NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

THESIS

MANAGEMENT OF THE SEVERELY MENTALLY ILL AND ITS EFFECTS ON HOMELAND SECURITY

by

Michael C. Biasotti

September 2011

Thesis Co-Advisors: David Brannan
Patrick Miller

Approved for public release; distribution is unlimited

THIS PAGE INTENTIONALLY LEFT BLANK

REPORT DOCUMENTATION PAGE			Form Approved OMB No. 0704-0188
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188) Washington DC 20503.			
1. AGENCY USE ONLY ***(Leave blank)***	**2. REPORT DATE** September 2011	**3. REPORT TYPE AND DATES COVERED** Master's Thesis	
4. TITLE AND SUBTITLE Management of the Severely Mentally Ill and its Effects on Homeland Security			**5. FUNDING NUMBERS**
6. AUTHOR(S) Michael C. Biasotti			
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Naval Postgraduate School Monterey, CA 93943-5000			**8. PERFORMING ORGANIZATION REPORT NUMBER**
9. SPONSORING /MONITORING AGENCY NAME(S) AND ADDRESS(ES) N/A			**10. SPONSORING/MONITORING AGENCY REPORT NUMBER**
11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. government. IRB Protocol number NPS IRB# NPS.2011.0049-IR-EM2-A.			
12a. DISTRIBUTION / AVAILABILITY STATEMENT Approved for public release; distribution is unlimited			**12b. DISTRIBUTION CODE** A

13. ABSTRACT (maximum 200 words)

As a result of the events of September 11, 2001, law enforcement agencies nationwide have been assigned a plethora of terrorism prevention and recovery related duties. Many federal documents outline and emphasize duties and responsibilities pertaining to local law enforcement. The prevention of acts of terrorism within communities has become a focal point of patrol activities for state and local police agencies. Simultaneously, local law enforcement is dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system. This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population. A nationwide survey of 2,406 senior law enforcement officials conducted within this paper indicates that the deinstitutionalization of the severely mentally ill population has become a major consumer of law enforcement resources nationwide. This paper argues that highly cost-effective policy recommendations exist that would assist in correcting the current situation, which is needlessly draining law enforcement resources nationwide, thereby allowing sorely needed resources to be directed toward this nation's homeland security concerns.

14. SUBJECT TERMS Law enforcement, severe mental illness, homeland security, law enforcement resources, assisted out-patient treatment, homeless population, prison overcrowding, New Windsor Police Department			**15. NUMBER OF PAGES** 155
			16. PRICE CODE
17. SECURITY CLASSIFICATION OF REPORT Unclassified	**18. SECURITY CLASSIFICATION OF THIS PAGE** Unclassified	**19. SECURITY CLASSIFICATION OF ABSTRACT** Unclassified	**20. LIMITATION OF ABSTRACT** UU

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. 239-18

THIS PAGE INTENTIONALLY LEFT BLANK

Approved for public release; distribution is unlimited

MANAGEMENT OF THE SEVERELY MENTALLY ILL AND ITS EFFECTS ON HOMELAND SECURITY

Michael C. Biasotti
Chief of Police, New Windsor Police Department, New Windsor New York
BS, Mercy College, Dobbs Ferry New York, 1986

Submitted in partial fulfillment of the
requirements for the degree of

MASTER OF ARTS IN SECURITY STUDIES
(HOMELAND SECURITY AND DEFENSE)

from the

NAVAL POSTGRADUATE SCHOOL
September 2011

Author: Michael C. Biasotti

Approved by: David Brannan
Thesis Co-Advisor

Patrick Miller
Thesis Co-Advisor

Harold A. Trinkunas, PhD
Chair, Department of National Security Affairs

THIS PAGE INTENTIONALLY LEFT BLANK

ABSTRACT

As a result of the events of September 11, 2001, law enforcement agencies nationwide have been assigned a plethora of terrorism prevention and recovery related duties. Many federal documents outline and emphasize duties and responsibilities pertaining to local law enforcement. The prevention of acts of terrorism within communities has become a focal point of patrol activities for state and local police agencies. Simultaneously, local law enforcement is dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system. This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population. A nationwide survey of 2,406 senior law enforcement officials conducted within this paper indicates that the deinstitutionalization of the severely mentally ill population has become a major consumer of law enforcement resources nationwide. This paper argues that highly cost-effective policy recommendations exist that would assist in correcting the current situation, which is needlessly draining law enforcement resources nationwide, thereby allowing sorely needed resources to be directed toward this nation's homeland security concerns.

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

I. INTRODUCTION 1
- A. PROBLEM STATEMENT 2
- B. RESEARCH QUESTIONS 5
  - 1. Primary Question 5
  - 2. Secondary Question 5
- C. LITERATURE REVIEW 6
- D. HISTORY OF THE ISSUE 7
  - 1. Results of Policy Change 12
  - 2. Law Enforcement Workload 13
  - 3. Homeless Population Strain on Law Enforcement 14
  - 4. Severely Mentally Ill as Crime Victims 15
  - 5. Prison and Jail Overcrowding 15
  - 6. Extent of Mentally Ill Population in Jails and Prisons 17
  - 7. Direct Acts of Untreated Mentally Ill as Homeland Security Issues 18
  - 8. Impact of Treatment Programs 19
  - 9. Anosognosia 20
  - 10. Opposition to Court-Ordered Psychiatric Treatment 22
  - 11. The States' Stances 22
  - 12. The International Experience 23

II. METHODOLOGY 27
- A. SURVEY DESIGN AND DELIVERY 28
- B. SURVEY SUMMARY 30

III. RESULTS AND ANALYSIS 33
- A. QUESTION 1 33
- B. QUESTION 2 34
- C. QUESTION 3 35
- D. QUESTION 4 37
- E. QUESTION 5 38
- F. QUESTION 6 40
- G. QUESTION 7 41
- H. QUESTION 8 43
- I. QUESTION 9 45
- J. QUESTION 10 51
- K. QUESTION 11 52
- L. QUESTION 12 54
- M. QUESTION 13 55
- N. QUESTION 14 56
- O. QUESTION 15 66
- P. QUESTION 16 68
- Q. QUESTION 17 69

R. QUESTION 18 71
S. QUESTION 19 73
T. QUESTION 20 74
U. QUESTION 21 75
V. QUESTION 22 77

IV. FINAL REVIEW 79
A. OPERATION RED EYE....80
B. POLICY RECOMMENDATIONS 83
C. SUMMARY OF RECOMMENDATIONS....84

APPENDIX A. IACP LETTER OF ENDORSEMENT....87

APPENDIX B. THE SURVEY....89

APPENDIX C. WRITTEN RESPONSES TO OPEN ENDED QUESTION #8.....93

APPENDIX D. WRITTEN RESPONSES TO OPEN ENDED QUESTION #9...103

APPENDIX E. WRITTEN RESPONSES TO OPEN ENDED QUESTION #14.111

APPENDIX F. RESULTS BY STATE (HYPERLINK)....127

APPENDIX G. RESULTS BY POPULATION (HYPERLINK) 129

LIST OF REFERENCES....131

INITIAL DISTRIBUTION LIST 137

LIST OF FIGURES

Figure 1. Numbers of Patients in Psychiatric Hospitals 1950–2005 (From Torrey, 2010) 8
Figure 2. United States Population 1950–2005 (From United States Census Bureau, 2005) 9
Figure 3. Question 1 33
Figure 4. Question 2 35
Figure 5. Question 3 36
Figure 6. Question 4 38
Figure 7. Question 5 39
Figure 8. Question 6 41
Figure 9. Question 7 43
Figure 10. Question 8 44
Figure 11. Word Cloud of Responses Regarding Causes of Increased Presence of Mentally Ill Within Calls for Service 45
Figure 12. Question 9 46
Figure 13. Word Cloud From Participant Responses Regarding Amount of Time Commitment 49
Figure 14. Question 10 51
Figure 15. Question 11 53
Figure 16. Question 12 54
Figure 17. Question 13 56
Figure 18. Word Cloud Created From Participant Responses to Question 14 57
Figure 19. National Results to Question 14 58
Figure 20. Question 14 62
Figure 21. Question 14 63
Figure 22. Question 15 67
Figure 23. Question 16 68
Figure 24. Question 17 70
Figure 25. Question 18 72
Figure 26. Question 19 74
Figure 27. Question 20 75
Figure 28. Question 21 76
Figure 29. Question 22 78

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF TABLES

Table 1. Degree of Deinstitutionalization: Public Psychiatric Beds per Population, 1955 and 2004–2005 (Torrey, Geller, & Staff, 2008) 9
Table 2. Number of Public Psychiatric Beds Needed to Meet Minimum Standards of Treatment (Torrey, Geller, & Staff, 2008) 11
Table 3. Question 1 34
Table 4. Question 2 35
Table 5. Question 3 36
Table 6. Question 4 38
Table 7. Question 5 40
Table 8. Question 6 41
Table 9. Question 7 43
Table 10. Question 8 44
Table 11. Question 9 46
Table 12. Question 9 47
Table 13. Question 10 52
Table 14. Question 11 53
Table 15. Question 12 55
Table 16. Question 13 56
Table 17. National Results Question 14....59
Table 18. Massachusetts Filter Response Question 14 62
Table 19. Arizona Filter Response Question 14 63
Table 20. Question 15 67
Table 21. Question 16 69
Table 22. Question 17 70
Table 23. Question 18 72
Table 24. Question 19 74
Table 25. Question 21 76
Table 26. Question 22 78

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF ACRONYMS AND ABBREVIATIONS

AOT	Assisted Outpatient Treatment
BJS	Bureau of Justice Statistics
CIA	Central Intelligence Agency
CSLLEA	Census of State and Local Law Enforcement Agencies
FBI	Federal Bureau of Investigation
IP	Internet Protocol
LEMAS	Law Enforcement Management and Administrative Statistics
NYSACOP	New York State Association of Chiefs of Police
NYSSA	New York State Sheriffs Association
IACP	International Association of Chiefs of Police

THIS PAGE INTENTIONALLY LEFT BLANK

ACKNOWLEDGMENTS

This thesis would not have been possible without the assistance of many people; people who saw both the importance of the program offered by the Naval Postgraduate School's Center for Homeland Defense and Security, as well as the importance of this thesis's topic. Enrollment and completion in this coveted program would not have been possible without the encouragement and support of New Windsor Town Supervisor George A. Green, a career law enforcement professional who understands how important continuing education is in maintaining a professional police department. Having a command staff more than capable of managing the daily administration of an active police department made competing academically possible, and for that I thank Deputy Chief Richard Hovey, Lieutenant Michael Faricellia, and Lieutenant Michael Farbent as well as Lois Manion, my Administrative Assistant. The survey undertaken within this thesis provided a wealth of information; for making that possible, I would like to thank the New York State Association of Chiefs of Police, its Executive Director John Grebert, for his assistance with distribution of the thesis, and especially Mark Spawn, Director of Research, Development and Training, whose cooperation was invaluable. I would be remiss in not thanking Erin Vermilye, the States Association of Chiefs of Police, Manager, for her assistance with the national distribution of the survey via the International Association of Chiefs of Police (IACP). Without the assistance of the IACP, the truly national scope of this issue would not have been displayed.

I cannot begin to thank the faculty and staff of the Center for Homeland Defense and Security for providing me with the opportunity to learn and expand my horizons; the experience has been both challenging and immensely rewarding. Thank you, Dr. David Brannan and Pat Miller, my thesis advisors, whose law enforcement experience made the thesis topic no stranger to either of them. Thank you to Dr. Christopher Bellavita, who convinced me (several times) that I could do this and is responsible for my being here to actually do it. I would like to acknowledge the Treatment Advocacy Center for their ongoing efforts in getting severely mentally ill persons the help they so desperately need to live a less tormented life, while simultaneously making our communities and nation

safer. A special thanks to Dr. E. Fuller Torrey whose tireless efforts and research helps immensely in bringing this issue the attention that it so rightfully deserves.

