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The Dark Frontier: The Violent and Often Tragic Point of Contact Between Law Enforcement and the Mentally Ill.

Gary Howell

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THE DARK FRONTIER: THE VIOLENT AND OFTEN TRAGIC POINT OF CONTACT BETWEEN LAW ENFORCEMENT AND THE MENTALLY ILL

GARY HOWELL*

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I. Introduction

There is a place in the collective conscience of society that few people take the time to consider. It is an uncomfortable place where reason and rule of law are twisted by the illogical and bewildering behavior of the mentally ill. This place—this dark frontier—violates our sense of justice because we do not know how to reconcile it with reality, so we turn away from it. It is this dark frontier that disrupts our personal realities when we see the mentally ill collide with society's reason and rule of law. In

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this dark frontier there is a point of contact between law enforcement and the mentally ill in which the rational rules of society have no meaning, no substance. It is a void between what is real and what the mentally ill see and hear. This void is filled with fear, despair, and unheard cries of pain. It is at this point of contact that violence and death manifest themselves; where the only apparent response for either side is violence or deadly force. Sometimes it is law enforcement that is harmed or killed; most times it is the mentally ill who pay the higher price. Is there a better way for our society to cope with this dark frontier than to turn away from it?

From the moment we become self-aware, we begin a journey of change. In this journey of self-realization, some lose their way and end up on a dark path of profound mental illness—trapped in a mind that is hard for others to understand. Sometimes, we can help guide these people back to what we believe to be reality and equilibrium. Many times, for a multitude of reasons, we cannot help and those we cannot understand end up in violent confrontations with family and friends, then strangers, and, ultimately, law enforcement. Often the lives of innocents are taken before a tragic and violent end comes to the mentally ill. This article examines this dark frontier of an increasing[1] trend of violent and, many times, deadly outcomes of disputes between the mentally ill and law enforcement, the astonishing history of this trend, and what must be done to change the outcome.

A. *A Personal Story*

To begin, I want to share how my perspective on mental illness was formed. It is a moment that I can recall with perfect clarity. When I was a small boy I watched in terror as my mother took a knife to herself. It wasn't until I heard her cries of pain that I could believe what my eyes were telling me. The confusion and fear were overwhelming. What could be so wrong that the most perfect person in my world would hurt herself? Although I did not know it at the time, I was witnessing what despair can drive a person to do, what the mind will cause a person to do when they cannot be understood. My mother was committed to a mental institution and was absent for what seemed like ages to a small boy. She was treated with what some considered the best medical science could offer at the time, electroconvulsive therapy.[2] When she came home, a part of her was

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1. *See* Gary Fields, *In Depth: Lives of the Mentally Ill, Police Collide in America—Narrowing the Range of Treatment Options Shifts More Responsibility to Law-Enforcement Officers*, WALL ST. J. EUR., Oct. 24, 2013, at 10 (explaining anecdotal evidence suggests an increase of violent attacks directed toward police by mentally unstable people).

2. *See Electroconvulsive Therapy*, MENTALHELP.NET, http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=8150 (last visited Nov. 3, 2014) (discussing the effectiveness

missing and, although I was just a child, I knew it and I felt it. In reality, what happened had changed us both. She rarely spoke of the treatment or the excruciating pain she suffered while going through it. It should be noted that, today, medical science is divided over the use of electroconvulsive therapy and its side effects.[3]

My mother went on to live a full and fruitful life, having two more children. She watched and guided all of us as we went on to have prosperous lives and a total of five children of our own. She was a wonderful mother and grandmother. She was by far the strongest, most unselfish, and dignified person I have ever known. She passed quietly in the summer of 2012. My life and identity were profoundly touched by her illness, treatment, and its aftermath.

Now, seemingly more frequently, we are all faced with reports of the conflicts between the mentally ill and their family, friends, strangers, and law enforcement. The bewildering and tragic reports from places like a movie theater in Aurora, Colorado or a small town elementary school in Newton, Connecticut touch a place in all of us where words are of little use. I am reminded of what I saw and felt as a boy, and how my experience could have turned out so very differently. My mother suffered the real harm, but in so many instances the hurt and loss brought on by mental illness spreads far beyond a mentally ill person to touch hundreds and even thousands of people directly.

B. *The Point of Contact—Violent and Tragic Encounters*

It is hard to determine with any specificity how many encounters, violent or otherwise, there are between law enforcement and the mentally ill because state laws and federal regulations restrict access to mental health records.[4] The best information available is anecdotal; however, it comes

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of electroconvulsive therapy, commonly referred to as ECT, and the decrease in its use with the development of medication used to treat some mental disorders).

3. *Id.*

4. *See HIPAA Privacy Rules for the Protection of Health and Mental Health Information,* N.Y. STATE OFF. OF MENTAL HEALTH, http://www.omh.ny.gov/omhweb/hipaa/phi_protection.html (last updated Nov. 15, 2012) (explaining the formation of HIPAA privacy rules and the basic principles of their application). The concerns over privacy are not without merit because of the stigma attached to mental illness; being diagnosed with a mental illness can have a prejudicial effect on employment opportunities, promotion and a person's willingness to seek treatment. *See generally* Patrick W. Corrigan et al., *Prejudice, Social Distance, and Familiarity with Mental Illness*, 27 SCHIZOPHRENIA BULL. 219 (2001), *available at* http://schizophreniabulletin.oxfordjournals.org/content/27/2/219.full.pdf (stating that "[t]he course of a person's experience with mental illnesses like schizophrenia is greatly hampered by social stigma . . . stigma is not a rare event; stigmas about mental illness are widely endorsed by the general public . . . [and] seem to affect public behavior toward persons with mental illnesses like schizophrenia").

from sources that have reason to know what is happening and to be concerned.[5] The executive director of the Fraternal Order of Police, James Pasco, who speaks for 330,000 members, believes violent confrontations between law enforcement and the mentally ill have steadily risen over the last decade.[6] A joint study issued by the Treatment Advocacy Center and the National Sheriff's Association stated that at least one-half of the people shot and killed by law enforcement in the United States have mental health problems.[7] Since there is no national data collected on such instances, the Treatment Advocacy Center and the National Sheriff's Association used the following criteria as the basis for their assertion:

- There has been a sixty-seven percent rise in justifiable homicides by law enforcement, from 153 to 255 per year since 1980;[8]
- Some of the victims were known by law enforcement to have mental health issues based on multiple encounters;[9] and
- Studies on "suicide by cop"[10] involve a high number of mentally ill persons.[11]

Both local and national news are replete with stories of deadly encounters between law enforcement and mentally ill persons. This is the dark frontier we send law enforcement into to confront the irrational mind and actions of the mentally ill. What follows are but a few of the hundreds of recent examples of the tragic outcomes at the point of contact between law enforcement and the mentally ill:

- In 2013 a mother was shot and killed by Washington D.C. police when she rammed her car into a White House barrier.[12] The police and family stated the woman had mental health issues.[13]
- In 2012, when Clay McCall's grandmother locked him out of her house because she couldn't control him, she called a mental health

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5. Fields, *supra* note 1, at 10.

6. *Id.*

7. *See* E. Fuller Torrey et al., Treatment Advocacy Ctr., Justifiable Homicides by Law Enforcement Officers: What is the Role of Mental Illness?, at 3 (2013), *available at* http://tacreports.org/storage/documents/2013-justifiable-homicides.pdf (noting a 2012 investigation, which included hundreds of interviews and thousands of pages of documents, concluded that at least half of the people shot and killed by police each year have mental health problems).

8. *Id.*

9. *Id.*

10. A situation in which a person intentionally provokes an officer into using lethal force.

11. Torrey et al., *supra* note 7, at 3. *See also* Fields, *supra* note 1, at 10 (explaining that another research body, the Police Executive Research Forum, also postulates "suicide by cop" incidents are on the rise).

12. Fields, *supra* note 1, at 10.

13. *Id.*

caseworker who called police.[14] When Charlotte, North Carolina police arrived McCall charged at them with ten-inch garden shears.[15] He was fatally shot.[16] McCall suffered from schizophrenia and had been violent in the past.[17]

- In 2010 a traffic stop in Portland, Oregon turned deadly when an officer tried to physically remove Keaton Otis from an automobile after several verbal attempts had been ignored.[18] The officer was outmaneuvered and shot twice by Otis.[19] When more officers responded, Otis, who police later learned suffered from depression and paranoia, was killed.[20]

This article describes the history and recent developments of the intersection of law enforcement with the mentally ill. Part II provides background on the nation's approach to mental illness. Part III then explores the current approach, called the Behavioral Health Continuum of Care Model, as well as its effects on the mentally ill, their families, and society at large. This section also considers the current challenges faced by law enforcement as they seek safer methods of interacting with the mentally ill. Part IV describes what has been termed a "mental health crisis," as well as the urgent need to bring change to this dark frontier. Finally, Part V presents recommendations on how to move forward towards progress, rather than exacerbating this tragic crisis.

