem-solving orientation to operational problems and the use of community partnerships to accomplish operational objectives. Application of these principles has fostered initiatives to improve the effective-

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ness of response to mental health crises in the community.[8,9]

Mental Health Training Programs

Despite this new focus on community policing, most departments still do not provide specialized mental health training. Patrol officers are on the front line, but they generally receive little post-academy mental health training. Cotton[7] surveyed police officers of three different police forces in Canada. These forces had not devoted significant time or resources to mental health training. None of these police forces had any particular specialized training for officers or a dedicated mental health program. Only a brief (one-hour), in-service session had been offered, even though senior officers identified mental health as an area of concern, and officers were interested in obtaining more information about working with and understanding individuals who are mentally ill. Police colleges in Ontario had provided a brief exposure to mental health subjects; but, unfortunately, only a few departments in large metropolitan areas had organized more extensive training. The sample provided by Vermette *et al.*[1] is unusual, in that the majority (73%) had attended at least some post-academy training.

Departmental Policy for Dealing with the Mentally Ill and Implications for Training

In addition to the lack of specialized mental health training, most departments lack a formal policy for dealing with the mentally ill. Most departments do not have specialized mental health teams to respond to calls.[2] Deane *et al.*[2] surveyed 174 police departments serving cities with populations of over 100,000. They found that 55 percent of the departments lacked a specialized response for handling incidents involving persons with suspected mental illness or emotionally disturbed persons (EDPs).

Those departments that have a formal policy use one of three models in crafting a specialized response to handling calls involving EDPs[2]: a police-based specialized police response, a police-based specialized mental health response, and a mental-health-based specialized mental health response. The amount and type of training offered by a department is often related to the strategy used in dealing with persons with mental illness.

Intensive specialized training is provided to officers in departments using a police-based specialized police response. This strategy involves having sworn officers with specialized mental health training provide crisis intervention services and act as liaisons to the formal mental health system. Deane *et al.*[2] found that only three percent of departments use this approach—among them, the Memphis Crisis Intervention Team (CIT). CIT officers make up about 15 to 20 percent of patrol officers and receive 40 hours of training that focuses on scenarios derived from actual incidents. Officers receive extensive training in de-escalation techniques.[9]

The second approach, a police-based specialized mental health response, was used by 12 percent of the departments. Mental health consultants, who were not sworn officers, were hired by the police department to provide on-site and telephone consultation to officers in the field. The third approach, a mental-health-based specialized mental health response, was used by 30 percent of the departments. This strategy involved reliance on mobile crisis teams. The teams were part of the local community mental health service system. The teams had developed a relationship with the local police departments to provide assistance on the scene.[2]

The crisis intervention officers in departments using the police-based specialized police response reported feeling the most prepared to handle calls involving mentally ill persons in crisis compared with officers in departments using a different strategy.[8] These officers had volunteered for their positions and received specialized training. This finding supports the view that training and preparation can improve officers' comfort and confidence in responding to mental health emergencies. All three approaches had a relatively low arrest rate when a specialized response was made.[10]

Goals and Benefits of Training

Improving Interaction with Mentally Ill Persons

There are numerous benefits to providing at least some basic mental health training to all patrol officers, regardless of the strategy of response. Mental health training can provide guidance in identifying and managing persons with mental illness. Training can provide a framework for distinguishing which persons with mental illness who have committed a minor crime can best be managed by diversion to the

mental health system. Training in de-escalation techniques can improve communication between officers and persons with mental illness and lead to improved handling of violent or potentially violent encounters. The training can decrease the risk of harm to officers and to persons with mental illness. De-escalation training can aid officers in managing a person who is threatening suicide. Training can also help in identifying and gaining access to available community resources.

Changing Attitudes and Combating Stereotypes

Changing attitudes about persons with mental illness also should be a fundamental goal of training. Police officers encounter persons with mental illness in a variety of situations, not just those persons who are experiencing a psychiatric crisis. In fact, persons with mental illness are more likely than others to become victims of crime,[11] and persons with mental illness can be witnesses to a crime. Because of stereotypes, persons with mental illness who are victims may not be seen to be as credible as those without a history of mental illness.[12]

Wahl[12] conducted a nationwide study of 1,301 persons with mental illness solicited through the newsletter of the National Alliance for the Mentally Ill (NAMI) and by members of NAMI's consumer council. Almost 80 percent of the sample reported direct experience with stigma and discrimination in a variety of settings, including communities, families, churches, coworkers, and mental health caregivers. Respondents reported trying to conceal their disorders and worrying a great deal that others would find out about their psychiatric status and treat them unfavorably. They urged public education to be a means of reducing stigma. Link *et al.*[13] found that 75 percent of the general public view persons with mental illness as being more dangerous and Kimhi *et al.*[14] found that police continue to share this belief.

In contrast, Cotton[7] found that police were actually more positive in their attitude toward the mentally ill than was the general public. Very few officers favored isolation of mentally ill individuals from society, and most officers supported the view that society should learn to be more tolerant. There was a belief in the therapeutic value of the community, the importance of integrating the mentally ill into normal neighborhoods, and a general acceptance of the principle of deinstitutionalization.