Most importantly, I would like to thank my wife, Barbara, who has been extremely supportive throughout this entire process. She has endured 18 months of both of our lives revolving around my constant immersion within this program. Most certainly without her support, I would not have been able to complete this journey.

I. INTRODUCTION

The law of unintended consequences pushes us ceaselessly, permitting us no pause for perspective.

—Richard Schickel, author, journalist and documentary filmmaker, (1933–present)

Due to the attack upon this nation on September, 11, 2001, law enforcement's role has changed significantly. Suddenly, terrorism has taken center stage among the duties normally assigned to federal, state and local law enforcement. The breadth of those new responsibilities is staggering. At a time when budgets are strained, a relatively small but identifiable portion of society is needlessly consuming resources not limited only to law enforcement but those of the entire criminal justice system, primarily due to a policy change. This thesis will show that this needless strain not only has a direct impact on the ability of law enforcement to effectively carry out the duties necessary to prevent acts of terrorism, but this unmonitored severely mentally ill segment of our population also provides a homeland security threat in and of themselves.

It is the goal of this thesis to present actionable recommendations for improving the method by which as a society we manage our severely mentally ill nationwide, not present prior to the policy change that created the current situation. The unintended consequence of this policy change was the shift in care of the severely mentally ill from the mental health community to the emergency services and corrections communities. This change has resulted in a reduction of the criminal justice system's resources available to combat other issues that are more discipline specific. It is also responsible for the consumption of resources desperately needed in areas such as prison and jail radicalization, in the case of our corrections community, and additional homeland security issues, such as protection of critical infrastructure by law enforcement.

A. PROBLEM STATEMENT

A societal policy change took place nationally beginning in the early 1970s when a combination of factors led to the systematic mass closing of residential psychiatric hospitals nationwide (Mechanic & Rochefort, 1990). During that period in our history, new legislation was being introduced in response to elevated crime rates and the political right moved to reduce public services and cut taxes from what was termed the "welfare state."[1] That plan included reducing the number of hospitals treating the mentally ill while mainstreaming mentally ill patients back into the public, a process which came to be referred to as deinstitutionalization (Bachrach, 1976). The political left was also in favor of such a move, believing that keeping anyone in a hospital against his or her will, regardless of their state of mental illness, was in violation of basic civil liberties (Ennis, 1972).

During the 1960s, federal financial support programs were introduced, such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Medicare, and Medicaid, all designed to help aged, blind and disabled people, including the mentally ill, who have little or no income and who are living in the community. It should be noted that hospitalized patients for the most part are not eligible for much of these federal funds (Torrey, 2010).

State psychiatric care hospitals were funded almost totally with state funds, so these federally-funded public assistance programs served as an unintended incentive to transfer the cost of the care of the severely mentally ill from the state budget to the federal budget by discharging mentally ill patients back into the community. The systematic closing of state mental care hospitals nationwide has caused a severe shortage in available beds for those afflicted with serious psychiatric disorders, which are in need of immediate longer term care (Bloom, Krishnan, & Lockey, 2008).

This change in policy resulted in thousands of severely mentally ill persons being returned to society, most often without the psychiatric care and follow-up that they

[1] Welfare state is a concept of government where the state plays the primary role in the protection and promotion of the economic and social well-being of its citizens.

require to function within societal norms. Mentally ill individuals released into the community without resources or treatment many times became homeless or involved in otherwise preventable criminal activity (O'Sullivan, 2009). The criminal justice system as a whole has thus seen significant increases in many areas of concern:

- Increase in police interactions with severely mentally ill persons (Bonovitz & Bonovitz, 1981).
- Increase in the presence of severely mentally ill persons within prison and jail populations (Lamb & Weinberger, 1998).
- Increase in the presence of severely mentally ill persons within the homeless population (Gillig & McQuistion, 2006).
- Increase in severely mentally ill persons' involvement in the violent targeting of political/governmental figures and national institutions, which also threatens our homeland security (Shore, Filson, & Rae, 1990).

Will a change in public policy have the effect of greatly reducing the strain now present on law enforcement's limited resources spent on responding to calls for service pertaining to severely mentally ill persons? Are policy options available that are both able to lessen the issues listed above and remain within the acceptable standards of society?

A 2003 study by the Human Rights Watch estimates the number of mentally ill men and women in United States prisons at approximately 300,000 (Abramsky & Fellner, 2003). Those 300,000 prisoners often represent the most troublesome inmates, requiring the highest amount of attention from the corrections officer staff. Corrections officers are tasked with the day-to-day management of high maintenance, mentally ill prisoners, at the expense of more directed surveillance and monitoring of the prison population in general (Grinfeld, 1993).

Research was not located regarding the effect of the societal transfer of the severely mentally ill from the mental health system to the criminal justice system as it relates to its effect on prison overcrowding and attempts at combating prison and jail radicalization.

Further research is merited in this area to determine the effects of current practices of managing the nation's severely mentally ill population with respect to:

- Prison/jail overcrowding and its correlation to radicalization.
- Preventable violent acts straining emergency services nationwide.
- Preventable violent acts targeting political figures and national institutions.
- Homeless severely mentally ill persons' strain on law enforcement.
- Legal aspects regarding the civil liberties of the mentally ill and the right to refuse treatment.
- Lack of sufficient educational training across criminal justice disciplines regarding the severely mentally ill segment of our population.

The United States of America today holds the distinction of having more persons imprisoned than any other nation in the world.[2] More than 2.7 million prisoners reside in our nation's prisons and jails (Cilluffo, Cardash, & Whitehead, 2006). Nationally, 751 persons out of every 100,000 citizens are in prison or jail, placing a burden on the entire prison infrastructure and the criminal justice system (Liptak, 2008). Overcrowded conditions within our jails and prisons tax the correctional employees' abilities to adequately oversee the social interactions of the prison population and amplify the conditions that lend themselves to issues such as prison radicalization. Crowded prisons are breeding grounds for radicalism, where prisoners first listen to propaganda and when released are motivated to act upon extremist ideas (Violence, 2010). With overcrowding making inmate surveillance and management so difficult, how are our prison systems to direct their attention toward homeland security issues, such as preventing radicalization among the prison population?

The causes of prison overcrowding are multifactorial and include two main themes: increasingly tougher legislation and the inclusion of mentally ill persons into the jurisdiction of the prisons. In comparison to the international community, the United States tends to have stricter penalties for less serious crimes. It is thought that higher crime rates during the 1960s and 1970s, combined with a spike in violent crime, brought

[2] In comparison, China which has a population of four times that of the United States is a distant second, with 1.6 million people in prison. For more information, please see http://www.globalresearch.ca/index.php?aid=8801&context=va

about a public outcry for tougher sentencing guidelines as well as mandatory sentences, which was answered by new federal and state legislation (The Economist, 2010).

B. RESEARCH QUESTIONS

1. Primary Question

Does the current method by which the United States manages its mentally ill population place an unreasonable strain upon our law enforcement resources to the point that it adversely affects their respective ability to focus on homeland security and anti-terrorism activities?

- If so, what steps or policies can be implemented to reduce the systematic strain upon the criminal justice system as a whole?
- To what extent does the management of the severely mentally ill effect the law enforcement resources within our communities?
- If not, are their social policy changes that can be suggested to improve the situation other than remaining status quo?

2. Secondary Question

What is the perception of law enforcement administration as to the significance of the burden placed upon their resources caused by the deinstitutionalization of the severely mentally ill? Within this question the following issues are considered:

- How much of a police department's time is consumed in calls for service centering on persons suffering with severe mental illness?
- Have police departments observed an increase in the mentally ill population within their communities?
- Have police departments observed an increase in suicides and attempted suicides?
- Have police departments seen an increase in the numbers of mentally ill detainees/prisoners?
- To what extent has the amount of time a police department spends on calls for service involving mental illness changed over the length of a law enforcement career?

- Where does the amount of time spent on calls for service involving persons with severe mental illness rank in comparison to other types of calls for service?
- Does a call for service involving a severely mentally ill person involve additional manpower?
- Should any exist, what are perceived as obstacles in referring mentally ill for care?
- How dangerous do police officers perceive the severely mentally ill segment of their community?
- How prevalent do police departments perceive that the mentally ill population is among the homeless population within their community?

C. LITERATURE REVIEW

The issues surrounding the management of the untreated severely mentally ill segment of our population affects homeland security on many levels. Literature exists that indicates the amending of public policy resulting in the deinstitutionalization of society's most severely mentally ill has had a profound effect on the criminal justice system, law enforcement, corrections, courts and the public at large. Literature also exists in contradiction to these studies, in fact finding quite the opposite—that persons with untreated serious mental illness are no more dangerous than the general public and do not pose an increased threat. Most of the dissenting opinions, however, center on the issue of civil liberties and the right to refuse treatment.

In the process of researching the topic of deinstitutionalization of the severely mentally ill and its effects on homeland security as the thesis topic, the literature is organized into several important areas of study, which include the following:

- The history of the issue.
- The results of the policy change affecting public safety and fiscal concerns.
- Its effects upon law enforcement resources.
- Its effects upon the homeless issue involving law enforcement.
- Its effects upon jails and prisons.

- Criminal acts of known untreated severely mentally ill as a homeland security issues, in themselves.
- Positive and negative effects of court ordered psychiatric treatment.

Each of the aforementioned issues has direct links affecting the security of our homeland and will be discussed within this paper.

D. HISTORY OF THE ISSUE

Dorthea Dix, a school teacher, volunteered to teach Sunday school in a jail just outside of Boston in 1841. Once inside the jail, she was shocked at the high number of mentally ill prisoners existing in deplorable conditions. Having a mentally ill father, she was sensitive to the plight of the severely mentally ill. She began a grassroots effort to create a system of care for mentally ill prisoners. Her lobbying of legislators resulted in the creation of 30 public psychiatric hospitals in 1880. It is not known exactly how many prisoners suffered with mental illness when Dorthea Dix first entered the jail, but 40 years later, less than 0.7 percent of inmates suffered from mental illness (Quanbeck, Frye, & Altshuler, 2003). Today, our system appears to have come full circle.

During the 1960s and the early 1970s, a movement began in California and was supported first by then-Governor Pat Brown (D) and then later by Governor Ronald Reagan (R), consisting of a move away from what was termed the "welfare state." The political move involved cutting taxes by reducing public services. One outcome of the movement came to be known as "deinstitutionalization" by some and "criminalization hypothesis"[3] by others. The policy change involved the systematic closure of mental intuitions throughout California and ultimately throughout the United States, a condition that continues today. (See Figure 1.)

[3] The criminalization hypothesis is based on the assumption that police inappropriately use arrest to resolve encounters with mentally disordered suspects.