II. BACKGROUND

A. *Evolution of the Nation's Approach to Mental Illness*

Today, the United States is at a point where law enforcement serves as the primary entity used for managing a significant portion of the mentally ill, especially the homeless mentally ill.[21] To understand how the county got to that point one must become familiar with the medical, political, and legal decisions that began in the first half of the nineteenth century. At that time, the nation became outraged when it learned that most of its

14. TORREY ET AL., *supra* note 7, at 18.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. Fields, *supra* note 1, at 10.
20. *Id.*
21. *See* Fernanda Santos & Erica Goode, *Police Confront Rising Number of Mentally Ill Suspects*, N.Y. TIMES (Apr. 1, 2014), http://www.nytimes.com/2014/04/02/us/police-shootings-of-mentally-ill-suspects-are-on-the-upswing.html (reporting that "[c]ounty jails and state prisons have become de facto mental institutions . . . . 'Frequent fliers,' as mentally ill inmates who have repeated arrests are known in law enforcement circles, cycle from jail cells to halfway houses to the streets and back").

mentally ill were incarcerated in jails and prisons.[22] The conditions in which the mentally ill were held were considered inhumane.[23] The cause of the mistreatment of the mentally ill was taken up by reformers, such as Dorothea Lynde Dix, who led movements across the United States to support the building of mental hospitals for the treatment of the mentally ill.[24] It was during this period the public was persuaded that hospitals, not jails and prisons, were where the mentally ill should be treated.[25]

For most of the nineteenth century the American public did not consider punishment an acceptable treatment for the mentally ill.[26] By the 1880s the majority of mentally ill persons in the United States, who were not cared for by their families, were in mental institutions.[27] For nearly a hundred years the nation maintained an equilibrium that kept most of the mentally ill out of jails and prisons and in institutions[28]—institutions that began with the most noble of intentions but, over time, became as notorious as the prisons they were meant to replace.[29]

As the American population increased, so did the populations of the institutions. Unfortunately there was not a corresponding increase in institutional capacity.[30] By the 1940s the deplorable treatment and conditions that caused America to build the mental institutions in the first place manifested in those very institutions.[31] Again, the American con-

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22. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2 (2010), *available at* http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

23. *Id.*

24. *Id.*

25. *See id.* (explaining that in the first part of the 20th century "the public was shocked to find that most mental ill persons were being housed in local jails and prisons").

26. *See id.* at 14 (discussing the events that led up to the change in opinion about how to effectively address mentally ill individuals).

27. *See id.* at 1 (citing the 1880 census of mentally ill individuals that revealed 40,942 mentally ill people were in hospitals or asylums for the insane, with less than one percent in jails and prisons).

28. *See id.* at 14.

29. *See Mental Health*, UNIVERSITY OF TOLEDO LIBRARIES, http://www.utoledo.edu/library/canaday/exhibits/quackery/quack5.html (last visited Jan. 10, 2015) (discussing the "moral treatment" of the insane and pointing out, "[b]y the 1880s, asylum conditions had deteriorated significantly, and neurologists began to vie for control of institutions").

30. *See* TORREY ET AL., *supra* note 22, at 1, 8 (explaining that even for individuals greatly in need, it is very difficult to find room for them in psychiatric hospital).

31. *See generally* Kimberly Leupo, *The History of Mental Illness*, KATHI'S MENTAL HEALTH REVIEW, http://www.toddlertime.com/advocacy/hospitals/Asylum/history-asylum.htm (last visited Nov. 4, 2014) (detailing the disturbing progression of the treatment of the mentally ill).

science stirred and the nation moved away from large institutions.[32] Without realizing it, the nation took a giant step backwards in coping with the plight of the mentally ill.[33] This was the beginning of a methodical, nationwide dismantling of mental institutions in a movement toward what is today called deinstitutionalization.[34] It should be noted that the purpose of the discussion on deinstitutionalization that follows is not to condemn the national approach to handling the plight of the mentally ill. There are numerous articles that perform that service.[35] This discussion is simply to provide the reader with some insight into how the dark frontier came to exist.

Deinstitutionalization is the term most often used to describe the movement from a centralized system of care for the mentally ill to the system of localized, although spotty, care we now see in the United States.[36] The pivotal swing in momentum toward deinstitutionalization began with the advent of psychotropic drugs in the 1950s, which caused a shift in the paradigm of where, when, and how treatment for mental illness could or should be delivered.[37] Chlorpromazine and Reserpine, also known as Thorazine and Raudixin respectively, became available in 1954

32. Patricia D'Antonio, *History of Psychiatric Hospitals*, WWW.NURSING.PENN.EDU, http://www.nursing.upenn.edu/nhhc/Welcome%20Page%20Content/History%20of%20 Psychiatric%20Hospitals.pdf (last visited Nov. 17, 2014) (explaining the downfall of asylums in 1950s).

33. *See generally Deinstitutionalization: A Psychiatric "Titanic,"* PBS.ORG, http://www .pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html (last visited Jan. 10, 2014) (discussing the history of deinstitutionalization beginning in 1955).

34. *See generally* TORREY ET AL., *supra* note 22 (explaining the conditions that led to the creation of mental health hospitals are, in fact, the same conditions that many mentally ill prisoners face today after deinstitutionalization).

35. *See e.g.* Natasha Tracy, *Patient Dumping: How Hospitals Treat the Mentally Ill*, HEALTHLINE BLOG (Sept. 11, 2013), http://www.healthline.com/health-blogs/bipolar-bites/ patient-dumping-how-hospitals-treat-mentally-ill (detailing how patients are treated until they are stable and then released prematurely); Aaron Kinikini, *My View: Inmates Need Better Mental Health Treatments*, DESERET NEWS (Nov. 1, 2014, 12:00 AM), http://www .deseretnews.com/article/865614317/Inmates-need-better-mental-health-treatments.html? pg=all (arguing for better treatment for mentally ill prisoners).

36. *See generally* Lorin Bradbury, *Deinstitutionalization of Psychiatric Patients*, DELTA DISCOVERY (Aug. 1, 2012), http://www.deltadiscovery.com/story/2012/08/01/contributors/%20deinstitutionalization-of-psychiatric-patients/353.html (stating that although deinstitutionalization had been helpful for some patients, in many cases it has been a "dismal failure").

37. *Id.* ("During the 1950s and 1960s there was a powerful movement to deinstitutionalize psychiatric patients. There was the belief that with the advent of modern medications to treat mental problems, patients would be able to live a much more normal life outside the institution.").

and were considered effective in treating psychotic disorders.[38] These drugs seemingly made it possible for the seriously mentally ill to be treated outside the confines of an institution.[39]

In the early 1960s President Kennedy, whose sister Rosemary suffered from mental illness, made the first major political decision affecting treatment of the mentally ill on a national scale.[40] President Kennedy's view favored a prevention-based approach to treatment, achievable through a policy of decentralization.[41] Care for the mentally ill would need to be spread out into the local communities to accommodate prevention and follow-up services.[42] President Kennedy and his advisors envisioned a treatment system that could be accessed locally by those in need.[43] The intent of this approach was to develop a community-based support system that would enable the mentally ill to move back into society and out of the isolation of the large institutions.[44] The large institutions were at the time considered the antithesis of prevention and recovery.[45] To support the President's vision, Congress passed legislation appropriately called the Community Mental Health Centers Act.[46] While the legislation was well-intentioned in initiated in good faith, it did not contemplate the transitional needs of the nation's population of institutionalized mentally ill as they moved back into unprepared communities that became quickly overwhelmed.[47]

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38. Pat Stubbs, *The Story of Deinstitutionalization*, MENTALHELP.NET (Sept. 1, 1998), http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=368.

39. *See* Bradbury, *supra* note 36 (stating with the introduction of these drugs many patients could lead a much more normal life outside the walls of a psychiatric institution).

40. Stubbs, *supra* note 38.

41. *See id.* (discussing President Kennedy's opinion that primary prevention was vital to mental health and could be achieved by supporting community mental health centers).

42. *See id.* (elaborating on President Kennedy's comment that "reliance on the cold mercy of isolation would be supplanted by the open warmth of community concern and capability").

43. *See id.* (discussing President Kennedy's reasoning and hope in enacting this legislation).

44. *See generally Community Mental Health Act: Kennedy's vision never realized*, ABC NEWS CHANNEL 8 (Oct. 20, 2013, 11:46 AM), http://www.wjla.com/articles/2013/10/community-mental-health-act-kennedy-s-vision-never-realized-95665.html (discussing the Community Mental Health Act as it neared its fiftieth anniversary in October 2013).

45. *See generally* Stubbs, *supra* note 38 (discussing the idea that community mental health centers were thought to be the best way to prevent and treat mental health issues).

46. *Id.*

47. *See generally id.* (pointing out the lack of communication between hospitals releasing mentally ill patients and the unprepared community mental health centers receiving them).

The medical and political movements toward deinstitutionalization served as a call to action for the legal community.[48] Lawyers championing the cause of civil liberties, mainly through organizations such as the American Civil Liberties Union (ACLU), were relentless in their attacks on civil commitment laws, which up to that point kept patients flowing into the large institutions.[49] The lawyers reasoned more stringent civil commitment laws would slow down the flow of the mentally ill into institutions, reducing the size of institutions or eliminating the their need altogether.[50]

One of the most notable cases the ACLU brought before the Supreme Court on behalf of the mentally ill was *O'Connor v. Donaldson*.[51] The plaintiff was mentally ill and held for fifteen years in a state mental hospital, where he was left untreated for his illness.[52] In applying the Constitution, the Court held the states could not confine a person who is not a danger to himself or others.[53] The Court went on to state the holding applied to the suicidal, as well as the seriously disabled, regardless of their ability to protect themselves, and whether they were alone or had the support of their family or friends.[54] As the plaintiff in this case received no treatment, the Court expressly did not determine "whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or, if it can, how much and what kind of treatment would suffice."[55] This issue remains unresolved to this day.[56]

48. *See ACLU History: Mental Institutions*, ACLU (Sep. 1, 2010), https://www.aclu.org/organization-news-and-highlights/aclu-history-mental-institutions (stating the next step to ensure the rights of the mental ill was through the legal system).

