Chapter 14
Police Interactions with Persons-in-Crisis: Emergency Psychological Services and Jail Diversion

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ABSTRACT

This chapter addresses the interaction of law enforcement officers and people who are psychologically impaired as a result of mental illness, emotional disturbance, or severe intoxication. The chapter consists of three major sections. Part One provides an overview of the larger legal and social factors that increasingly require law enforcement to develop specialized programmatic responses for responding to a Person-in-Crisis (PIC). Part Two provides an overview of different types of programmatic attempts to address the problems associated with these at-risk populations. Part Three offers recommendations to police psychologists on how to develop programmatic solutions to the challenges faced by law enforcement when dealing with PICs.

INTRODUCTION

Law enforcement agencies are increasingly developing programs for responding to a *Person-in-Crisis* (PIC), i.e., an individual who is significantly psychologically impaired as a result of mental illness, emotional disturbance, or substance intoxication. PICs may or may not be a danger to self or others, but they are experiencing psychological impairment and difficulty coping with the stressors of life that is sufficient to generate a state of crisis characterized by short-term, reactive, or defensive thought and behavior.

The new law enforcement-based programs for responding to PICs are designed to accomplish two goals: (1) de-escalate and provide emergency psychological services for PICs, and (2) divert as many

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people as appropriate from the criminal justice system into the mental health system (CMHS, National Gains Center, 2007; Hails & Borum, 2003). Emergency psychological services, sometimes referred to as crisis services, are in some sense the logical extension of Emergency Medical Services (EMS). Emergency psychological services and EMS focus on providing immediate interventions to prevent death, harm, and suffering, and also to connect the PIC to appropriate follow-up treatment.

In this chapter we address: (1) social and legal changes necessitating the development of these programs, (2) different types of programmatic responses, and (3) recommendations for creating, improving, and maintaining such a program. Our geographic focus is the United States as a whole, but we will highlight data derived from one such program, with which we are associated, the *Honolulu Emergency Psychological Services and Jail Diversion Program* (HEPSJDP).

PART ONE: SOCIAL FACTORS AND LAW ENFORCEMENT RESPONSES TO PICs

In 2014, there were approximately 12 million people in the United States with a serious mental illness (Centers for Disease Control and Prevention, 2013; Kids Count Data Center, 2015). A significant portion of this population will have one or more mental health crises during their lifetimes that will result in encounters with law enforcement. A study of 174 police departments across the United States found that 7 to 10% of all police interactions involved individuals experiencing symptoms of serious mental illness (SMI; Deane, Steadman, Borum, Veysey, & Morrissey, 1999). While we do not have historical data for comparison, it appears likely that these encounters have dramatically increased in recent decades (Hails & Borum, 2003). The reasons for the likely increases in these interactions cannot be accounted for by increases in rates of mental illness or drug abuse (NIH, 2015) and, therefore, have to be understood in terms of changes in public policy (Torrey, 2014).

Deinstitutionalization

Prior to the 1970s, police had far fewer encounters with people suffering from SMI because a much higher percentage of people with SMI were institutionalized, often for life (Torrey, 2014). Beginning in the 1950s, a variety of scientific, medical, moral, and legal changes lead to a new and radically different public mental health care policy that has come to be known as *deinstitutionalization* (Torrey, 2014). Deinstitutionalization is a general term for a set of policies intended to reduce the number of people in mental health hospitals. In the 1950s, mental health hospitals began shutting down in response to lawsuits, government investigative findings of inhumane conditions, and the hopes generated by the development of new psychotropic medications (Torrey, 2014). Over the last half century, the primary effect of deinstitutionalization has been, as intended, to release hundreds of thousands of people with SMI from mental heath hospitals, and prevent others from being institutionalized.

Unfortunately, many people who were released from hospitals have not received adequate outpatient care, and have instead simply been re-institutionalized in jails and prisons, or left to live on the streets as chronically ill and homeless persons (Torrey, 2014). While the failure to fully fund community health care centers that were intended to provide outpatient mental health care for the people released from hospitals is probably the most important factor in the increase in interactions between PICs and law enforcement officers (LEOs), it is also true that community-based treatments often fail (Torrey, 2014).