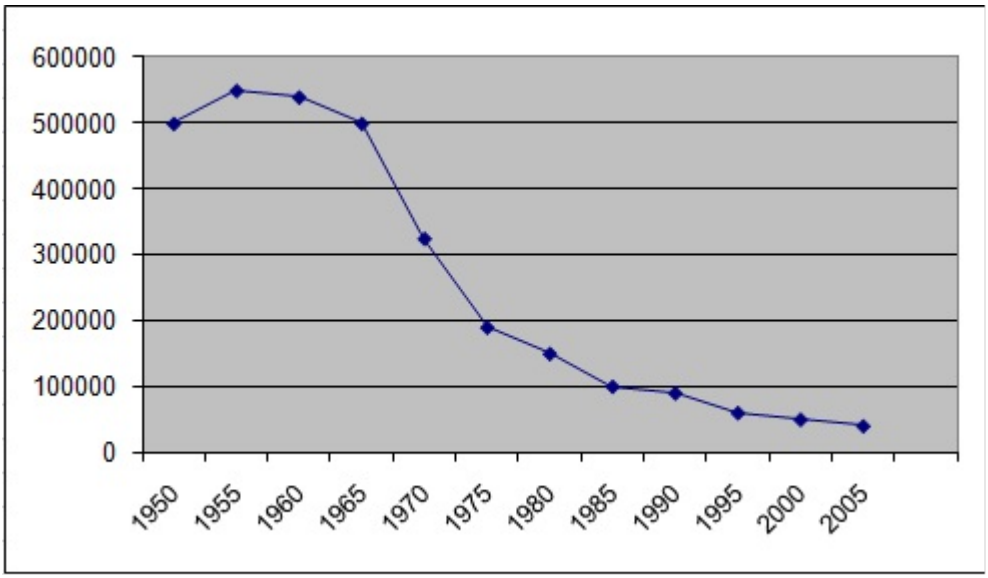

Figure 1. Numbers of Patients in Psychiatric Hospitals 1950–2005
(From Torrey, 2010)

This drastic reduction in the number of patients in psychiatric hospitals during the 1960s and early 1970s is dramatically contrasted when considering the population explosion that was occurring within the general population of the United States during the same time period. (See Figure 2, and Tables 1–2.)

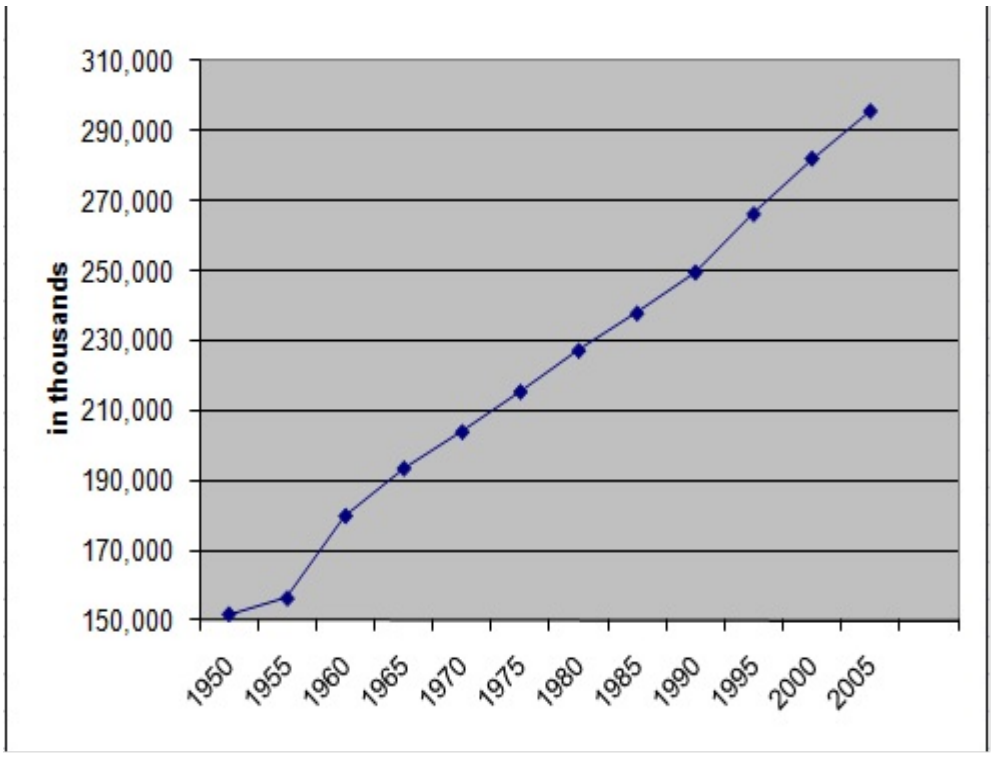

Figure 2. United States Population 1950–2005
(From United States Census Bureau, 2005)

Table 1. Degree of Deinstitutionalization: Public Psychiatric Beds per Population, 1955 and 2004–2005 (Torrey, Geller, & Staff, 2008)

State	**Beds per 100,000 population 1955**	**Beds per 100,000 population 2004–2005**	**2004–2005 beds as percentage of 1955 beds**
Mississippi	250.8	49.7	19.8%
South Dakota	236.8	40.3	17.0%
Delaware	359.9	33.8	9.4%
New Jersey	410.7	32.4	7.9%
New York	599.5	27.4	4.6%
Minnesota	360.7	26.8	7.4%
North Dakota	310.4	25.9	8.3%
Connecticut	386.8	25.4	6.6%
Wyoming	214.1	24.1	11.3%
New Mexico	119.5	22.3	18.7%
Virginia	315.8	22.2	7.0%

State	Beds per 100,000 population 1955	Beds per 100,000 population 2004–2005	2004–2005 beds as percentage of 1955 beds
Alabama	237.3	22.1	9.3%
Kansas	214.6	21.7	10.1%
Maryland	347.4	21.6	6.2%
Missouri	291.2	21.5	7.4%
Montana	303.2	20.9	6.9%
Nebraska	346.7	20.7	6.0%
Louisiana	282.6	20.2	7.1%
Indiana	257.5	19.3	7.5%
Oregon	292.8	19.2	6.6%
Washington	296.9	18.9	6.4%
Pennsylvania	366.7	18.9	5.2%
Georgia	323.1	18.5	5.7%
Tennessee	225.1	18.1	8.0%
California	285.5	17.5	6.1%
New Hampshire	490.7	17.2	3.5%
North Carolina	232.4	17.1	7.4%
Colorado	369.3	16.9	4.6%
Massachusetts	462.1	15.8	3.4%
Kentucky	256.2	15.6	6.1%
Illinois	404.7	14.3	3.5%
West Virginia	280.7	14.2	5.1%
Utah	171.2	13.8	8.1%
Hawaii [4]	NA	13.5	NA
Wisconsin	405.5	13.0	3.2%
Maine	331.0	12.6	3.8%
Rhode Island [5]	407.3	12.5	3.1%
Florida	232.5	12.1	5.2%
Texas	192.0	12.1	6.3%
Idaho	200.5	11.3	5.6%
Alaska	NA	11.3	NA
Oklahoma	369.6	11.0	3.0%
South Carolina	264.7	10.6	4.0%
Ohio	319.7	10.6	3.3%
Michigan	301.2	9.9	3.3%
Vermont	342.3	8.9	2.6%
Iowa	198.2	8.1	4.1%

[4] The District of Columbia was not included, since its public psychiatric hospital was used for many years for admissions of non-District residents and its data are not comparable with the states. Data are not available for Alaska and Hawaii in 1955, since they were not states at that time.

5 Rhode Island has no state or county psychiatric hospital but maintains psychiatric beds in a general hospital.

State	Beds per 100,000 population 1955	Beds per 100,000 population 2004–2005	2004–2005 beds as percentage of 1955 beds
Arkansas	284.3	6.7	2.4%
Arizona	172.4	5.9	3.4%
Nevada [6]	195.6	5.1	2.6%

Table 2. Number of Public Psychiatric Beds Needed to Meet Minimum Standards of Treatment (Torrey, Geller, & Staff, 2008)

State	Number of beds available, 2005–2005	Minimum number of beds needed	Number of beds to be added to meet minimum standards
Mississippi	1,442	1,456	14
South Dakota	311	384	73
Delaware	281	413	132
New Jersey	2,820	4,338	1,518
New York	5,269	9,580	4,311
Minnesota	1,368	2,533	1,165
North Dakota	164	315	151
Connecticut	889	1,743	854
Wyoming	122	254	132
New Mexico	425	944	519
Virginia	1,659	3,778	2,119
Alabama	1,001	2,275	1,274
Kansas	594	1,381	787
Maryland	1,203	2,798	1,595
Missouri	1,238	2,879	1,641
Montana	194	461	267
Nebraska	361	880	519
Louisiana	914	2,285	1,371
Indiana	1,201	3,079	1,878
Oregon	691	1,818	1,127
Washington	1,170	3,079	1,909
Pennsylvania	2,349	6,182	3,833
Georgia	1,635	4,459	2,824
Tennessee	1,068	2,967	1,899
California	6,285	18,485	12,200
New Hampshire	224	659	435
North Carolina	1,461	4,297	2,836
Colorado	776	2,282	1,506
Massachusetts	1,015	3,172	2,157
Kentucky	646	2,084	1,438
Illinois	1,821	6,279	4,458
West Virginia	258	921	663

[6] In 2007, Nevada opened a new state mental hospital. Thus, its ranking on availability of beds would now be higher than is reflected by these 2005 and 2006 data. More recent statistics are not yet available.

State	Number of beds available, 2005–2005	Minimum number of beds needed	Number of beds to be added to meet minimum standards
Utah	329	1,175	846
Hawaii [7]	171	633	462
Wisconsin	716	2,754	2,038
Maine	166	664	498
Rhode Island [8]	134	536	402
Florida	2,101	8,754	6,653
Texas	2,730	11,375	8,645
Idaho	157	683	526
Alaska [4]	74	322	248
Oklahoma	386	1,754	1,368
South Carolina	443	2,109	1,666
Ohio	1,210	5,762	4,552
Michigan	1,006	5,030	4,024
Vermont	55	306	251
Iowa	239	1,494	1,255
Arkansas	184	1,415	1,231
Arizona	338	2,817	2,479
Nevada [9]	119	1,190	1,071
TOTALS	**51,413**	**147,233**	**95,820**

What was not anticipated was the unintended effect that this change in public policy would have upon our law enforcement services and correctional systems nationwide, with regard to the management of the resulting displaced severely mentally ill population.

1. Results of Policy Change

While the population of the United States grew exponentially, the residents of psychiatric hospital beds dwindled into statistical nonexistence, as the mentally ill were returned into the community. The effects of the policy change were immediate: tolerance

[7] The District of Columbia was not included, since its public psychiatric hospital was used for many years for admissions of non-District residents and its data are not comparable with the states. Data are not available for Alaska and Hawaii in 1955, since they were not states at that time.

8 Rhode Island has no state or county psychiatric hospitals but maintains psychiatric beds in a general hospital.

9 In 2007, Nevada opened a new state mental hospital. Thus, its ranking on availability of beds would now be higher than is reflected by these 2005 and 2006 data.

for deviant public behavior was, and still is, severely strained, giving birth to the aforementioned criminalization hypothesis by opponents of the policy change.

While Figures 1 and 2 reflect the extent and speed of which the psychiatric treatment facilities were emptied in comparison to the rate of growth of the nation, Tables 1 and 2 display the resulting number of beds both available and minimally recommended on a state-to-state basis.

A central question within the debate regarding deinstitutionalization continues: Where are these people now and how are they fairing within society? A 2003 study by Sasha Abramsky indicates a strong correlation exists between the deinstitutionalization of psychiatric patients from psychiatric facilities and a resulting increase in crime, arrest rates, incarceration, and homelessness among the mentally ill within 81 cities (Abramsky & Fellner, 2003). As an example, in California, county jails hold more severely mentally ill people than all the hospitals in their respective counties (Quanbeck et al., 2003). A similar study indicates that the rates of schizophrenia and the major affective disorders are three to six times greater within the prison population than within the community at large (Robins & Regier, 1991).

A 2002 study conducted by Seena Fazel, M.D., was described as a systematic review of 62 surveys regarding serious mental disorders among 23,000 prisoners in 12 western countries (Fazel & Danesh, 2002). That study indicated that the risk of having serious psychiatric disorders was two to four times higher in prisoners than in the general population (Fazel & Danesh, 2002). The report also noted that the burden upon the correctional staff in terms of dealing with treatable serious mental disorders in prisoners was "substantial." The report studied the U.S. prison system and suggested that a few hundred thousand prisoners may have psychotic illnesses, major depression, or both, pointing out that the numbers are twice that of the number of all of the mentally ill patients in all American hospitals combined (Fazel, Khosla, Doll, & Geddes, 2008).