49. *See id.* (citing cases where the ACLU fought and protected the rights of the mentally ill); *see e.g.* Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972) (advocating for the rights of the mentally ill and cited above); Wyatt v. Aderholt, 503 F. 2d 1305 (5th Cir. 1974) (advocating for the rights of the mentally ill and cited above).

50. *See generally ACLU History*, *supra* note 48 (citing cases where lawyers have focused on narrowing the criteria used to determine whether a mentally ill individual truly needs to be institutionalized).

51. *Id.*; *see* Mary Ann Bernard, *Supreme Court Mental Health Precedent and its Implications (9/09)*, MENTAL ILLNESS POLICY ORG., http://mentalillnesspolicy.org/legal/mental-illness-supreme-court.html (last visited Oct. 23, 2014) (explaining the Supreme Court has not revisited the issue of establishing more rigorous standards to hold a mentally ill individual institutionalized).

52. O'Connor v. Donaldson, 422 U.S. 563, 564 (1975).

53. *Id.* at 572–73.

54. Bernard, *supra* note 51.

55. *O'Connor*, 422 U.S. at 573–74 n.10.

56. *See* Bernard, *supra* note 51 (illustrating the ambiguity surrounding whether a correlation exists between treatment and the constitutionality of involuntary detention).

Another important case brought on behalf of the mentally ill was *Jackson v. Indiana*.[57] In this case the Court held that "mentally ill criminal defendants who are incompetent to stand trial cannot be indefinitely committed on that basis alone. The nature and duration of civil commitment must bear a reasonable relationship to the purpose of the commitment."[58]

These decisions by the Supreme Court set precedent by establishing that a person cannot be involuntarily committed to a mental institution unless that person posed an imminent threat of harm to himself or others.[59] This initiated a nationwide reduction in the populations of mental health institutions.[60] Both liberal and conservative political bodies agreed on deinstitutionalization, but for different reasons.[61] For liberals, deinstitutionalization presented an opportunity to make political hay over civil rights; for conservatives, deinstitutionalization presented an opportunity to make political hay over reducing budgets.[62]

The mass release of the mentally ill from state hospitals began in the 1960s.[63] The ratio of state supported mental hospital beds available to patients in 1955 was three hundred and forty beds per one hundred thousand people.[64] By 2005, the ratio of state supported mental hospital beds available to patients had dropped to seventeen beds per one hundred thousand persons.[65] Because there is no established methodology, there is no agreement among organizations and professionals as to how many beds is enough, because there is no established methodology with which to arrive at a number.[66] However, there is a consistent theme of fifty

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57. Jackson v. Indiana, 406 U.S. 715 (1972); *see* Bernard, *supra* note 51 (signifying the importance of this case as it reflects one of the earlier Supreme Court rulings regarding confinement of the mentally ill).

58. Bernard, *supra* note 51 (citing Jackson v. Indiana, 406 U.S. 715, 737–738 (1972).

59. *See generally id.* (detailing how Supreme Court decisions have shaped the constitutional landscape surrounding metal illness and civil commitment law regarding institutionalization).

60. *See generally id.* (establishing the legal implication of Supreme Court decisions in giving states considerable leeway in defining mental illness and dangerousness).

61. *See* E. Fuller Torrey, *Stop the Madness*, WALL ST. J., July 18, 1996, at A14, *available at* http://mentalillnesspolicy.org/imd/closed-hospitals-eftwsj.html (pointing out that conservatives focused on budget restraints, while liberals centered on mental patients' freedoms).

62. *See id.* at A14 (illustrating the divergent motivations driving each party to the same outcome).

63. *Id.* at 2.

64. *Id.*

65. *Id.*

66. LAUDAN ARON ET AL., NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES 2009: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS 33 (2009), *available at* http://www2.nami.org/gtsTemplate09.cfm?Sec

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beds per one hundred thousand people put forth as a *minimum* standard ratio of state supported mental hospital beds.[67] Based on this ratio, forty-two of fifty states currently have less than half the number of beds required to meet the minimum standard.[68]

Few would argue that, had the motives behind deinstitutionalization been realized, there would be a significant change in the current trajectory of both the homeless mentally ill and those mentally ill likely to confront law enforcement.[69] The trifecta of medical, political, and legal action that led to deinstitutionalization became an irresistible force in changing how the mentally ill received care then, and how they receive care now.[70]

III. Here and Now

Today, the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the United States Department of Health and Human Services, advocates the concept of a Behavioral Health Continuum of Care Model.[71] SAMHSA states one of the benefits of this model is that it presents a structure that helps one see the multiple opportunities to address mental health problems.[72] This continuum is made up of four components: Promotion, Prevention, Treatment, and Maintenance.[73]

- Promotion: "These strategies are designed to create environments and conditions that support behavioral health and the ability of

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67. E. Fuller Torrey et al., Treatment Advocacy Ctr., The Shortage of Public Hospital Beds for Mentally Ill Persons 2 (2008), *available at* http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf.

68. *Id.*

69. *See generally* 145 Cong. Rec. 15539, 15539–41 (1999) (elaborating on the aftermaths of deinstitutionalization and the side effects in a speech given before the U.S. Senate by Senator Patrick Moynihan, July 12, 1999).

70. *See generally* E. Fuller Torrey, Out of the Shadows: Confronting America's Mental Illness Crisis 8–10 (1998) (explaining how deinstitutionalization created a crisis for the mentally ill by not providing them adequate treatment in order to live a successful life, which crisis continues to this day).

71. *See generally* Substance Abuse and Mental Health Services Admin., Information Sheet 1: A Behavioral Health Lens for Prevention (2012), *available at* http://captus.samhsa.gov/sites/default/files/capt_resource/capt_behavioral_health_fact_sheets_2012_0.pdf (advocating the use of a behavioral lens to the prevention efforts through the use of the Behavioral Health Continuum of Care Model).

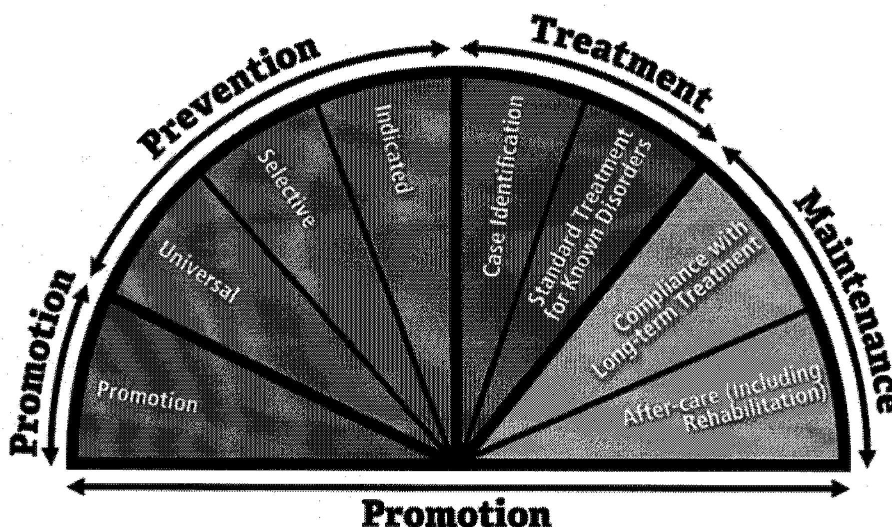
72. *Id.* at 2.

73. *Id.*

individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services."[74]

- Prevention: "Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use."[75]
- Treatment: "These services are for people diagnosed with a substance use or other behavioral health disorder."[76]
- Maintenance: "These services support individuals' compliance with long-term treatment and aftercare."[77]

The graphic below appears in SAMHSA's report "A Behavioral Health Lens for Prevention" as an illustration of the continuum of care.[78]



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SAMHSA places a high premium on prevention and the incidence of comorbidity[80] in the manifestation of mental illness.[81] "An estimated

74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.*
80. The relationship between alcohol, drug, emotional, or physical abuse and mental illness on-set.
81. *See generally* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., INFORMATION SHEET 1, *supra* note 71, at 1–2 (elucidating that comorbidity is when people

37% of alcohol abusers and 53% of other drug abusers also have at least one serious mental illness."[82] The central idea of the prevention approach is if one causal factor can be reduced or illuminated, more serious mental health issues may be avoided.[83]

Unfortunately the continuum, like society, does not address the dark frontier, nor the point of contact between law enforcement and the mentally ill. Society continues to present a steady state of reality that does not contemplate a segment for those that cannot reconcile their current set of circumstances against any section of the continuum—those who do not register anywhere on the continuum's situational ark. The mentally ill who do not register on the continuum are the ones living with fractured families who are unable to cope with their behavior, the homeless, the incarcerated, those whom suffer from anosognosia,[84] and the mentally ill—in essence, the outliers. The continuum of care needs to be expanded to accommodate these outliers. It should have points on the ark that recognize the failings of deinstitutionalization and provide a point of access that anticipates the needs of the outliers. Instead of an ark, a circle that acknowledges the full spectrum of mental illness situations is a better graphic representation of a continuum of care. It should represent and address both the ideal situation, in which a mentally ill person receives treatment, and leads a happy, productive life, *and* a situation in which a mentally ill person searches garbage cans for food, and lives in a box, soiled in his or her own waste.

