Police and Forensic Psychological Practitioner Collaborations for Mental Health Responses: **Risk Assessment Paradigm**

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Law enforcement personnel are tasked with responding to critical incidents, including hostage situations (Chrabot & Miller, 2004), barricaded subject incidents (Feldmann, 2004), attempted suicide/suicide by cop cases (Call, 2008), and confrontations with irate, violent, and/or mentally challenged individuals (Oliva & Compton, 2008). This article explores risk assessment faced by mental health professionals working collaboratively with police in on-scene psychological-related responses to these incidents.

Response strategies to these incidents have evolved over the past 30 years. Prior to the 1970s, it was common for law enforcement officials to address hostage incidents or barricaded subject situations in one of three ways. They could surround the individual, order him/her to surrender, then wait for the surrender to occur; they could use chemical agents to force surrender; or they could use a tactical team (or snipers) to forcibly end the incident (Hatcher, Mohandie, Turner, & Gelles, 1998; Strentz, 2006).

The Psychiatric Emergency Response Team and the Mental Health Professional

In the last two decades, specialized intervention teams have been developed to support and assist law enforcement in responding to calls for persons with mental illness. The Psychiatric Emergency Response Team (PERT), is a partnership between San Diego County Health and Human Services, San Diego County Law Enforcement, National Alliance on Mental Illness (NAMI) San Diego, and the Community Research Foundation (CRF). Founded in 1998 as a 501(c)(3), the agency is based on the premise that “individuals with mental illness must be assessed with respect to their unique and personal needs and be referred to assistance that is appropriate to those needs” (Community Research Foundation, 2010). PERT provides a Behavioral Health Emergency Response Plan (ERP) that individuals can fill out in advance. This form includes special instructions, emergency contact information, medications, mental health and/or substance use, counselor/ therapist, preferred crisis house, and preferred hospital. The form lists examples of police/ emergency services calls, questions the emergency operator might ask, and things to remember when the police arrive (Community Research Foundation, 2011).

The shift of policing from a response and enforcement model to a community-based model, plus the addition of federal funding for research and development have resulted in increased contact between citizens and police, which leads to increased police

contact with people with mental illness (Lurigio & Swarz, 2000; and Sherman, 2004; as cited by Sellers, Sullivan, Veysey, & Shane, 2005). Traditionally, police officers "have some latitude in determining what happens to persons with mental illnesses, and they generally choose from three options: (i) settle informally, (ii) arrest, or (iii) initiate a civil commitment or hospital evaluation (Cohen, 1996; Green, 1997; Steadman, 1992; Teplin, 1984; as cited by Sellers et al., 2005). To facilitate interactions with people with mental illness, Crisis Intervention Teams (CITs) were conceived.

One of the first CITs, the Memphis Crisis Intervention Team founded in 1988 has become a model for subsequent CITs. In the "Memphis model", the mental health and law enforcement personnel have been educated in the following core areas: signs/symptoms of mental illness, psychiatric drugs and uses, and de-escalation skills. A key feature of the Memphis CIT framework is a no-refusal policy, which guarantees that individuals with "existing mental health substance use/abuse issues, as well as those who are violent towards themselves or others, can be admitted…[to] sites [that] are housed within a fully staffed hospital" (Browning et al., 2011, p.237). The CIT depends on a collaborative framework that includes no-refusal treatment facility access and legal provisions to facilitate facility admission via police referrals (Browning, Hasselt, Tucker, & Vecchi, 2011). This policy was put into place after the Memphis Police Department responded to a call for a young man who was suicidal with a diagnosis of schizophrenia. The officers who responded were unfamiliar with the young man; when they asked him to drop his knife he became upset, moved towards them, and was shot and killed. This tragedy prompted training in non-lethal strategies for intervention, de-escalation in crisis situations, and facilitation of treatment facility admissions.

Charette, Crocker, and Billette (2011) analyzed data collected from police responses to people with mental illnesses in a large Canadian city on three randomly selected days in one year. The data analysis demonstrated that hospitalization—in 36% of outcomes, and arrest—in 3.7% of outcomes, were the least time-efficient interventions. The most time-efficient outcomes included referral to mental health care services, 6.3%; and informal disposition, 38.2%. The non-exclusive specific issues present at the police interventions with the 272 people with mental illness included homelessness, 8.1%; drugs or alcohol, 23.9%; suicidal, 20.2%; aggressiveness, 30.1%; court order, 5.1%; emergency response unit required, 35.7%; male person with mental illness, 62.1%; and presence of psychosocial crisis intervention team, 1.5% (Charette et al., 2011, p. 680). Though time-efficient, mental health care referral was fairly infrequent. Further research would be required to see if CITs can increase favorable outcomes and increase time-efficiency; however this data appears to support the use of informal disposition. CITs may facilitate informal disposition through use of de-escalation techniques, safety assessments, and other mental health interventions.

Risk Assessment Operational Elements of On-Scene Crisis Support

Though important empirical data is lacking, a brief review of current available data on Mobile Crisis Units and Crisis Intervention Teams reveals several specific things mental health professionals can do on-scene to assist police officers. First and foremost, mental health professionals must understand that situations involving persons in crisis

are often volatile and dangerous. The number one concern of every team member should be the safety of everyone on-scene (Crisis Intervention Handbook, 2005). As Henry (2005) states, “The first responder who rushes in and becomes a victim may exacerbate the overall problem, consuming precious time and resources.” After an assessment of safety is conducted, mental health professionals need to be able to step in and do their job effectively and quickly (Lamb, Weinberger, DeCuir, 2002). So prior to going out into the field, the mental health professional must understand what is expected on-scene, (2002). Often, the mental health professional will function as psychological and behavioral consultant for the team (Augustin and Fagan, 2011). The mental health professional provides information on the person in crisis that may be relevant to resolution of the case, including any mental health diagnoses, previous behavioral issues, prior hospitalizations, and any triggers or positive topics that could make the situation worse or better. In many cases, this information is privileged due to laws of confidentiality, and a mental health professional may be the only one who can access and disseminate critical information among the team (Lamb, Weinberger, DeCuir, 2002). The mental health professional on-scene also often uses clinical training and risk assessment techniques to determine potential for violent or suicidal behavior (Augustin and Fagan, 2011). The mental health professional will attempt to prevent unnecessary arrests or psychiatric hospitalizations, through the use of de-escalation strategies to diffuse dangerous behavior. (Young and Brumley, 2009). The mental health professional can also be a therapeutic asset to the team, providing psychological support in very stressful situations (Augustin and Fagan, 2011). The mental health professional can address concerns of on-scene collaterals— family, friends, neighbors, and witnesses (Young and Brumley, 2009). Non-uniformed mental health professionals can be perceived by collaterals as less-threatening, facilitating approach for information and interviews. (Augustin and Fagan, 2011).

Conclusions and Implications for Practice

Previous off-scene training on mental health approaches and screening for team weaknessess can build a more effective crisis intervention team. (Augustin and Fagan, 2011). Overall, the inclusion of a mental health professional in a crisis team can both streamline crisis services and make interventions more effective.

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