2. Law Enforcement Workload

In 1981, J. C. Bonovitz and J. S. Bonovitz conducted a study using longitudinal data collected from a suburban police department in order to ascertain if the number of

police interactions involving mentally ill individuals within a state with restrictive civil commitment laws had increased. Employing the hypothesis that police would arrest disorderly/nondangerous persons to expedite their removal from the community, the authors studied the outcome of all incidents within a five-month period involving mentally ill individuals. Their findings showed that police involvement in mental illness related incidents had increased 227.6 percent from 1975 to 1979 (Bonovitz & Bonovitz, 1981).

As an additional example of the massive impact upon police departments, in New York City the police department responds to a call involving a person with mental illness once every 6.5 minutes (Reuland, 2005). In the state of Florida, the police transport over 40,000 people a year for involuntary psychiatric examination, a number exceeding the number of persons arrested within the state for aggravated assault or burglary (Reuland, 2005).

3. Homeless Population Strain on Law Enforcement

A related issue that continually drains law enforcement resources is that of the homeless population, which is most prevalent in our cities but exists to varying extents nationwide. A 1989 study conducted in Baltimore, Maryland by William Breakey, randomly selected from missions, shelters, and jails, 298 men and 230 women to be interviewed for extensive socio-demographic and health related data (Breakey et al., 1989). In part, the study found a high prevalence of mental illness and psychiatric disorders among the homeless population (Breakey et al., 1989). Several studies have shown reasonably consistent rates among homeless people of one-third to one-half with psychiatric disorders (Gillig & McQuistion, 2006).

A 1999 study by Robin E. Clark, PhD entitled, *Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders*, examined 203 persons enrolled in specialized treatment for dual disorders. Cost and utilization data were collected over a three-year period, from police, sheriffs and deputies, officers of the courts, public defenders, prosecutors, private attorneys, local and county jails, state prisons and paid legal guardians. The costs involved with arrest per person

was $2,295, nonarrest involvements with police $385.00 and the combined three-year cost averaged $2,680.00 per person (Clark, Ricketts, & McHugo, 1999). The study indicated that continued substance use and homelessness were associated with a greater likelihood of arrest. Poor treatment engagement was associated with multiple arrests. According to Dr. Clark:

> It is interesting to note that the study found that although effective treatment of substance use among persons with mental illness appeared to reduce arrests and incarcerations, it did not reduce the frequency of non-arrest encounters with the police. It was also noted that stable housing may also reduce the likelihood and number of arrests. (Clark, Ricketts, & McHugo, 1999)

4. Severely Mentally Ill as Crime Victims

A 2005 study titled, *Crime Victimization in Adults with Severe Mental Illness, Comparison with the National Crime Victimization Survey*, randomly sampled 16 outpatient, day, and residential treatment facilities for severely mentally ill persons in Chicago, Illinois (Teplin, McClelland, Abram, & Weiner, 2005). The survey found that more than one-quarter of persons with severe mental illness had been the victim of violent crime within the past year; a rate more than 11 times greater than the general population rates even after controlling for demographic differences between the two samples ($p<.001$) (Teplin, McClelland, Abram, & Weiner, 2005). Annual incidence of violent crime in the severely mentally ill sample was more than four times higher than the general population rates (39.9 incidents per 1000 persons) ($p<.001$) (Teplin, McClelland, Abram, & Weiner, 2005). The report further found that, depending on the type of violent crime, prevalence was six to 23 times greater among persons with severe mental illness than among the general population (Teplin, McClelland, Abram, & Weiner, 2005).

5. Prison and Jail Overcrowding

Much has been written regarding prison overcrowding, law enforcement and emergency services with resources thinly stretched. However, literature was not found as to how much of an effect our current method of managing the severely mentally ill

affects the ability of our jails to combat radicalization within their walls or its effects upon our emergency services resources nationwide.

Prisons and jails are envisioned as places where criminals are reformed and again become productive members of society, avoiding the type of antisocial acts that resulted in their incarceration. However, prisons and jails have become hotbeds for the radicalization of segments of their inmate populations (Cilluffo et al., 2006). Prisons and jails contain an abundance of persons in search of an identity, persons in need of protection, as well as nonconformists (Cilluffo et al., 2006). It is a condition not unique to prisons within the United States but existing in prisons around the world. The problem of prison radicalization becomes exacerbated when massive overcrowding is combined with insufficient staffing of the correctional systems (Violence, 2010). Between 1990 and 1995, state and federal governments added 213 prisons and more than 280,000 prison beds, representing a 41 percent increase in prison capacity (Stephan, Karberg, & United States. Bureau of Justice Statistics, 2003). In 1995, state prisons were on average operating at four percent above rated capacity and federal prisons at 25 percent above capacity (Stephan, et al., 2003). At mid-1995, about one in four state correctional facilities was under court order or consent decree to limit population or to address specific conditions (Stephan et al., 2003).

Literature exists regarding how the United States prison system became so overcrowded, and much of it points to political, cultural and societal changes: how we enforce our laws and what we have come to expect in the way of punishment. The United States justice system levies much harsher prison sentences with mandatory minimums as punishment for crimes which, in comparison, most of the free world adjudicates with treatment programs and community probation (Tonry, 1999). For example, the United States Supreme Court has declared that incarceration may be imposed for such trivial matters as smoking cigarettes in the New York City Subway System and driving without a seatbelt, both issues thought absurd in Western Europe (Parker, 1988).

Higher crime rates during the 1960s and 1970s, combined with a spike in violent crime, brought about a public outcry for tougher sentencing guidelines. Elected officials

responded with tougher laws and elected judges responded with tougher sentences; a public perception of being soft on crime would not be advantageous to a judge's reelection (The Economist, 2010).

6. Extent of Mentally Ill Population in Jails and Prisons

- A 1998 study by the American Psychiatric Association refers to clinical studies indicating that six percent to 15 percent of persons in city and county jails and 10 percent to 15 percent of persons in state prisons have severe mental illness (Lamb & Weinberger, 1998). Another study conducted of the Cook County, Illinois jail system indicated that its jail census increased by 40 percent between 1978 and 1983 and an additional 28 percent by 1987 (Teplin, 1990). The study speculated;
- That jails have become a repository for the severely mentally ill, more so than the prisons, employing the rationale that jail populations are comprised of prisoners awaiting trial or serving sentences of less than one year, while prisons contain convicted criminals serving sentences of greater than one year (Teplin, 1990).;
- That severely mentally ill inmates are often diverted to forensic psychiatric facilities (Teplin, 1990).

A 2003 comprehensive study indicated that one in five of the 2.1 million Americans in jail and prisons are seriously mentally ill, far more than the number of mentally ill who are in mental hospitals (Abramsky & Fellner, 2003).

There is evidence from practitioners that by default, jails and prisons are forced to be pseudo [mental] hospitals, according to Michael Mahoney, warden, Montana State Prison (Abramsky & Fellner, 2003). "We are literally drowning in patients, running around trying to put fingers in bursting dikes, while hundreds of mentally ill men continue to deteriorate psychiatrically before our eyes into serious psychoses." (Torrey, 2010).

The state of Iowa's Director of Prisons, John Baldwin, is quoted as stating, "We have become, by default, the state's mental-health system for people who are difficult to manage" (Leys, 2011). Baldwin was referring to a decline in the number of facilities that are able to take people with serious mental illnesses.

He said:

> Authorities often have no outside alternatives for mentally ill inmates who have been released from prison after serving their sentences, and as a result about 75 such people have been civilly committed to the prison system because judges could not find anywhere else to send them. A few of those people have been living that way for years, he added. Such arrangements used to be 'very, very rare.' Now it's fairly common. (Leys, 2011)

As the laws that caused deinstitutionalization began to go into effect, critics of the new laws began to talk about the "balloon theory" originally coined by Lionel Penrose in 1939 (Penrose, 1939).

His theory was that the populations of mental hospitals and prisons are inversely correlated: a decrease in one causes an increase in the other. No studies have been located that contain direct surveys of jail, prison or law enforcement administrators attempting to quantifying the consumption of additional resources expended pertaining to the current management of the severely mentally ill, and how that impacts their ability to direct resources towards homeland security concerns.

7. Direct Acts of Untreated Mentally Ill as Homeland Security Issues

Many incidents exist that were first thought to be acts of terrorism, violent assaults against persons, and attacks on locations of national importance that were later determined to have been perpetrated by individuals with long histories of severe untreated mental illness. Literature examining the cause of the lack of effective management of these severely mentally ill individuals prior to their violent acts has not been located. Individuals such as:

- The Pentagon Shooter: John Patrick Bedell
- Whitehouse Shooter: Robert W. Pickett
- Whitehouse Attacker: Leland William Modjeski
- Presidential Shooting: John Hinckley, Jr.
- Attack on California State Capital: Mike Bowers
- Discovery Channel Hostage Taker: James J. Lee

Many incidents involving persons with long histories of severe untreated mental illness exist. While they are often found to be isolated attacks of untreated mentally ill individuals rather than calculated attacks by individuals representing a terrorist movement, they nonetheless affect our national security.

In Washington, D.C., the Uniformed Division of the Secret Service is responsible for delivering many mentally ill people to St. Elizabeth's Hospital where they are known as "White House Cases." They arrive at the White House seeking to meet with the president regarding "very important matters" (Shore et al., 1990). A study of 192 cases indicated an excess of arrests for both violent and nonviolent offenses (Shore et al., 1990). Many millions of dollars have been spent increasing facility and personnel security in response to these preventable acts.

8. Impact of Treatment Programs

There are programs aimed at mandating outpatient treatment for the most seriously mentally ill segment of our population, those who possess long histories of severe mental illness and who also have histories of violent acts and noncompliance with treatment. Many severely mentally ill persons respond favorably to treatment (Perlin, 2003). Court-ordered proactive treatment to prevent rehospitalization and violent acts, which have been shown to occur in the absence or refusal of such treatment, has proven to result in a substantial reduction in rates of arrests, homelessness, incarcerations and violent crimes. A 2009 Duke University study, commissioned by the New York State Office of Mental Health to assess the effectiveness of New York's Assisted Outpatient Treatment (AOT) Laws, known in New York State as Kendra's Law, resulted in the following findings.

The report found that of the persons under court ordered AOT programs:

- 74 percent fewer experienced homelessness;
- 77 percent fewer experienced psychiatric hospitalization;
- 83 percent fewer experienced arrest; and
- 87 percent fewer experienced incarceration. (Swartz et al., 2010)

Both the Duke and Columbia University's independent studies revealed phenomenally successful results indicating great improvement with seriously mentally ill persons managed within the Assisted Outpatient Treatment program, in areas which now cause needless consumption of local law enforcement resources. The relieving of that strain would allow a greater focus on the homeland security issues that is now limited in much of the nation. The current strain upon the criminal justice would be lessened across all disciplines.

A team of Columbia University researchers, in collaboration with the University of Michigan and the New York State Psychiatric Institute, concluded a study funded by the New York State Office of Mental Health titled, *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State* (Kendra's Law), and presented their findings in February, 2010. Bruce Link, professor of epidemiology and social medical sciences as well as lead investigator of the study, was quoted as stating:

> Our study has found that Kendra's Law has lowered risk of violent behaviours, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. Outpatient commitment for people with mental illnesses is enormously controversial—it's been heralded as necessary and effective by some, and as overly coercive and counterproductive by others—but our study has found few of the negative consequences feared by critics of Kendra's Law. (Perlin, 2003)

The researchers found that the patients enrolled in mandatory treatment who had more violent histories were four times less likely than members of the control group to perpetrate serious violence after undergoing treatment (Perlin, 2003).