A. *Unintended Consequences*

The actions of the well-intentioned crusaders so long ago have brought us to the unintended consequences now reflected by our prison popula-

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that have more than one behavioral disorder, their disorders interact and that contributes to the creation of other disorders, which means that interventions do not always fit into one single category).

82. *Id.* at 1.

83. *See generally id.* (indicating the prevention efforts will help address health problems in a more comprehensive way, because there is evidence that proves several problems overlap and noticing the connections between substance abuse and other health problems will allow for a more collaborative way of addressing the problems).

84. *See* Katherine B. Cook, *Revising Assisted Outpatient Treatment Statutes in Indiana: Providing Mental Health Treatment for those in Need*, 9 IND. HEALTH L. REV. 661, 666–67 (2012) (describing that an individual with anosognosia is truly not aware that they are ill). The individual with this condition lacks insight that allows them to comprehend their illness, and "[b]etween 40 and 60% of those diagnosed with schizophrenia and manic-depressive illness may be truly unaware that they are ill and thus find no reason to take treatment". *Id.* As a result of anosognosia these individuals will stop taking their medication because they do not see any problems with themselves. *Id.*

tions.[85] The American Psychiatric Association reported in 2000, twenty percent of prisoners in the United States suffered from a serious mental illness, of which 5% were psychotic at some point in time.[86] In a 2002 report to Congress, the National Commission on Correctional Health Care stated approximately 17% of inmates had schizophrenia.[87] A survey conducted by the Department of Justice in 2006 indicated that 15% of state prison inmates and 24% of jail inmates presented at least one psychotic disorder.[88] Collectively these reports indicate that between 15% and 20% of jail and prison inmates suffer from a serious mental illness.[89]

Today we know the prevention of mental illness is possible up to a point; however, there is no panacea.[90] We also know the mentally ill make up an inordinate percentage of the homeless population.[91] As a society, we search for reasonable legislative and political answers to an illness that knows no reason. We struggle with a value system that puts individual rights at the top of our priorities as a nation, then feebly search for the bright line to show where individual rights stop and medical and legal intervention must begin.[92] Then there is the sinister aspect of large institutions, along with the social conditioning of the last fifty years, that has convinced us that no good can come from large institutions, so instead we build more and more prisons to house both criminals and the mentally ill.[93] British psychiatrist and mathematician Lionel Penrose posited that the populations of hospitals for the mentally ill and prisons are

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85. *See generally* TORREY, *supra* note 70 (reporting that deinstitutionalization has increased the number of mentally ill in the prison systems).

86. *Id.* at 4.

87. *Id.*

88. *Id.*

89. *Id.*

90. *See generally* WORLD HEALTH ORG., PREVENTION AND PROMOTION IN MENTAL HEALTH (2002), *available at* http://www.who.int/mental_health/media/en/545.pdf (discussing the evolution of preventing mental illness and what can be done to mitigate its effects once a mental illness has been diagnosed).

91. *See* SANDRA J. NEWMAN, THE SEVERELY MENTALLY ILL HOMELESS: HOUSING NEEDS AND HOUSING POLICY 2 (1992) (reporting that the government has adopted an estimation that one out of three homeless individuals suffer from a mental illness).

92. *See generally* ILLNESS POLICY ORG., http://mentalillnesspolicy.org/aot/overview.html (last visited Nov. 16, 2014) (describing how courts have compromised and allowed assisted outpatient treatment instead of committing an individual to a hospital).

93. *See generally* TORREY ET AL., *supra* note 22 (describing the trend of closing mental health facilities while having to increase the number of prisons to house mentally ill individuals who end up incarcerated).

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inversely correlated, and when one population increases the other population decreases.[94]

B. *How Mental Illness Affects a Family*

Families who have a mentally ill member are faced with the dilemma of confronting both the behavior and the resistance to treatment, or acquiescing to what seems an inevitable fracture in the family.[95] Those families that find a way to successfully confront the behavior provide protection to a loved one in the most vulnerable of conditions, a person who can be easily influenced, misled, and manipulated.[96] Those fortunate to have this type of support system exist in the relative safety that a caring family can provide, safety that allows them a chance to achieve some measure of equilibrium.[97]

Many times these families are forced to commit their loved ones to mental institutions in order for the family member to regain a baseline of rational behavior.[98] When a loved one is released back to the family there tends to be resentment, mistrust, and a sense of betrayal on the part of the person committed.[99] In some cases there is no forgiveness, and all that can be achieved is a peaceful coexistence that keeps the mentally ill person safe.[100] Those families that are unable to confront the behavior suffer the heartbreak of witnessing a loved one slip into a reality that can lead to violence, homelessness, physical and sexual abuse, and, all too often, violent encounters with law enforcement.[101]

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94. *Id.* at 15 (explaining that Penrose's theory is known as the balloon theory, and is best illustrated by squeezing one end of a balloon and noting the bulge at the other end).

95. *See generally* A SOURCEBOOK FOR FAMILIES COPING WITH MENTAL ILLNESS: A GUIDE FOR PREVENTING THE OTHER SHOE FROM DROPPING (Michael R. Berren, ed., 2d ed. 2002), *available at* http://www.nami.org/Content/Microsites316/NAMI_PA,_Cumberland_and_Perry_Cos_/Home310/Home_and_Running_Calendar/Source2ndEdition.pdf (describing the challenges family members are faced with when trying to communicate with another member of the family who has a mental illness).

96. *See id.* at 58 (describing how successful communication with a family member with a mental illness can improve their quality of life).

97. *See generally id.* (describing the advantages of living with a loved one when suffering with a mental illness).

98. *See generally id.* at 107 (listing various housing options for individuals with mental illness).

99. *See generally id.* (discussing how individuals with a mental illness can have difficulty understanding what their family members are trying to convey to them).

100. *See generally id.* (focusing on overcoming communication barriers, and the lack of trust between the mentally ill and their family).

101. *Homelessness: One of the Consequences of Failing to Treat Individuals with Severe Mental Illnesses*, TREATMENT ADVOCACY CTR., http://www.treatmentadvocacycenter.org/index.php?option=com_content&id=1379&Itemid=217 (last updated Mar. 2011) (discussing the difficulties the homeless face).

Most civil commitment laws are predicated on the assumption that no one should be committed until they become a danger to themselves or others.[102] This approach disallows any preemption, so by the time an untreated mentally ill person gets close to any help, a crime has likely been committed or they have actually harmed themselves or others.[103] There is irony in laws that cause some of society's most vulnerable people to be exposed to some of society's greatest evils—homelessness, hunger, and physical and sexual abuse.[104]

In thirty-five states there are now laws on the books that allow Assisted Outpatient Treatment (AOT).[105] In AOT states the laws allow the courts to order high-risk individuals into AOT if they wish to live in the community.[106] The mentally ill suffering from disorders like schizophrenia, must take medication in order to control their own thoughts and behavior.[107] Occasionally these individuals do not acknowledge they are ill ("Anosognosia") and thus have no willingness to be treated.[108] Left untreated, these individuals decompensate and typically become homeless, commit suicide, or end up in confrontations with law enforcement.[109] Until these laws were passed, family members could not intervene until the loved one had deteriorated to the point of becoming a danger to himself or others.[110]

C. *Criminalization of Mental Illness*

In 2008, Chad Scott published a book on the criminalization of mental illness.[111] It is an examination of the unintended consequence of deinsti-

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102. *See Civil Commitment: Information about the Process for People Alleged to be Mentally Ill*, DISABILITY RIGHTS OHIO, http://www.disabilityrightsohio.org/civil-commitment#someofyour (last visited Nov. 10, 2014) (listing the requirements for committing an individual).

103. *See id.* (describing the conditions necessary for a patient in the criminal justice system to be committed to a state hospital).

104. *See* TREATMENT ADVOCACY CTR., *supra* note 101 (estimating that one-third of the nation's homeless have a serious illness).

105. *See* E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 PSYCHIATRIC SERVICES 778, 781 tbl.1 (1995) (displaying a table of the states allowing assisted outpatient treatment).

106. *Id.* at 778.

107. *See id.* (noting that outpatient commitments are used commonly for schizophrenic patients to force them to comply with medication).

108. TREATMENT ADVOCACY CTR., *supra* note 101.

109. *See* Torrey & Kaplan, *supra* note 105, at 779 (discussing the effects of medication noncompliance and lack of outpatient commitment).

110. *See id.* (describing concern from families of mentally ill regarding their inability to obtain care for mentally ill family members who refuse treatment).