Corrigan *et al.*[15] studied perceptions of discrimination by 1,824 persons with serious mental illness. The authors found that 37.7 percent of the study participants who were recruited from community mental health centers reported some experience of discrimination due to their mental disability. Respondents stated that one of the areas in which discrimination frequently had occurred included interactions with police. The researchers suggested targeting police as a category of power group whose discrimination is particularly problematic for persons with mental illness.[15,16]

Watson and colleagues[17] examined whether the knowledge that a person has a mental illness actually influences police perceptions, attitudes, and responses. Police officers attending one of 30 in-service training sessions were randomly selected and given one of eight vignettes describing a person in need of assistance, a victim, a witness, or a suspect who was either labeled as having schizophrenia or for whom no further information about mental illness was mentioned. Police officers viewed persons with mental illness as being less responsible for their situation, more deserving of pity, and more worthy of help, but, at the same time, more dangerous than persons for whom no mental illness information was available.

The information that a person had schizophrenia significantly increased the perception of violence across all role vignettes. Watson *et al.*[17] hypothesized that this heightened sense of risk could cause an officer to approach persons with mental illness more aggressively and escalate the situation and evoke unnecessary violence.

The mental health label did not affect the credibility rating of a suspect or a witness. Unfortunately, there was a lower perceived credibility of a victim with a mental illness. Since victims with mental illness have higher rates of victimization, Watson and colleagues[17] recommended education to counter this perception of lower credibility. They cautioned that assuming a person who has a mental illness is incapable of providing credible information could lead to the loss of valuable leads and the neglect of persons who have been victimized. The authors recommended combating exaggerated perceptions of dangerousness by education and opportunities for positive contact with persons with mental illness who are stable in the community.

Encouraging a Dialogue Between Psychiatrists and Law Enforcement Officers

Another goal of mental health training would be the encouragement of a dialogue between psychiatrists and law enforcement officers. Vermette *et al.*[1] recommended that courses be jointly taught by a mental health professional and a law enforcement officer. This approach offers a level of comfort for officers who are often suspicious of psychiatrists and other mental health professionals, and it would allow an opportunity for mental health professionals and officers to explain their own perspective and solve problems together.

Topics to be Covered in Training

While there is clearly a need for training, one needs to ask what topics should be covered when time for training is limited. The findings by Vermette and colleagues[1] raise questions about what topics should be included in mental health training. The authors pointed out that their sample might not be representative, as over half of the officers volunteered to attend and 70 percent had already received some post-academy training. Therefore, the sample may have over-represented officers with an interest in mental health training. The authors did not provide information about the topics to which officers were exposed in their earlier mental health training. This could have influenced the officers' choice of further subjects.

Vermette *et al.* found that all topics were rated as important but the subjects of Dangerousness, Suicide by Cop, Decreasing Suicide Risk, Mental Health Law, and Your Potential Liability for Bad Outcomes were given the highest ratings. Police appeared to be most interested in these more advanced topics related to safety and liability.[1]

The police officers may have been interested in Mental Health Law because this topic included discussion about laws governing commitment. There were written comments requesting more information about civil commitment laws and how to communicate with mental health professionals. Police complained about being frustrated when they take persons with suspected mental illness to the emergency room for assessment only to have them rapidly released.

Redondo and Currier[3] found differences between persons referred by police to a psychiatric emergency room and persons referred by other sources. Persons referred by police were significantly more likely to be male, to have been referred because of violent behavior, to exhibit violent behavior in the emergency room, and to have a lifetime history of violence. Persons referred by police were rated as having more severe psychosocial stressors and spent more time in the emergency room than did those referred by other sources. However, patients referred by the police were not more likely to be admitted to inpatient psychiatric units.

If persons referred by police indeed do exhibit more violent behavior, then it should not be surprising that officers might question why violent behavior does not always lead to hospitalization. Officers in the study by Vermette and colleagues[1] ranked the topic of Mental Health Law very high, perhaps because the officers wanted to understand the laws governing commitment and why persons brought in for psychiatric admission were not admitted. Explaining what occurs in the decision-making process would be helpful in forming a partnership with law enforcement.

In light of the challenges faced by patrol officers, one might have expected that patrol officers would rate high topics such as Effective Communication With Persons With Mental Illness and Overview of Specific Types of Mental Illness. Vermette *et al.* pointed out that for the training programs attended by study respondents, police chiefs and training coordinators were specifically asked to design curricula that included education about the types and manifestations of mental disorders. They noted that learning about the basic differences between specific mental illnesses would be useful in improving communication and understanding of persons whom they encounter. Therefore, one should consider including those topics most likely to result in improved interaction between police officers and persons with mental illness, while still taking into account the requests of patrol officers.

It is of concern that Role-playing was rated significantly lower than other training modalities, whereas Videos and Small Group Discussion had the highest mean scores. Officers who receive advanced training in crisis negotiation are routinely exposed to all three modalities. There is a great deal of emphasis on enacting scenarios to ensure that officers practice their skills. In addition, officers are often encouraged to improve their skills further by volunteering for sui-

cide hot lines. Practicing skills is an accepted part of firearm training and SWAT training. While role-playing can be an uncomfortable experience, it is a good way to improve skills and learn de-escalation techniques.

Conclusion

Vermette *et al.*[1] have approached the question of what topics and what modalities to use in mental health training by surveying patrol officers about their opinions. This is an important effort because training should address the topics considered of importance to patrol officers. Vermette and colleagues suggest a collaboration between mental health providers and law enforcement officers in designing a program that is useful and relevant to the target audience, but at the same time meets the goals of improving the interaction between law enforcement officers and persons with mental illness.

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