9. Anosognosia

A critical factor when discussing civil liberty issues surrounding court-ordered assisted outpatient treatment is a medical condition known as anosognosia. Anosognosia is reported in approximately 57 percent of all individuals with schizophrenia (Amador & Gorman, 1998). It is the person who suffers with schizophrenia and is among the approximately 57 percent with anosognosia who believe that nothing is wrong with him, who most often refuses medication for his or her illness (Ghaemi & Rosenquist, 2004). It

is interesting that a large number, who adamantly oppose treatment by court order, are thankful once stable due to the treatment that has been imposed upon them (Levine, 2004).

This most dangerous subgroup of schizophrenics is often characterized by the presence of command hallucinations, both auditory and visual in nature (McNiel, 1994). It is this segment of the mentally ill population that this thesis paper is attempting to address. They comprise the most volatile segment of the mentally ill population, and it is this segment that police and corrections officers are now involved with on a daily basis.

There is an inherent Catch-22 scenario at play: normally, a person who is suffering from a treatable illness makes a conscious decision to seek treatment to return to a state of relative health. The brain is the organ that makes that conscious decision, but in the case of anosognosia, where the illness prevents the brain from understanding that an illness is present, a mentally ill person has no internal drive to seek treatment and is therefore left without assistance unless it is imposed upon him. As a society, which scenario violates civil liberties to a greater extent: assisting a mentally ill person against his will via court-ordered treatment? Or leaving that individual in a psychotic state where he may be of harm to himself or others (and there are many examples),[10] not to mention deprived of his chance to be a productive member of society with the help of treatment? Could it not be argued that leaving someone in a state of mental illness when steps can be taken to assist that person back to a state of relative mental stability, is in itself violating that person's civil liberties?

> Civil libertarians say no—that it is our right to commit crimes that land us in prison that it is our choice to be so ill that we prefer to forage through garbage and live on the streets, that it is our prerogative to let voices in our heads torment us into sleepless nights. But something tells me that the people locked up in San Quentin with a mental illness, and the people roving the back alleys of skid row, are not singing "God Bless America". (Randall, 2006).

[10] Using New York State, Syracuse May 18, 2011 police justifiably shoot and kill mentally ill Benjamin Campionen (Dowty, 2011). He was pointing what turned out to be a pellet gun at them. On Long Island, New York November 21, 2010 police justifiably shot mentally ill Thomas Scimone eight times after he started a fire and ran down the streets brandishing a shotgun. Both men possessed long histories of untreated mental illness (Morales & Lauinger, 2010).

10. Opposition to Court-Ordered Psychiatric Treatment

A main area of concern regarding psychiatric treatment is the existence of conflicting legal theories among the mental health professionals. The group is split into two camps: those who support a civil libertarian point of view and those who center on treatment and welfare rights of patients, or a treatment-oriented point of view (Gutierrez, 1996).

Most of the literature in opposition to the concept of court-ordered psychiatric treatment centers on both civil liberty and religious issues. One critical opponent, Dr. Thomas Szasz, in his book *Liberation by Oppression: A Comparative Study of Slavery and Psychiatry*, likens the oppression of the slave master to the slave with the psychiatrist to their patient, seeing treatment for mental illness as an issue of individual rights.

> It is dishonest to pretend that caring coercively for the mentally ill invariably helps him, and that abstaining from such coercion is tantamount to 'withholding treatment' from him. Every social policy entails benefits as well as harms. Although our ideas about benefits and harms vary from time to time, all history teaches us to beware of benefactors who deprive their beneficiaries of liberty There is neither justification nor need for involuntary psychiatric interventions. (Szasz, 2003)

Another opponent, Dr. Robert Whitaker, in his book, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, compares U.S. physicians' treatments of the mentally ill to medical experiments and sterilizations in Nazi Germany (Whitaker, 2003).

11. The States' Stances

While verbally supportive of assisted outpatient treatment programs (AOT), many states' Directors of Mental Health fail to implement AOT laws, claiming that the programs are too costly at a time when mental health offices lack sufficient funding. As an example, in 2000, the cost of a day in a Milwaukee jail was $60.00, state prison $200.00 and the county inpatient mental health complex $527.00 (Torrey, 2010). However, these figures fail to take into consideration the costs of repeated incarcerations, criminal acts, court proceedings and corrections staff as emergency services resources

(Torrey, 2010). The dollars spent regarding emergency services as a result of the lack of treatment of the severely mentally ill needs to be taken into consideration when accessing the overall cost of an assisted outpatient treatment program. The political decision not to initiate court-ordered assisted outpatient programs for those most severely mentally ill, and in need, postpones the civil liberties controversy that would arise regarding involuntary medical treatment. However, it also allows the continual deterioration of the mentally ill individual, statistically increasing his/her chances of violent acts, substance abuse, arrest, homelessness and incarnation rates, which is evident when considering the aforementioned Duke University study (Duke University School of Medicine et. al., 2009).

12. The International Experience

The deinstitutionalization of a country's severely mentally ill populations is not particular to the United States; it also quickly spread throughout European countries. I will compare and contrast the history and policy differences between Italy and the United States regarding the issue as there are sections of Italian mental health policy that would be useful to incorporate into the United States' policies in an attempt to create a best practice.

In 1978, a piece of Italian legislation known as *Legge Basaglia, Legge 180,* or the Italian Mental Health Act of 1978, was very similar to the deinstitutionalization movement that was already in full implementation at the same time within the United States. The Italian law, also known as the Basaglia Law, named after its creator, Franco Basaglia, initiated the systematic closure of psychiatric hospitals throughout Italy. The law gained worldwide attention as other European countries began to copy the Italian model (Saillant & Genest, 2007).

By 1998, the state psychiatric hospital system in Italy had been totally dismantled. As in the United States, the theory was to provide services to the mentally ill, outside of the hospital setting, changing from defense of community to increased care within the community (Burti, 2001).

The closing of psychiatric hospitals in both countries caused immediate effects on both societies; each country's tolerance for deviant public behavior was and is still tested. As deinstitutionalization began to go into effect in Italy, critics just as in the United States also began to talk about the balloon theory. Pointing to the fact that in Italy between 1978 and 1983 commitments to psychiatric, detention hospitals for the **criminally** insane had increased 57.6 percent, pointing yet again to the criminalization of the mentally ill (Ferracuti, 1985). At the time, the Italian press conducted a journalistic inquiry regarding the socio-psychiatric situation in Italy post the Basaglia Law-180, and defined the law as "a complete fiasco" (Dini, 1988).

As indicated within the literature, both the United States model and the Italian model have created much debate concerning the sociopolitical implications. Internationally, the thought was that if individuals with mental illness were well cared for they would not be dangerous and that only short-term predictions of dangerousness could be forecasted (Gatti, 1985). Both the American and Italian societies felt that a prediction of dangerousness could be injurious to an individual's life and compromise his integration into society, affecting his self-image and the image that others have of him (Gatti, 1985).

Prior to Italy's passing of the Basaglia Law in 1978, the United States General Accounting Office, in a report to Congress regarding deinstitutionalization of the mentally ill within the United States, described serious problems that the law was causing here in the United States (Braun et al., 1981). The report stated that the law failed to evaluate adequately the effect of discharging so many thousands of chronically ill patients from mental hospitals into the community (Braun et al., 1981). Literature could not be located that would indicate that the Italian government considered the unintended consequences outlined within the United States General Accounting Office's report when crafting its legislation.

The issue of severely mentally ill representation among Italy's homeless population was addressed in Italy with the formation of community residential facilities. These facilities cater to a large portion of the severely mentally ill population who, due to their illness, are unable to maintain employment or to care for themselves. Discharge

from these facilities to independent accommodations was found to be uncommon (De Girolamo et al., 2005). This practice reduces the presence of the severely mentally ill within Italy's homeless population.

Civil liberties became a central political concern for Italy, just as it did within the United States, primarily with regard to the legality of treating the severely mentally ill, even the dangerously mentally ill, without acceptance on the part of the individual.

A major difference between the deinstitutionalization laws of the United States and Italy is that Italy's involuntary commitment law does not solely rely upon imminently dangerousness as the criterion for commitment purposes. On the other hand, many individual states within the United States actually use involuntary commitment laws, require that the person be "imminently dangerous to themselves or others," which creates a very high threshold for emergency services personnel to work within. The fact that the person in question is in a very psychotic state does not necessarily meet the threshold of imminently dangerous to themselves or others. In comparison, Italy does not require that its emergency services wait until an obviously psychotic person crosses into the dangerous realm before an involuntary psychiatric evaluation. In Italy, severely mentally ill people are treated long before committing dangerous acts, rather than waiting until the dangerous acts can be described as "imminent" or until after such an act has occurred. Lowering of the imminently dangerous threshold would have the desirable affect of minimizing the impact on emergency services, courts and prisons, while simultaneously creating a safer community and providing psychiatric care for the segment of the mentally ill population most severely mentally ill.

A second major difference between the Italian model and the United States model pertains to the United States Federal Health Insurance Portability and Accountability Act, (HIPAA) "Privacy Rule." In the United States, information regarding the medical status of any patient is closely guarded, while in comparison Italy's policy requires the immediate family of the mentally ill person be directly involved in the process of determining the care of their mentally ill family member. This would appear to be a severe shortcoming of the United States HIPAA law as it pertains to mentally ill persons. It assumes that the patient is mentally capable of decisions regarding hospital care and

treatment, while their immediate family who are most familiar with the problem, and most often the victims of their violence, are excluded from involvement. It literally makes the severely mentally ill person the sole decision maker, when in many cases, they themselves believe that they are not mentally ill and are simply carrying out commands from auditory hallucinations that their mind convinces them are real.

We can take away several important lessons from Italy's method of responding to its severely mentally ill population. First, it appears that the effects of anosognosia have been considered, as Italy does not require a person to be "imminently dangerous" as a precursor to action on the part of its emergency services. Second, its decision to not only allow, but also to mandate, the involvement of family members in the decision making process that is employed to determine care for the mentally ill family member, reduces the alienation that the mentally ill individual experiences from his/her family and promotes a collaborative treatment process. This is in direct contrast to the practices in the United States where allowing or barring family participation is based solely upon the wishes of the severely mentally ill individual.

II. METHODOLOGY

The literature review covers a wide range of issues directly related to the policy change leading to the deinstitutionalization of the severely mentally ill. No national strategic guidance or operational models exist that would encourage states to modify policies or enact policies in states where none exist.

The following research questions have guided the initial investigation.

- Does the current method by which the United States manages its mentally ill population place an unreasonable burden upon both its prison system and its law enforcement resources to the point that it adversely affects their respective abilities to focus on homeland security/anti-terrorism activities?
- Has there been a substantial increase in the rate of involvement observed by U.S. law enforcement executives pertaining to interactions with the severely mentally ill population over the course of their careers?
- If so, what steps or policies can be implemented to reduce the systematic strain upon the criminal justice system as a whole?
- If not, are their social policy changes that can be suggested to improve the situation other than remaining status quo?
- To what extent does the management of the severely mentally ill affect community law enforcement resources within the United States?

Using these questions as a starting point to consider the issues identified within the review of the related literature, a survey was developed to determine the perceptions of law enforcement administrators with regards to the effect that deinstitutionalization has had and continues to have nationwide, both today and over the course of their respective careers.

The survey was designed as a tool with which to gauge and identify areas of law enforcement resource consumption directly related to involvement with severely mentally ill persons. It also seeks senior law enforcement personnel's perceptions nationwide as to issues of concern which may be contributing to the problem, such as the growth of the issue over the length of the officer's career, and the representation of the mentally ill

among the homeless population within their communities. Most importantly, this information will be useful as policy planners seek to improve upon the current problem as it exists today.