111. CHAD SCOTT, CRIMINALIZATION OF THE MENTALLY ILL: AN INQUIRY INTO THE QUALITY OF LIFE OF POST-RELEASE OFFENDERS WITH PSYCHIATRIC ILLNESS (2008).

tutionalization—the high proportion of the mentally ill among the nationwide prison population.[112] In the book, he describes how deinstitutionalization has essentially criminalized mental illness because the alternative, large mental institutions, are no longer a viable option in many states.[113] The nation had traded one form of human warehousing—state mental institutions—for one more brutal and unforgiving—the prison system.[114]

As a result of the decisions made and perpetuated over the last fifty years, there now exists a dark frontier between the mentally ill and law enforcement.[115] It is a unique frontier, fashioned from the lack of any alternatives—a point in space and time where the rational application of societal norms and the law come into contact with the fog and friction of the irrational behavior of the mentally ill.[116] Law enforcement is asked to cope with the unknown, to confront a situation in which the rules of everyday life do not apply.[117]

D. *Law Enforcement Struggling to Cope*

Unfortunately in many cases, law enforcement is ill-equipped to deal with a mentally ill person in a conflict situation.[118] Generally, they are equipped with only blunt instruments, such as a taser or firearm, with

112. *Id.*

113. *Id.*

114. *Id.*

115. *See* UNIV. OF NEBRASKA PUB. POLICY CTR., NEBRASKA JUSTICE MENTAL HEALTH INITIATIVE: NEEDS ASSESSMENT 5–6 (2008), *available at* http://dhhs.ne.gov/behavioral_health/Documents/NEJusticeMHInitiative-Needs%20AssessmentReport06102008.pdf (noting that a majority of law enforcement officers in Nebraska are not properly trained to engage mentally ill subjects).

116. *See generally Law Enforcement*, N.J. GOVERNOR'S COUNCIL ON MENTAL HEALTH STIGMA, http://www.state.nj.us/mhstigmacouncil/community/law (last visited Nov. 3, 2014) (describing the challenges faced by law enforcement officials in both dealing with mental illness themselves and encountering mental illness in the line of duty).

117. *See generally* Lou Reiter, *Are You Providing Reasonable Training and Policy Direction on the Handling of the Mentally Ill and Emotionally Disturbed Persons?*, PUBLIC AGENCY TRAINING COUNCIL, http://www.patc.com/weeklyarticles/handling-handicapped.shtml#citations (last visited Jan. 28, 2014) (discussing policing problems, relevant cases, and actionable steps for encounters with mentally and emotionally disturbed persons).

118. *See* David Arroyo, *Mentally Ill Four Times More Likely to be Killed by Police*, LAS VEGAS GUARDIAN (Oct. 8, 2013), http://guardianlv.com/2013/10/mentally-ill-four-times-more-likely-to-be-killed-by-police (noting that many police officers are not equipped to deal with the mentally ill); *see also* Gary Fields, *Lives of Mentally Ill, Police Collide*, WALL ST. J., (Oct. 24, 2013), http://online.wsj.com/articles/SB10001424052702304561004579135623495179250 (noting half the nation's population live in areas where police do not receive training on handling the mentally ill).

which to respond to situations that spiral quickly out of control.[119] Statistically, a law enforcement officer is more likely to be trained in the delivery of CPR than on how to diffuse a high-threat situation with a mentally ill person.[120] Ironically, of these two situations, the one that is most likely to cause law enforcement personnel harm is the situation for which they have little or no training.[121] There is no coherent nationwide approach to training law enforcement personnel to cope with what is clearly a nationwide problem.[122] Then there is the drain on law enforcement resources that successfully resolving a crime involving a mentally ill person requires, in relation to a crime that does not.[123] Crimes involving the mentally ill require significantly more of an officer's time than a crime committed by someone who has no mental health issues.[124]

There is a higher statistical likelihood that a crime involving a mentally ill person will end violently.[125] Society now has names for some of the behaviors that occur in the dark frontier such as "[s]uicide by cop," a term most often applied when someone commits a crime with the sole intention of being killed by the police. In some situations the mentally ill person may harm or kill an officer or bystander in order to force another officer to act with deadly force.[126] In many cases the person killed is mentally ill.[127]

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119. Arroyo, *supra* note 118 (discussing the use of lethal and nonlethal devices by police officers).

120. *Id.*

121. *See id.* (stating "officers simply are not equipped to deal with the mentally ill").

122. *See generally id.* (describing a set of guidelines released by the Department of Justice that address ways to deal with the mentally ill in the line of duty, and asserting few states have adopted such guidelines).

123. *See* MICHAEL C. BIASCOTTI, THE IMPACT OF MENTAL ILLNESS OF LAW ENFORCEMENT RESOURCES 1 (Dec. 2011) *available at* http://www.treatmentadvocacycenter.org/storage/documents/The_Impact_of_Mental_Illness_on_Law_Enforcement_Resources.pdf (asserting that "calls involving mental illness increase the diversion of resources away from public safety").

124. *See id.* at 9 (comparing the amount of time spent on criminal calls involving mentally ill perpetrators and all others).

125. *See generally* Arroyo, *supra* note 118 (stating "mentally ill [people are] four times more likely to be killed by police").

126. CLINTON R. VAN ZANDT, NAT'L CENTER FOR THE ANALYSIS OF VIOLENT CRIME, F.B.I ACADEMY, SUICIDE BY COP 12 (n.d.).

127. *See* Gerald Landsberg & Ashley Fresenius, *Neglected Issues—Police Killings of the Mentally Ill and the Lack of Police and Mental Health Relations*, HUFFINGTON POST (June 12, 2013, 5:12 AM), http://www.huffingtonpost.com/gerald-landsberg/neglected-issues-police-k_b_3071717.html (explaining at least half the people killed by police each year are mentally ill).

E. *The Faulty Dilemma*

Another unfortunate term that is now widely used is "mercy arrest."[128] In most jurisdictions in the United States, it is easier for an officer to cite, arrest, and jail a mentally ill person than to pursue civil commitment.[129] Many officers make the mercy arrest choice in hopes the person jailed will be identified while in the jail system and receive the help they need.[130] With regard to draining resources, this approach gets the officer back on the street much more quickly than a commitment proceeding.[131] Unfortunately, the recidivism rate for those arrested is much higher than for those who are civilly committed.[132]

Should law enforcement training resources be prioritized to minimize the risks in confrontational encounters between law enforcement and mentally ill persons in relation to other high-risk encounters?[133] Would this lead to a reduction in violence? Once a situation with a mentally ill person develops and requires law enforcement intervention, the statistical likelihood that violence will occur increases by 25%.[134] The risk of violence does not differentiate between who may be harmed—it may just as likely be a member of law enforcement as a mentally ill perpetrator.[135]

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128. Jessica Burns, *A Restorative Justice Model for Mental Health Courts*, 23 S. CAL. REV. L. & SOC. JUST. 427, 442–43 (2014).

129. *See* Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, NAT'L INST. OF JUST. J., July 2000, at 10 (2000) *available at* https://www.ncjrs.gov/pdffiles1/jr000244c.pdf (describing the practical challenges faced by law enforcement officers when attempting to have someone committed to a hospital).

130. *See Law Enforcement and People With Severe Mental Illness—Backgrounder,* TREATMENT ADVOCACY CTR. (Oct. 2007), http://www.treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/jail/1385 (explaining that police try to protect severely mentally ill people by getting them off the streets using mercy bookings).

131. *See* Teplin, *supra* note 129, at 8, 10 (describing the lengthy and rigorous process of admitting a mentally ill person to a hospital, and noting admitted patients typically have to be exhibiting extreme signs of distress, such as being actively delusional or suicidal).

132. *See* Kathleen Wilson, *Recidivism High Among Mentally Ill Inmates,* VENTURA COUNTY STAR (Oct. 11, 2009, 12:01 AM), http://www.vcstar.com/news/2009/oct/11/recidivism-high-among-mentally-ill-inmates (attributing high rates of recidivism of mentally ill patients to a shift from placing those patients in mental hospitals to regular criminal jail facilities).

133. *See generally* Reiter, *supra* note 117 (outlining various cases in which the courts have asserted law enforcement need to have training in how to deal with the mentally ill in order to "do their jobs professionally" and to avoid being held liable for violating constitutionally protected rights).

134. *See generally* Arroyo, *supra* note 118 (stating that mentally ill people are four times more likely to be killed by police officers than the general public).

135. E. Fuller Torrey, *Law enforcement and people with severe mental illness,* MENTAL ILLNESS POLICY ORG., http://mentalillnesspolicy.org/crimjust/law-enforcement-mental-illness.html (last visited Nov. 12, 2014).

Ancillary to the law enforcement and mentally ill point of contact violence statistics cited above, are the statistics concerning homicide rates in correlation to civil commitment standards and access to adequate care.[136] A study published in the 2011 edition of *Social Psychiatry and Psychiatric Epidemiology* found evidence of reduced homicide rates in states with less restrictive civil commitment laws and well run mental health institutions.[137]

F. *Exposed to a High-Risk Environment without Adequate Training*

Based on the statistics and the level of training most law enforcement agencies receive in dealing with the violent mentally ill, most members of law enforcement are asked to enter into and control a situation for which they are inadequately trained and that puts them at increased risk of injury or death.[138] Controlling high-risk situations with a mentally ill person may or may not require any special equipment; it requires the intellectual skills, however, to diffuse the threat, or at least recognize it and bring the mentally ill person under control.[139] The societal costs that result when force is used in confrontations between law enforcement and a mentally ill person ripple out beyond the immediate harm.[140]

> A particularly tragic incident occurred in New York City recently where a woman called the police about a family member who was seen to be an emotionally disturbed person. When police arrived the man who was called about was found on his fire escape, screaming. A police officer saw the man from the ground and tasered him at which point the man fell to the ground to his death. The despondent police officer committed suicide a few weeks after this incident resulting in a tragedy for both families.[141]

136. *See generally* Steven P. Segal, *Civil Commitment Law, Mental Health Services, and US Homicide Rate*, 47 SOCIAL PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY 1449 (2011), *available at* http://mentalillnesspolicy.org/national-studies/commitmenthomiciderates.pdf (providing a broad discussion of the occurrence of homicide in relation to civil commitment statutory provisions).