It is important to note that several of the survey questions are designed around the participant's observations and perceptions during the length of their careers as law enforcement executives. The vast majority, 75.3 percent (or 1,593) respondents have careers spanning more than 20 years, with an additional 14.1 percent (or 299) respondents having careers in excess of 16 years. This pool of respondents' longevity provides the survey with perspectives that span more than two decades of hands-on interaction with the subject matter and will allow for a clear picture of the officers' perspectives surrounding the subject matter.

A. SURVEY DESIGN AND DELIVERY

The literature review revealed that there are no previously published surveys that elicit the perceptions of law enforcement administrators as relevant stakeholders into the unintended consequences of deinstitutionalization. Hence, the author developed *The Impact of the Mentally Ill Population on Law Enforcement Resources Survey*. The survey was designed around the areas of law enforcement concern as well as the thesis research problems.

The survey contains 22 questions all of which are meant for senior administrative law enforcement personnel. The participants rated their perceptions as to the extent of their respective agencies resources consumed as well as obstacles encountered when handling incidents involving severely mentally ill, both as calls for service and as members of their community's homeless population. The survey contains several types of multiple choice questions, with options ranging from yes/no/remained the same, to decreased/substantially decreased/stayed the same/increased/substantially increased and minimal time/ routine time/substantial time/extensive time. Several questions allowed for an area within which to make comments. Five demographic questions exist; they are:

- How long have you been a police officer?
- Which best describes your agencies jurisdiction (local, county, state, federal)?
- In which state are you located?
- Please provide the number of sworn personnel within your agency as well.
- Please provide the approximate population served by your department.

These demographic questions will assist in analyzing the collected data enabling the identification of areas where the problem may be greater than others and allows for future analyzing of the collected data as to why that may be so.

The survey itself was conducted using SurveyMonkey software. It was designed as an anonymous survey and, as such, no I.P. or e-mail addresses were captured by the author. The only identifiers of any type were self input by the participant in the form of the aforementioned demographic questions. The SurveyMonkey tool allowed for rapid distribution of the survey link to the targeted population. That distribution was accomplished in the following manner. The survey link was initially distributed by the New York State Association of Chiefs of Police (NYACOP), of which the author is a member, to its membership e-mail list. The Executive Director of the New York State Association of Chiefs of Police then forwarded the survey link to the International Association of Chiefs of Police (IACP), State Association of Chiefs of Police Division (SACOP), who in turn forwarded the link to the executive directors of each state police chiefs association within the nation, seeking their members' participation in the survey. The current president of the New York State Sheriffs' Association (NYSSA) was also contacted and solicited to forward the survey link to members of the New York State Sheriffs' Association, requesting that the executive director of the New York State Sheriffs' Association also forward the survey link to the executive directors of each of the states sheriffs' associations within the nation. It should also be noted that not all members of the professional associations polled are necessarily police chiefs or sheriffs; these associations also have as members, senior command staff of police departments and sheriffs' offices. As such, results likely include departments with multiple responses, from varying members of the command staff.

The inclusion of sheriffs is important as in many locations in various states sheriffs' offices are the sole law enforcement agencies for a given jurisdictional region. All of the associations through which the survey was circulated are comprised of senior administrative members of law enforcement agencies. Since the target populations are working individuals all possessing work related e-mail addressed known to the organizations requesting participation, the Internet-based survey presented a cost-effective method of reaching this author's target population. Being received through work e-mail, it is hoped the survey garnered greater attention. (Schonlau, Fricker, and Elliott, 2002)

B. SURVEY SUMMARY

The survey, *The Impact of Mental Illness on Law Enforcement Resources*, sought the input of participants of the target groups (e.g., law enforcement executives nationwide) by contacting them through their respective professional associations. It should be noted that not all police chiefs or sheriffs are members of the professional organizations that agreed to distribute the survey via their member e-mail list; however, it does represent a cross-section nationwide of senior law enforcement perspectives on the issue, which had not existed until now. As a result of the nature of the survey design, (anonymous and voluntary) as well as the method of distribution, indirectly via membership in professional associations, the number of law enforcement officials actually targeted and received an invitation to participation in the survey is unknown. The survey was advanced tested on January 25, 2011 by the author asking senior law enforcement classmates within cohorts 1001 and 1002 of the Center for Homeland Defense and Security at the Naval Postgraduate School to take the survey and comment on their understanding of the survey questions. As a result of the advanced testing, several questions received minor adjustments prior to the launching of the actual survey. The survey was physically created on January 10, 2011, with approval from the Institutional Review Board (IRB) received February 16, 2011. The first e-mail message seeking participation was generated by the New York State Association of Chiefs' of Police to its members on February 22, 2011 at 9:49 A.M. The survey ceased collection

of responses on Friday March 18, 2011 at 6 P.M. P.S.T. Survey responses first began being received from states outside of New York on Thursday, February 24, 2011 indication that SACOP had successfully distributed the survey link to the IACP member state associations. A copy of the IACP letter of endorsement appears in Appendix A.

THIS PAGE INTENTIONALLY LEFT BLANK

III. RESULTS AND ANALYSIS

The survey, *The Impact of Mental Illness on Law Enforcement Resources*, ran for a total of 25 days and generated 2,406 responses with all 50 states represented.

A. QUESTION 1

"I agree to participate in the survey; Yes/No." Question 1 establishes the voluntary criteria of the survey. Of the 2,406 initial respondents 99.71 percent (or 2,391) respondents agreed to participate in the survey, with 0.29 percent (seven) respondents opting not to participate. Of the 2,406 participants who visited the survey link, a total of 88.8 percent (or 2,136) participants continued on to complete the survey. (See Figure 3 and Table 3.)

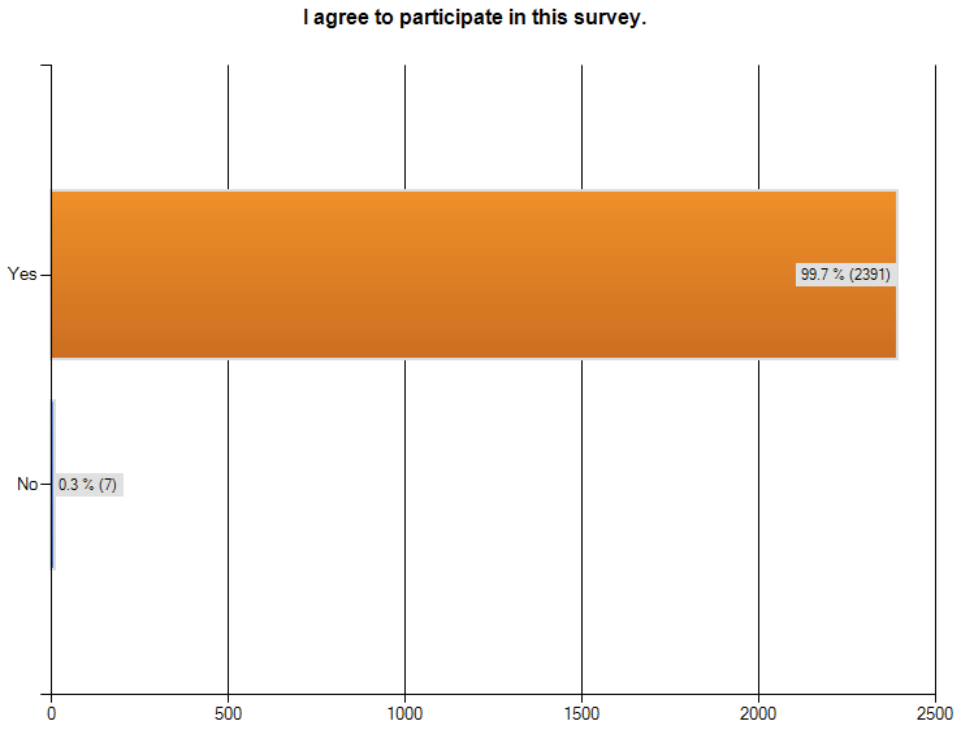

Figure 3. Question 1

Table 3. Question 1

Participation	(n)	Actual %
Yes	2391	99.71%
No	7	0.29%
Sample (n)	**2398**	

B. QUESTION 2

"What percentage of your officers' time is spent dealing with the mentally ill?" This question seeks the law enforcement executive's perception as to the percentage of his officer's time consumed by dealing with issues surrounding the mentally ill population?" The results indicate that 77.14 percent (n=1,697) of respondents reported that up to 20 percent of their officers' time involves interacting with the mentally ill population. Moreover, 18.5 percent (n=407) of respondents indicated 21 percent to 40 percent with an additional total of 1.63 percent (n=36) respondents reporting that somewhere over 61 percent of their officers' time is spent in this area. (See Figure 4 and Table 4.)

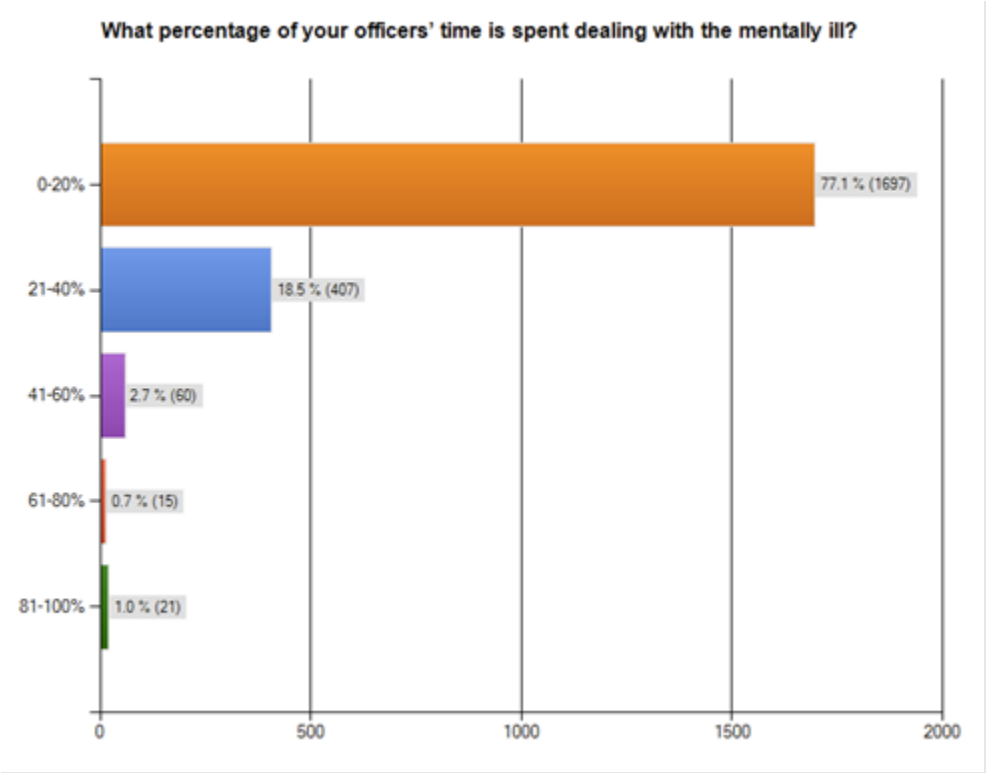

Figure 4. Question 2

Table 4. Question 2

Percentage of Time	(n)	Actual %
0-20%	1697	77.147%
21-40%	407	18.5%
41-60%	60	2.73%
61-80%	15	0.68%
81-100%	21	0.95%
Sample (n)	**2200**	

C. QUESTION 3

"From your observations has there been an increase in the mentally ill population over the length of your career?" A resounding 84.28 percent (or 1,866) of respondents answered yes to this question. Such an overwhelming affirmative response

indicates an obvious observable increase nationwide, with only 12.6 percent (n=279) respondents indicating that the population has remained the same, and 3.12 percent (n=69) respondents having observed no increase within the mentally ill population. (See Figure 5 and Table 5.) Results remain relatively consistent when analyzing results state to state. (See Appendix F.)

Figure 5. Question 3

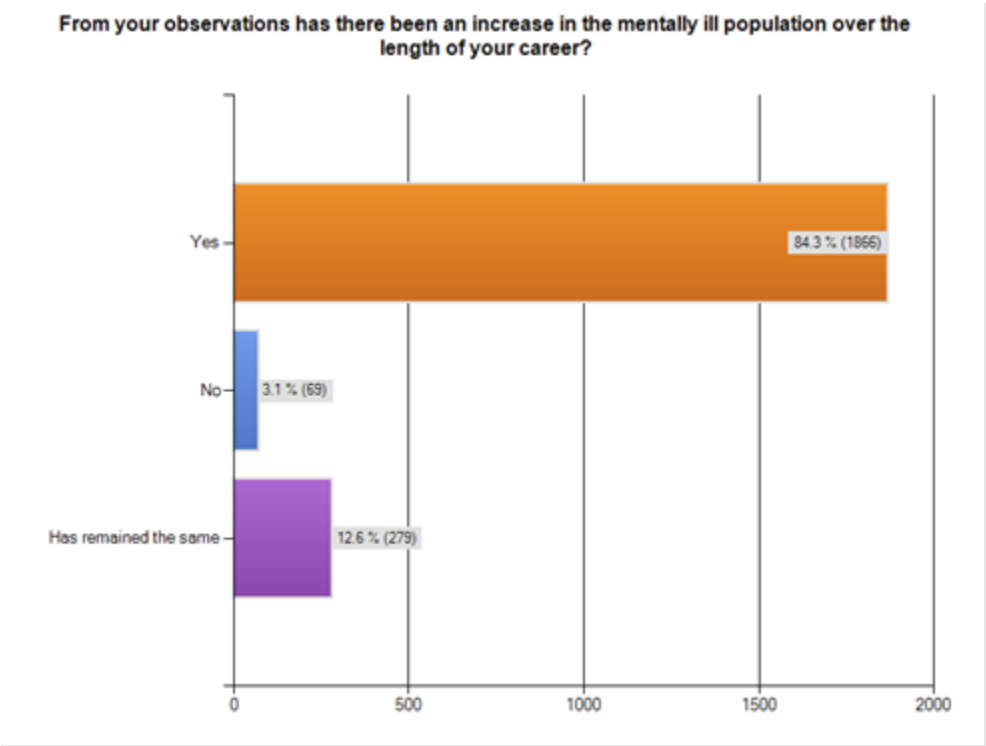

Table 5. Question 3

Increased Population	(n)	%
Yes	1866	84.28%
No	69	3.12%
Has Remained the Same	279	12.6%
Sample (n)	**2214**	

D. QUESTION 4

"From your observations, has there been an increase in suicides and suicide attempts in your jurisdiction over the length of your career?" This question directly relates to the local communities rate of mental illness as observed by the police officer over the length of his/her career, although other social issues may have an effect on the rate of suicides and suicide attempts, such as poor economy, jobless and divorce rates. It is, however, indicative of the increase in mental health issues observable within the community. The survey indicates 61.37 percent (n=1,357) of respondents have observed an increase in suicides and attempted suicides within their respective jurisdictions, with only 9.3 percent (n=206) respondents indicating that they have not noticed an increase, and 29.31 percent (n=648) respondents seeing the rate as remaining constant. (See Figure 6 and Table 6.)

Suicides and attempted suicides in themselves are massive consumers of police resources. From a law enforcement perspective each suicide must be initially investigated as a death suspicious in nature until foul play can be ruled out. In the interim, resources are devoured in preparation of a lengthy investigation, crime scene resources, manpower in securing the scene, medical examiner and district attorney office personnel are all necessary until a determination of suicide is agreed upon. The first step in the investigation is often researching the medical history of the deceased, with special attention to paid to the home's medicine cabinet. A 2002 study examined rates of contact with mental health care professionals and primary care physicians by individuals before they died by suicide. The results indicated that approximately one third of the suicide victims had had contact with mental health services, with about one in five having had contact with mental health services within one month prior to their death (Luoma, Martin, & Pearson, 2002).

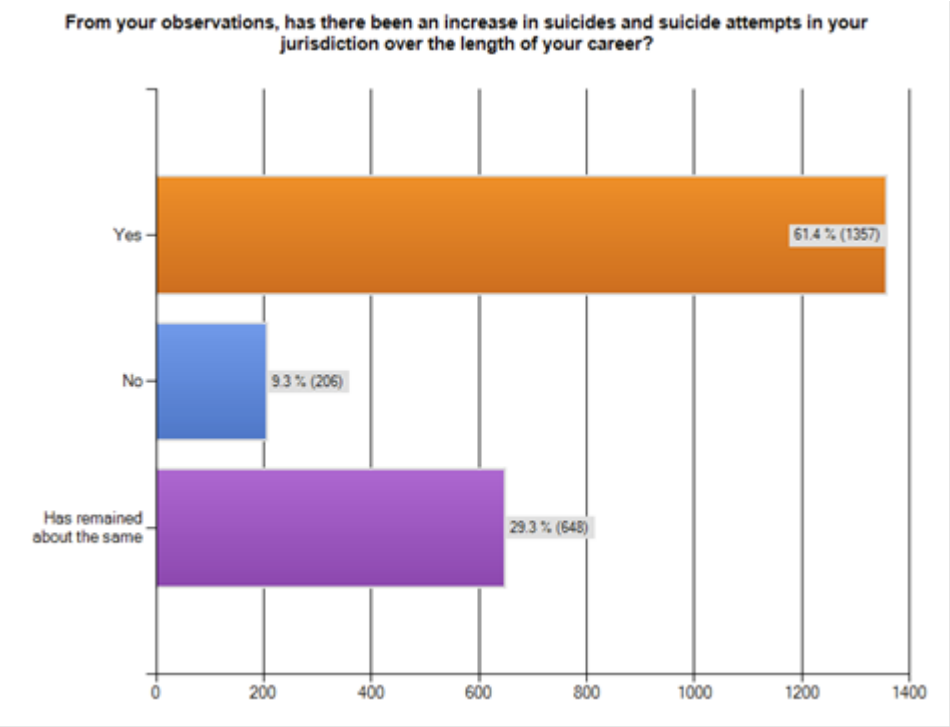

Figure 6. Question 4

Table 6. Question 4

Increased Suicides	(n)	%
Yes	1357	61.37%
No	206	9.32%
Has Remained the Same	648	29.31%
Sample (n)	**2211**	

E. QUESTION 5

"From your observations, has there been an increase in the number of mentally ill detainees/prisoners requiring more direct supervision over the length of your career?" The results of this survey question are very similar to the preceding question, which tends to indicate a correlation between the apparent observations of increased suicides and attempted suicides within the mentally ill population and the increase of that populations

presence within the criminal arrest rate. The results indicate that 75.63 percent (n=1,667) of the respondents indicated that they have observed an increase in the number of mentally ill detainees and prisoners over then length of their careers, with 7.53 percent (n=166) of the respondents stating that they have not observed any increase within the detainee/prisoner population, and an additional 16.83 percent (n=371) of the respondents indicating that the numbers have remained constant throughout their careers. Although this question is specifically directed towards law enforcement and has little or no input from corrections personnel, it is representative of the additional consumption of man hours required to properly supervise mentally ill prisoners after arrest. Due to the unpredictable actions of mentally ill detainees, additional resources are required to ensure their safety while in custody. (See Figure 7 and Table 7.)

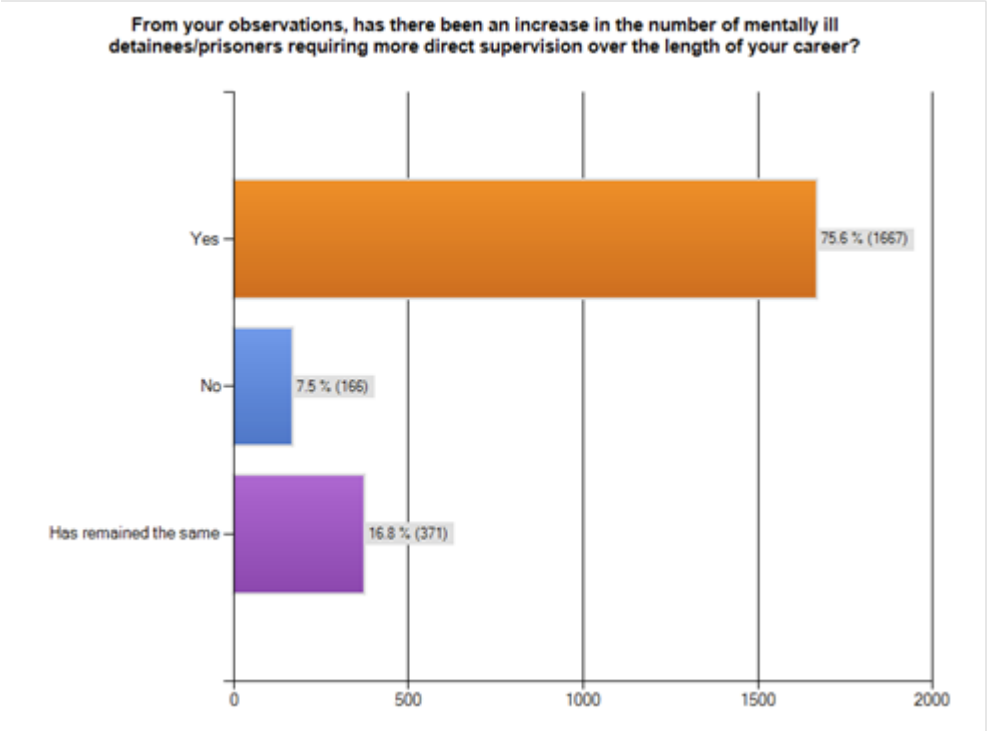

Figure 7. Question 5

Table 7. Question 5

Increased M.I. Detainees	(n)	%
Yes	1667	75.63%
No	166	7.53%
Has Remained the Same	371	16.83%
Sample (n)	2204	

F. QUESTION 6

"From your observations what percentage of your department's time is spent on calls for service or other activities involving individuals with mental illness?" Question 6 differs from question 2 in that question 2 solicits an estimate of an individual officer's day, while question 6 pertains to the entire department as a routine course of business. Law enforcement administration routinely deals with issues of concern that often arise surrounding facilities and businesses within their jurisdictions that regularly interact with the mentally ill population, such as local adult day care facilities for the mentally impaired, doctor's offices, medical centers and retail stores. Libraries and other locations frequented by the homeless population have become a major issue, due primarily to the over representation of the mentally ill among the homeless population (Gillig & McQuistion, 2006). As an example the main branch of the San Francisco library, where hundreds of homeless people spend every day, have trained staff on how to handle mentally ill and drug addicted patrons (Nieves, 2010). As mentioned earlier within this paper, several studies have shown reasonably consistent rates among homeless people of one-third to one-half with severe psychiatric disorders (Gillig & McQuistion, 2006). Libraries and retail malls offer places to keep warm and often provide a food source for the mentally ill homeless, who have no issue with rummaging through garbage cans for discarded food items. Often their bizarre behavior, such as carrying on conversations with themselves or acting in an agitated manner, causes notification of local law enforcement, which accounts for their presence within the results of Question 2 as detainees and the similarity of the survey results regarding the two question results. (See Figure 8 and Table 8.)