137. *See generally id.* (laying out an abstract and discussing different hypotheses that arise out of data collected by the study).

138. *See generally* TREATMENT ADVOCACY CTR., *supra* note 130 (discussing the safety risks to police officers and mentally ill persons when law enforcement are not properly trained).

139. *See generally,* TREATMENT ADVOCACY CTR. *supra* note 130 (discussing how the use of crisis intervention training, mental health officers, mental health courts, and assisted outpatient treatment can drastically decrease the potential for dangerous encounters between officers and mentally ill people).

140. *See generally* Landsberg & Fresenius, *supra* note 127 (addressing the tragedies that ensue after fatal altercations with police and the mentally ill).

141. *Id.*

IV. Moving Forward: Tragedy Brings Action

Some states have begun to respond to what has been called a "mental health crisis."[142] They have reformed their civil commitment laws to enable judges to determine whether a mentally ill person would choose to receive care were they capable of making a coherent choice, instead of waiting for the person to present a clear danger to themselves or others.[143] Other states have instituted procedures that involve mental health professionals when high-risk confrontations with mentally ill persons arise.[144]

The city of Memphis, Tennessee has become a wellspring for advanced techniques in handling high-threat situations between law enforcement and the mentally ill.[145] In 1987, Joseph Dewayne Robinson, a person known to have mental health issues, was shot and killed by Memphis Police.[146] The circumstances of his death caused a public outrage that motivated city leaders to take sweeping actions to minimize the occurrence of such needless deaths and violence.[147] Built on the naked impotence of a police force unable to cope with high-threat encounters with the mentally ill, the Crises Intervention Team (CIT) was born.[148] Through the cooperation of local universities, mental health professionals, hospitals, police,

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142. *See* Alana Horowitz, *U.S. Mental Healthcare System Failing Patients, Advocates Say*, Huffington Post (Jan. 10, 2013, 10:03 AM), http://www.huffingtonpost.com/2012/12/26/us-mental-healthcare-system_n_2353319.html (identifying the Missouri mental health system as one in crisis).

143. *See generally* Beverly Maher, *The Light Side of Darkness*, Treatment Advocacy Ctr. (Jul. 13, 2013, 4:56 AM), http://beverlymaher.blogspot.com/2013/07/the-treatment-advocacy-center-tac.html (discussing the promotion of laws that will enable mentally ill patients who were frequently treated to avoid involuntary commitments into jails and prisons as a result of non-treatment).

144. *See Memphis PD Initiatives*, Memphis Police Dep't, http://memphispolice.org/Initiatives.asp (last visited Nov. 12, 2014) (highlighting the importance of a direct response to mentally ill crisis events, facilitated by the partnership between the Memphis Police Department and specialized mental health workers).

145. *See id.* (stating "since the inception of the CIS program, the Memphis Police Department has responded to inquiries from other law enforcement agencies seeking assistance and information").

146. Kathleen Sweeney, *Sheriff says existing policy is functional, appropriate*, The Florida Times-Union (Jan. 10, 1999, 10:13 PM), http://jacksonville.com/tu-online/stories/011099/met_1a1memph.html.

147. *See generally Crisis Intervention Team (CIT): CIT Overview*, Rochester, N.H. Police Dep't, http://www.rochesterpd.org/rpd_066.htm (last visited Nov. 12, 2014) (identifying the catalyst that led to the creation of the Crisis Intervention Team).

148. *See generally Crisis Intervention Team*, City of Memphis, http://www.memphistn.gov/Government/PoliceServices/CrisisInterventionTeam.aspx (last visited Nov. 12, 2014) (discussing the establishment and goals of the Memphis Crisis Intervention Team).

Howell: The Dark Frontier: The Violent and Often Tragic Point of Contact

and city officials, resources were realigned to support police at the frontier between law enforcement and the mentally ill.[149]

Today, Memphis police are specifically trained in diffusing high-threat situations with the mentally ill.[150] They are backed up by a system that allows them immediate access to mental health professionals who may be either on scene or in radio contact with police.[151] Once a situation is brought under control, a mental health care system enables a police officer to divert[152] a mentally ill person from the jail system and into appropriate mental health care.[153]

Beginning in 1987, the city of Memphis began to keep records of law enforcement contact with the mentally ill.[154] Statistically, the number of contacts had increased by almost one hundred percent by 1997 and the incidence of injuries to the mentally ill in confrontations with police had shrunk by forty percent.[155] This result illustrates the effectiveness of a program that provides law enforcement with alternatives to the wasteful, confrontation-subdue-arrest-repeat cycle many law enforcement entities often find themselves. The Memphis CIT model has been studied and emulated nationwide, although with varying levels of success.[156]

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149. *See generally id.* (providing an overview of the partnerships that created the Crisis Intervention Team).

150. Randolph Dupont, *Memphis Crisis Intervention Team: Overview*, UNIV. OF MEMPHIS (2008), http://cit.memphis.edu/information_files/CIT_Brief_Overview_Presentation_Slides.pdf.

151. *See generally id.* (providing an overview of the Memphis Crisis Intervention Team Model).

152. *See* NAT'L ASS'N OF COUNTIES, BLUEPRINT FOR SUCCESS: THE BEXAR COUNTY MODEL 31 (2010), *available at* http://www.naco.org/programs/csd/Documents/Criminal%20Justice/Jail%20Diversion%20Forum%20Materials/Jail%20Diversion%20Toolkit.pdf (illustrating the growth, efficiency, and success of the Bexar County Jail Diversion Program).

153. *See generally* Dupont, *supra* note 150 (providing a model to guide law enforcement on implementing Crisis Intervention Teams).

154. *See* Johnny K. Jines, *Crisis Intervention Teams: Responding to Mental Illness Crisis Calls*, FBI.GOV (Jan. 2013), http://leb.fbi.gov/2013/january/crisis-intervention-teams-responding-to-mental-illness-crisis-calls (explaining the success of the Memphis program of over twenty-five years).

155. *See e.g.*, Meg Kissinger, *Houston's solution to mental health system problems offers a case study for Milwaukee*, JOURNAL SENTINEL (June 8, 2013), http://www.jsonline.com/news/milwaukee/houstons-solution-to-mental-health-system-problems-offers-a-case-study-for-milwaukee-b9928490z1-210715811.html (recognizing the success of a similar Houston program, specifically referring to the 37% decrease of patients being referred to the mentally ill public hospital, thus leading to less police confrontations).

156. *See e.g.*, Maxine Bernstein, *Portland police efforts to fix crisis response are a failure, feds say*, THE OREGONIAN (Sept. 15, 2012, 10:19 PM), http://www.oregonlive.com/portland/index.ssf/2012/09/portland_police_efforts_to_fix.html (addressing the Portland Police Bureau's failed implementation of crisis training for its officers).

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Over the last ten to fifteen years, most major metropolitan areas have acknowledged the need for the special handling of the mentally ill when a law enforcement confrontation occurs.[157] In 1999, Harris County, Texas (the City of Houston) acknowledged the decades old problem and created a CIT program of its own.[158] Unfortunately, while it addressed the initial encounter of law enforcement with the mentally ill, the program did not contemplate the follow-up care required to prevent the perpetual re-cycling of the mentally ill back through the system after initial treatment.[159] Over the years Harris County's CIT Program evolved into what is now known as the Crisis Intervention Response Team (CIRT) Program.[160]

Today, Harris County still struggles with law enforcement confrontations with the mentally ill. In fact, the Harris County Sheriff's Office has the reputation as the largest mental health facility in the state.[161] However, now the county has identified an economic reason to act.[162] It costs twelve times more to treat an incarcerated mentally ill person per day than one who is treated on an outpatient basis ($137 versus $11).[163] More than 25% of the inmates in the Harris County jail system receive some form of psychotropic medication.[164]

Further exacerbating the county's problem, "[a]ccording to Harris County officials, of the nearly one thousand inmates who cycled through the jail at least five times in the past two years [2011-2012], 600 had been diagnosed with a mental illness."[165] So, not only is it expensive to incarcerate the mentally ill, but the system has had no means of breaking the

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157. *See generally* Deborah L. Bower & W. Gene Pettit, *The Albuquerque Police Department's Crisis Intervention Team: A Report Card*, FBI LAW ENFORCEMENT BULL., Feb. 2001, at 1, *available at* http://leb.fbi.gov/2001-pdfs/leb-february-2001 (addressing the challenges facing large metropolitan police departments in their pursuit to establish Crisis Intervention Team programs).

158. STEVEN B. SCHNEE, EXPANDED AND ENHANCED CRISIS CARE (1999), *available at* http://www.mhmraharris.org/documents/EXReports/ExRNovember99.html.

159. *Id.*

160. *See generally* Kissinger, *supra* note 155 (discussing the evolution and progress of the Harris County CIT program).

161. *See generally* Crystal Simmons, *Harris County Sheriff's Office Voices Support for Mental Health Bills,* THE POTPOURRI: TOMBALL EDITION, (June 3, 2013), http://www.yourhoustonnews.com/tomball/news/harris-county-sheriff-s-office-voices-support-for-mental-health/article_2f5a63ea-d0e0-55e8-86a7-a548d896f3cf.html (discussing the need for two Bills to become law to increase the funding for the mental care system, which would have a positive impact on the Harris County Jail system).

162. *See id.* (comparing the cost per day to treat mentally ill offenders in jail with the cost per day of outpatient treatment).

163. *Id.*

164. *Id.*

165. *Id.*

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cycle of recidivism up to that point, and costs have continued to rise.[166] Now, thanks to state and local funding, the CIRT program, which had been the only diversion program[167] the county had for coping with mentally ill offenders, has a back-up system in place to afford follow-up care for mentally ill offenders taken in by law enforcement.[168]

Whatever the motive, economic or humanitarian, Harris County appears to have developed a system that could reduce violent outcomes in high-risk confrontations between law enforcement and the mentally ill.[169] It also provides for a means of follow-up care that should reduce the revolving door effect.[170]

Other law enforcement entities have developed Mobile Crisis Teams (MCT) to deal with the increasing frequency of high-risk confrontations with the mentally ill.[171] In Baltimore the MCT arrives in plain clothes and unmarked vehicles so as to not to intensify what could be a high-risk situation.[172] Like the older Harris County model, however, the Baltimore MCT does not contemplate the revolving door of the mentally ill being cycled through the system again and again, for lack of a process to provide sustained care after a mentally ill person is taken in by law enforcement and diverted to mental health care professionals.[173]

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166. *See generally id.* (providing a cost analysis of the treatment of mentally ill offenders in jails as well as outpatient treatment).

167. *See generally Dr. Regina Hicks to head major jail diversion project designed to keep mentally ill out of jail*, THE MEMORIAL EXAMINER (Dec. 13, 2013, 3:49 PM), http://www.yourhoustonnews.com/memorial/news/dr-regina-hicks-to-head-major-jail-diversion-project-designed/article_8cfe79fa-196a-5bbb-8f4a-90acd11a0561.html (announcing Harris County's effort to develop a mental health jail diversion program directed by Dr. Regina Hicks, a nationally renowned mental health and juvenile justice expert).

168. *See* Simmons, *supra* note 161 (discussing the parts of Senate Bill 1185 that set up funding and a pilot program for mentally ill jail diversion).

169. *See id.* (highlighting the positive outcomes that have resulted from the CIRT program).

170. *See* Kissinger, *supra* note 155 (showing the successful steps Houston has taken to decrease the revolving door, specifically noticing a 30% decrease in the psychiatric emergency room, which is providing Milwaukee with a great model to combat mental illness).

171. *See generally Mobile Crisis Teams*, N.Y. CITY DEP'T OF HEALTH AND MENTAL HYGIENE, http://www.nyc.gov/html/doh/html/mental/mobile-crisis.shtml (last updated Dec. 12, 2012) (providing an overview of the services offered by the Mobile Crisis Teams in New York City).

172. *Id.*

173. *See generally* BALTIMORE CRISIS RESPONSE INC., http://www.bcresponse.org/homepage.html (last visited Nov. 30, 2014) (providing information on services provided by Baltimore's Crisis Response unit).

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V. RECOMMENDATIONS

There is no coherent nationwide approach or policy to cope with what is a nationwide tragedy, a tragedy that plays out in local news and national headlines almost every day.[174] Until the national movement toward deinstitutionalization in the 1960s, the states were left to their own devices in dealing with the mentally ill.[175] At this point it is hard to discern whether, if left alone, the states would have found a better solution than deinstitutionalization. What we as a nation must now acknowledge, however, is the human tragedy caused by failed policies of the past that must be corrected.[176] To this day, the states alone have been unable to effectively deliver on the deinstitutionalization promise: the local care and support of any given community's most vulnerable and needy—the mentally ill.[177]

There are at least fifty different answers to this national problem—a problem precipitated by federal policy. Since it was federal intervention that led to the predicament currently facing the nation, perhaps it is federal intervention that can correct the issues the policy of deinstitutionalization created.[178] There is an urgent need for a coherent, federal policy that mandates adequate, standardized training of all law enforcement entities, funding linked to the adherence of national standards, and the measurement of law enforcement interaction with the mentally ill.

Establishing and mandating a national training standard for law enforcement entities that are likely to confront the mentally ill does not require the building of another bureaucracy. The infrastructure to develop and deliver a national standard already exists. The Substance

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174. *See* Damian Dovarganes, *Police training eyed after mentally ill man dies*, USA TODAY (Aug. 6, 2011, 2:24 AM), http://usatoday30.usatoday.com/news/nation/2011-08-06-police-training-california-homeless-death_n.htm (addressing an incident when police officers in California killed a man suffering from schizophrenia).

175. *See generally Timeline: Treatments for Mental Illness*, PBS, http://www.pbs.org/wgbh/amex/nash/timeline/timeline2.html (last visited Nov. 4, 2014) (discussing how the advancement of anti-psychotic drugs in the 1960s furthers deinstitutionalization of the mentally-ill in the United States).

176. *See* E. Fuller Torrey, *How to Bring Sanity to Our Mental Health System*, The Heritage Foundation (Dec. 19, 2011), http://www.heritage.org/research/reports/2011/12/how-to-bring-sanity-to-our-mental-health-system (discussing the reforms of the 1960s and the states' current dependency on the federal government in regard to mental illness issues).

177. *See generally* Leupo, *supra* note 31 (highlighting the shift in focus to protecting the human rights of the mentally ill, but asserting there is still a lot of work that needs to be done).

178. *See* 145 CONG. REC. 15, 339–41 (1999) (statement of Sen. Patrick Moynihan) (echoing that the national standard established by Congress was unrealistic, but a national standard could also be the solution if implemented correctly).

Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, could serve to coordinate development of the mental health component of a national training standard.[179] The Federal Law Enforcement Training Centers, which fall under the Department of Homeland Security, could serve to coordinate development of the law enforcement component of a national training standard. In fact, the Federal Law Enforcement Training Centers already have a course titled "Basic Peer Support Crisis Intervention Training Program."[180] Based on its description, it addresses many of the confrontational issues law enforcement must deal with in high-stress situations, which includes the mentally ill.[181] With the curriculum already being taught jointly by experienced mental health professionals and law enforcement instructors, the apparatus for developing and delivering the training is already in place.[182] A cooperative effort on the part of organizations such as these could quickly yield a national law enforcement training standard that could significantly reduce the risk to both the mentally ill and law enforcement personnel in high-risk confrontations. Once established, the states could meet or exceed the requirements based on the politics of the individual state.

In order to make training mandatory, the states need to earmark federal law enforcement dollars that would be normally spent on other law enforcement activities. In 2013, the Department of Justice budgeted two billion dollars in assistance to law enforcement entities at every level, to be used for training and equipment procurement.[183] For example, grant money can be acquired through the Bureau of Justice Assistance, a U.S. Department of Justice agency, which can be used for any number of law enforcement initiatives.[184] There are also Community Oriented Policing Services (COPS grants), another Department of Justice program which recently earmarked money for addressing methamphetamine crime in

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179. *See generally* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., LEADING CHANGE: A PLAN FOR SAMHSA'S ROLES AND ACTIONS 2011–2014 (2011), *available at* http://store.samhsa.gov/shin/content//SMA11-4629/01-FullDocument.pdf (identifying the agency's role within the U.S. Department of Health and Human Services and its role with mental illness).

180. *Basic Peer Support Crisis Intervention Training Program (BPSCITP)*, FLETC .GOV, https://www.fletc.gov//training-program/basic-peer-support-crisis-intervention-training-program-bpscitp-0 (last visited Nov. 4, 2014).

181. *Id.*

182. *Id.*

183. U.S. DEP'T OF JUSTICE, FY 2013 BUDGET REQUEST, STATE, LOCAL AND TRIBAL LAW ENFORCEMENT 1 (2012), *available at* http://www.justice.gov/sites/default/files/jmd/legacy/2014/03/19/state-local-tle.pdf.

184. Ed Stine, *Federal Grants for Police Departments*, EHOW.COM, http://www.ehow .com/info_8029700_federal-grants-police-departments.html (last updated Aug. 30, 2014).

Native American Tribes as well as grants for fighting sexual exploitation crimes against children.[185]

If a portion of this grant money were allocated toward specialized training for law enforcement personnel in diffusing high-risk confrontations with the mentally ill, how many injuries could be avoided and how many lives could be saved? There is no glamor in dealing with the mentally ill. Rare are the headlines celebrating law enforcement's handling of a crisis involving a mentally ill person that ends peacefully. The enthusiasm for soliciting federal or state grant money for training in the handling of high-risk situations involving the mentally ill pales in comparison to the enthusiasm for acquiring new high-tech devices that grab headlines for their novelty.[186] While all law enforcement endeavors are important, they need not be mutually exclusive. If grant money for the non-violent handling of high-risk situations involving the mentally ill were set aside at the federal or state level, it would incentivize law enforcement entities to avail themselves of the opportunity to train.

At the state level there exists the nonpartisan Council of State Governments Justice Center, which is uniquely situated to interface between mental health, law enforcement, and federal policy makers in executing a federally mandated training standard.[187] The organization, which has a nationwide footprint, has extensive expertise on many of the issues that plague law enforcement in coping with the mentally ill.[188] Of particular note is the center's Criminal Justice/Mental Health Consensus Project, which was "a national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system."[189]

Once training standards are established and funding for training is earmarked, the next logical step is to measure the nation's progress toward reducing violent outcomes between law enforcement and the mentally ill. The old adage "what gets measured gets done" is appropriate for addressing the situation the nation finds itself in as it confronts the legacy

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185. *Id.*

186. *See e.g.* Portsia Smith, *Grants will help local police agencies*, FREDERICKSBURG.COM (Dec. 20, 2013, 8:47 PM), http://news.fredericksburg.com/newsdesk/2013/12/20/grants-will-help-local-police-agencies (providing an example of how a police department allocates funds emphasizing equipment over training to properly address the mentally ill).

187. *About the Justice Center*, COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., http://csgjusticecenter.org/about-jc (last visited Nov. 4, 2014).

188. *See About the Mental Health Program*, COUNCIL OF STATE GOVERNMENTS JUSTICE CTR., http://csgjusticecenter.org/mental-health/about/ (last visited Nov. 30, 2014) (discussing the organizations paper (published in 2012) recommending a strategic plan involving the criminal justice system and the mentally ill).

189. *About the Justice Center*, *supra* note 187.

of deinstitutionalization. A federal database to track law enforcement encounters with the mentally ill, and the results of those encounters, would be an effective means of determining where our biggest problems are and what additional resources may be required to better deal with confrontations that end violently.

An existing federal database that could be easily adapted to such an endeavor is the National Instant Criminal Background Check System (NICS).[190] It is currently used to perform background checks on individuals wishing to purchase firearms. One of the components of the database is information on mentally ill individuals who are prohibited from purchasing a firearm.[191] From a functional standpoint, it makes sense to enhance this database since it already contains a significant amount of information about the mentally ill. Another possibility is the Substance Abuse and Mental Health Data Archive maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA).[192]

The FBI also has a database that tracks what are termed justifiable homicides and defined as, "[t]he killing of a felon by a law enforcement officer in the line of duty."[193] This database does not differentiate between those that are and those that are not mentally ill. Figures from a joint report published by the Treatment Advocacy Center and the National Sheriff's Association highlighted a sixty seven percent increase in justifiable homicides resulting from an attack on law enforcement personnel, up from an average of 153 homicides in 1980 to 255 homicides in 2008.[194] The report went on to assert at least half of those killed under these circumstances suffered from mental illness.[195] An adaptation of the FBI's justifiable homicide database, to track those killed who were mentally ill, would be an important component of a federal database to track law enforcement encounters with the mentally ill, and the results of those encounters. Once again, there appears to be an existing infrastructure in which a database could be developed without dramatic expansion of the bureaucracy.

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190. *National Instant Criminal Background Check System: Fact Sheet*, FBI.GOV, http://www.fbi.gov/about-us/cjis/nics/general-information/fact-sheet (last visited Nov. 4, 2014).

191. *Id.*

192. *Data Archive*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., http://www.samhsa.gov/data/ (last visited Nov. 4, 2014).

193. *See Expanded Homicide Data Table 14: Justifiable Homicide by Weapon, Law Enforcement, 2006–2010*, FBI.ORG, http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/10shrtbl14.xls (last visited Nov. 4, 2014) (providing statistical data on justifiable law enforcement homicides).

194. TORREY ET AL., *supra* note 7, at 3.

195. *See id.* (quoting informal studies and accounts that, "at least half of the people shot and killed by police each year in this country have mental health problems").

There is evidence that some measurement is already taking place, negative as it may be. There are four major police departments that have been cited by the Department of Justice for routinely using excessive force when confronting mentally ill suspects (Portland, Seattle, New Orleans, and Puerto Rico).[196] The City of Albuquerque is currently under investigation by the Department of Justice for use of excessive force in dealing with mentally ill suspects.[197] Perhaps if these cities had better, or more appropriate training in how to control high-risk confrontations with the mentally ill, there may have been better outcomes.[198]

It is apparent that correcting at least this small aspect of the continuum of care, the point of contact between law enforcement and the mentally ill, is more a matter of political will than a lack of resources. The primary duty of any law enforcement organization is to first do no harm. That is not what is happening. Through standardized, federally mandated training, funded by existing mechanisms, with results measured through in-place databases, the risk to both the mentally ill and law enforcement personnel can be significantly reduced. Implementation of these recommendations would be the first step in a process that begins to fulfill the broken promise of deinstitutionalization.

Although not contemplated when deinstitutionalization began, for a significant segment of the mentally ill, law enforcement, by default, now represents a key component of the community-based support system President Kennedy put forth in his vision of how we care for the mentally ill. In order for law enforcement to adequately fill its involuntarily assumed role, law enforcement personnel must be trained in the coping methods of confronting the mentally ill in high-risk situations with little or no violence. Through appropriate training and support, the point of contact can be made far less dangerous for both the mentally ill and law enforcement.

VI. Conclusion

There currently exists a widespread and unacceptable risk of violence between law enforcement personnel and mentally ill suspects.[199] This risk has its roots in a lack of training of law enforcement personnel in

196. *See* Anna Werner, *In confrontations with mentally ill, cops face tough choices*, CBS News, (Mar. 6, 2013, 6:30 PM), http://www.cbsnews.com/news/in-confrontations-with-mentally-ill-cops-face-tough-choices (discussing police officer's decision when confronting mentally-ill gunmen).

197. *Id.*

198. Reiter, *supra* note 117.

199. *See* Pamela Kulbarsh, *Mentally Ill & Potential Violence*, Officer.com, (Nov. 10, 2010), http://www.officer.com/article/10232250/mentally-ill-potential-violence (discussing the tragic violence encountered between the mentally ill and police officers).

understanding and appropriately engaging mentally ill people in high-risk situations.[200] The point of contact between law enforcement and the mentally ill has evolved over the last fifty years and can trace its origins to deinstitutionalization.[201] It was a policy that endeavored to close large, centralized, state mental health institutions in favor of decentralized, local, community-based mental health care facilities.[202] In the rush to close the large facilities, state and federal government officials failed to arrange for follow-up care and failed to recognize whether the communities the mentally ill patients would return to were capable of providing the care the patients required.[203] In the years since this initiative began, the reality of deinstitutionalization manifested itself into an inordinate number of homeless mentally ill persons, or families with mentally ill members in crisis, with little or no access to the care they need.[204] In many cases there is unwillingness on the part of the mentally ill person to receive treatment.[205] In both situations the mentally ill have a very high propensity to engage in high-risk confrontations with law enforcement.[206]

The noble virtues of deinstitutionalization helped us feel better as a nation about our treatment of the mentally ill without ever truly examining its consequences. By the 1970s, One Flew Over The Cuckoo's Nest, a movie based on the 1962 novel by Ken Kesey, validated national sentiment that deinstitutionalization was the right answer. As a result, the homeless mentally ill, and those that went untreated, were shrouded in a fog of civil rights puffery and movie stigmas that ensured a person's self-determination rights, but ignored the suffering of those who could not

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200. *See* Abigail S. Tucker et al., *Law Enforcement Response to the Mentally Ill: An Evaluative Review*, 8 BRIEF TREATMENT AND CRISIS INTERVENTION 236, 238 (2008), *available at* http://btci.stanford.clockss.org/cgi/reprint/8/3/236.pdf (evaluating the lack of specialized training for police officer's for appropriate assessment of the mentally ill).

201. *See Survey: Police Needlessly Overburdened by Mentally Ill Abandoned by Mental Health System*, MENTAL ILLNESS POLICY ORG., http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.html (last visited Nov. 4, 2014) (evaluating the shift from mental illness being treated by the medical community to being handled by the criminal justice system).

202. *See* Jada Grabis, *Assessing the Affects of the Deinstitutionalization Movement*, WORLD ISSUES 360, (Feb. 3, 2008), http://www.worldissues360.com/index.php/assessing-the-affects-of-the-deinstitutionalization-movement-63768 (discussing whether it is better to have the mentally ill in the community versus in large institutions).

203. *See id.* (examining the lack of resources for the community outreach program intended to support the mentally ill while in the community).

204. Torrey, *supra* note 61.

205. *See id.* (noting that advocates of deinstitutionalization assumed that those who are mentally ill would voluntarily seek treatment if they needed it, when in fact only about half of the patients discharged from psychiatric hospitals seek treatment once discharged).

206. *See* MENTAL ILLNESS POLICY ORG., *supra* note 201 (presenting data that highlights the mentally ill propensity to confront law enforcement).

help themselves. The consequences of those sentiments are now laid bare on a daily basis in the news, and more importantly in the lives of those touched by the violence and loss caused by the rational application of laws to the irrational behavior of the mentally ill.

Mental illness reminds every person of our human frailties and fears. It is a part of ourselves that we do not understand—this dark frontier of our society that we turn away from with shame and ignorance. When the point of contact between law enforcement and the mentally ill jumps into the headlines, we wonder what could have been done to change the outcome.

The first step to changing the outcome is changing the way law enforcement is trained to cope with the mentally ill. We must, as a nation, openly confront the unnecessary and unacceptable loss of life and injury that occurs in any given place, on any given day, when law enforcement is forced to respond to a high-threat crisis involving a mentally ill person. Without adequate training and organizational support of law enforcement personnel, the needless hurt and suffering of some of our nation's most vulnerable will continue.