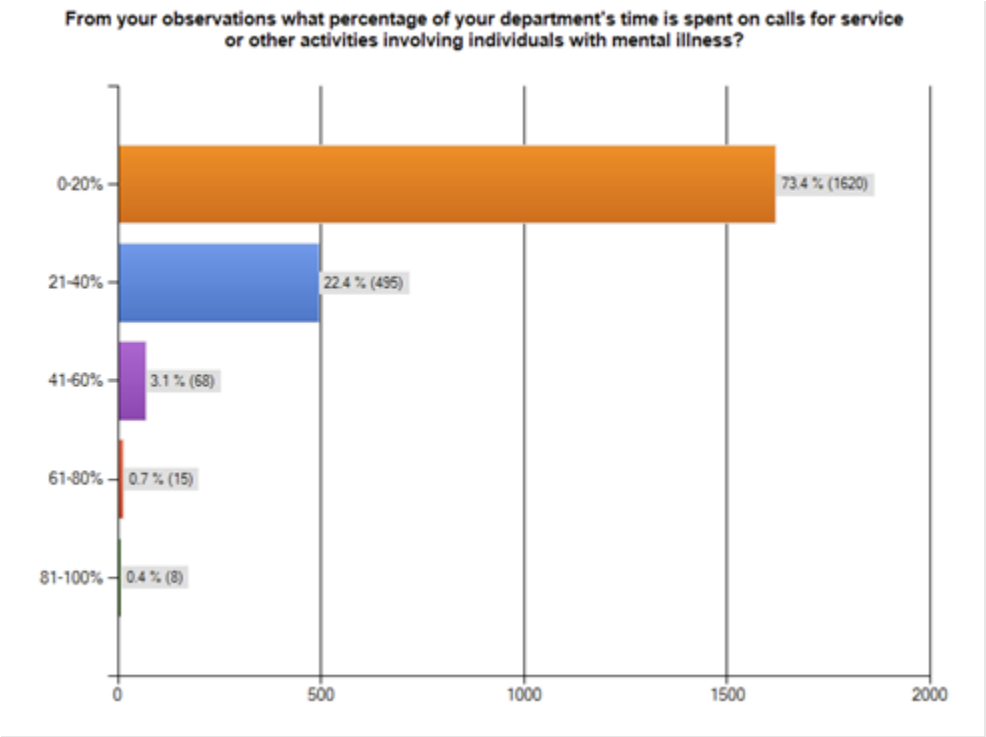

Figure 8. Question 6

Table 8. Question 6

Department's Time on M.I.	(n)	%
0-20%	1620	73.44%
21-40%	495	22.44%
41-60%	68	3.08%
61-80%	15	0.68%
81-100%	8	0.36%
Sample (n)	**2206**	

G. QUESTION 7

"How has the amount of time that your department spends on calls for service involving individuals with mental illness changed over the length of your career?" This question seeks to solicit from the perspective of senior law enforcement officers, the

extent to which the department's time has increased, decreased or stayed the same in its interactions with the mentally ill population. In analyzing this question's results, it is important to realize that deinstitutionalization was in full process during the early 1970s and through the 1980s. While the vast majority of the respondents to this survey indicate careers spanning more than 20 years, for most, the majority of the deinstitutionalization process had already occurred either early within their careers or before their respective careers began. These respondents are observing the issue from the position of already dealing with a shortage of facilities specifically designed to manage the mentally ill population. The responses recorded would be expected had the respondent's careers spanned the late 1950s through the early 1980s. The overwhelming response to this question reflects the severity caused by the unintended consequences of deinstitutionalization. Of the respondents, 0.77 percent (n=17) reported that time spent by the department on calls for service involving individuals with mental illness had substantially decreased and 1.0 percent (n=22) of the respondents reported that the calls had decreased. A total of 1.8 percent (n=39) of respondents claimed the time spent had decreased. Additionally, 17.49 percent (n=386) of the respondents reported the amount of time spent on individuals with mental illness had remained constant. An overwhelming amount, 63.03 percent (n=1,391) of the respondents, reported that the time spent has increased (during their career). An additional 17.72 percent (n=391) reported that the time spent had substantially increased, totaling 70.7 percent (n=1,782) of respondents reporting an increase. It is likely that the overwhelming indication that the time spent on calls for service involving mentally ill individuals has increased or substantially increased and continues to escalate due to the continuing reduction in beds at acute care facilities (Lamb & Weinberger, 1998). (See Figure 9 and Table 9.)

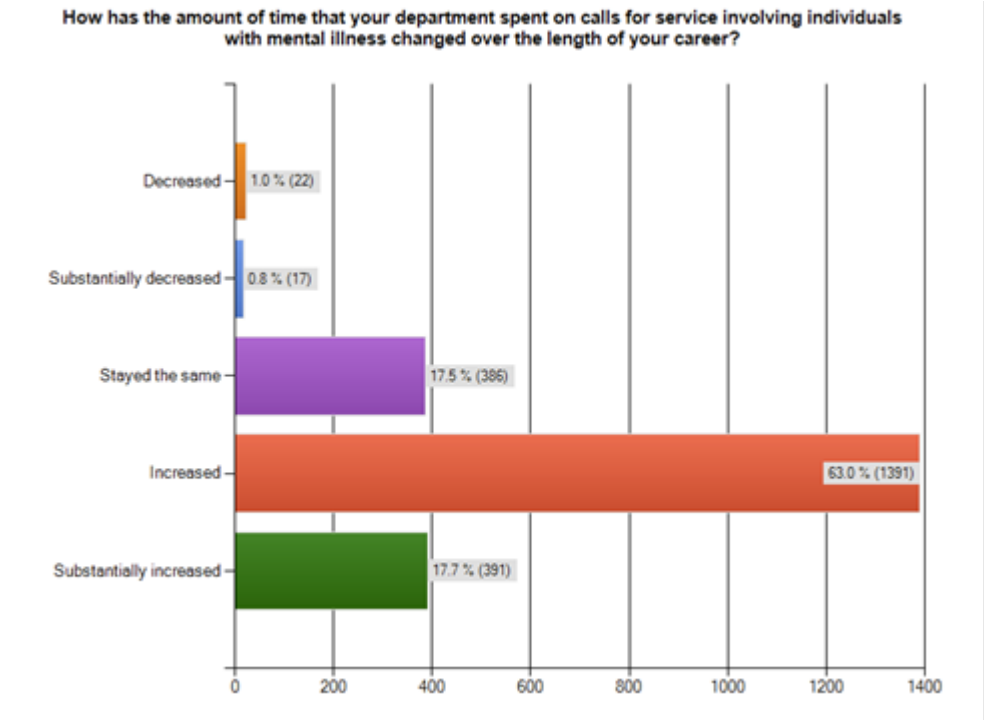

Figure 9. Question 7

Table 9. Question 7

Percentage of Time Change over Career	(n)	%
Decreased	22	1%
Substantially Decreased	17	0.77%
Stayed The Same	386	17.49%
Increased	1391	63.03%
Substantially Increased	391	17.72%
Sample (n)	**2207**	

H. QUESTION 8

"If there is an increase in your jurisdiction regarding calls for service involving individuals with mental illness, what do you attribute the increase in calls to?" The question allows the respondent to check all categories that may apply. This question is

designed to ascertain what the law enforcement executive believes to be contributing factors. This information, particularly when broken down by state response will assist in forming directed training in any areas where the laws pertinent to the issue may be misunderstood, or require clarification. (See Figure 10 and Table 10.)

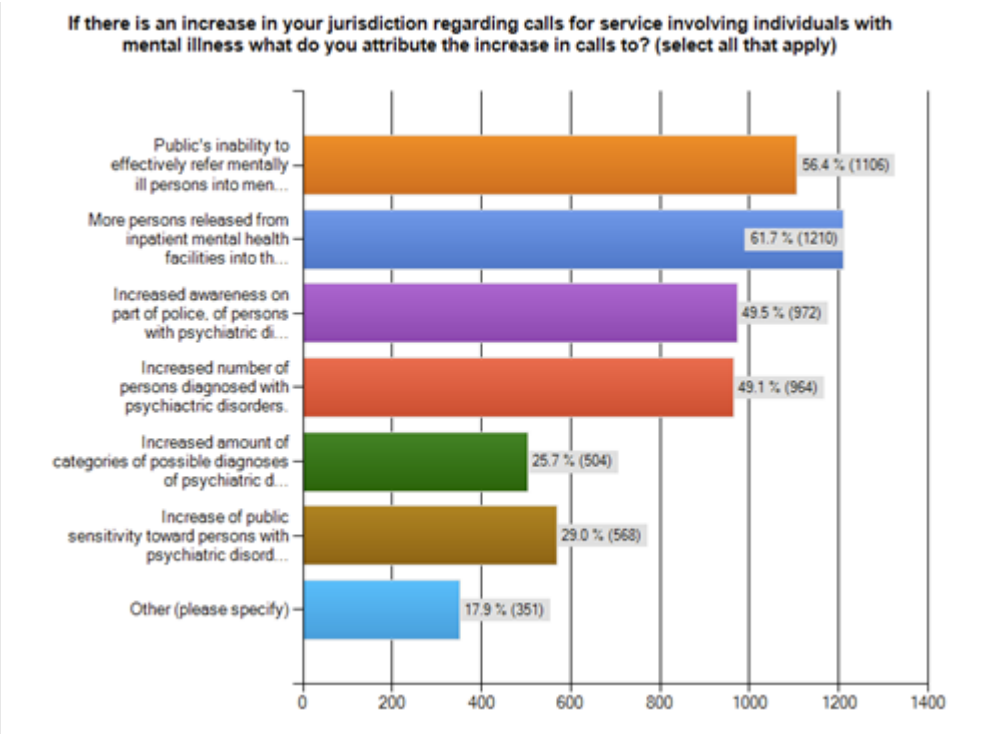

Figure 10. Question 8

Table 10. Question 8

Perception of Cause	(n)	%
Public Inability	1106	56.37%
Increased Releases	1210	61.67%
Police Increased Awareness	972	49.54%
Increased persons Diagnosed	964	49.13%
Increased Areas of Diagnosis	504	25.69%
Increased Public Sensitivity	568	28.95%
Other (Open Ended)	351	17.89%
Sample (n)	**1962**	

In that Question 8 is an open-ended question, a "word cloud"[11] was created using the *SurveyMonkey* software. The ability to analyze the respondent's statements helps gain insight into their attitudes, behaviors, concerns, motivations and culture. Three hundred and fifty-one respondents entered statements within the open-ended section of the question, with all 351 answers pertaining directly to the respondents' perceptions as to the cause of a perceived increase in numbers of calls for service involving mentally ill individuals. The *SurveyMonkey's* text analysis tool allows for quantitative research on open-ended questions such as Question 8.

The cloud indicates which words appear more often across the respondents write in statements. The more frequently the words appear within the responses the larger text is within the cloud. The words most frequently appearing are: Mental health, facilities, increase, drugs, public resources and programs, in that order. (See Figure 11.)

Figure 11. Word Cloud of Responses Regarding Causes of Increased Presence of Mentally Ill Within Calls for Service

I. QUESTION 9

"Rank the following typical calls for service as to the amount of time commitment required." This question attempts to compare the perceptions of the law enforcement executives pertaining to man hours consumed regarding several routinely occurring calls for service: routine larceny report, domestic incident report, traffic accident and mentally

[11] Word cloud: A visual depiction of user generated terms, which are represented by increasing font size in relation to the frequency of the use of the term by different respondents. (SurveyMonkey)

ill individual. As this survey review is analyzing only the national results, the author notes that the individual state responses portray a very similar response rate from state to state. The statistical results in Table 11 and Table 12 reflect this observation when compared to many of the various individual states results contained within Appendix F. (See Tables 11 and12, Figure 12 and Appendix F.)

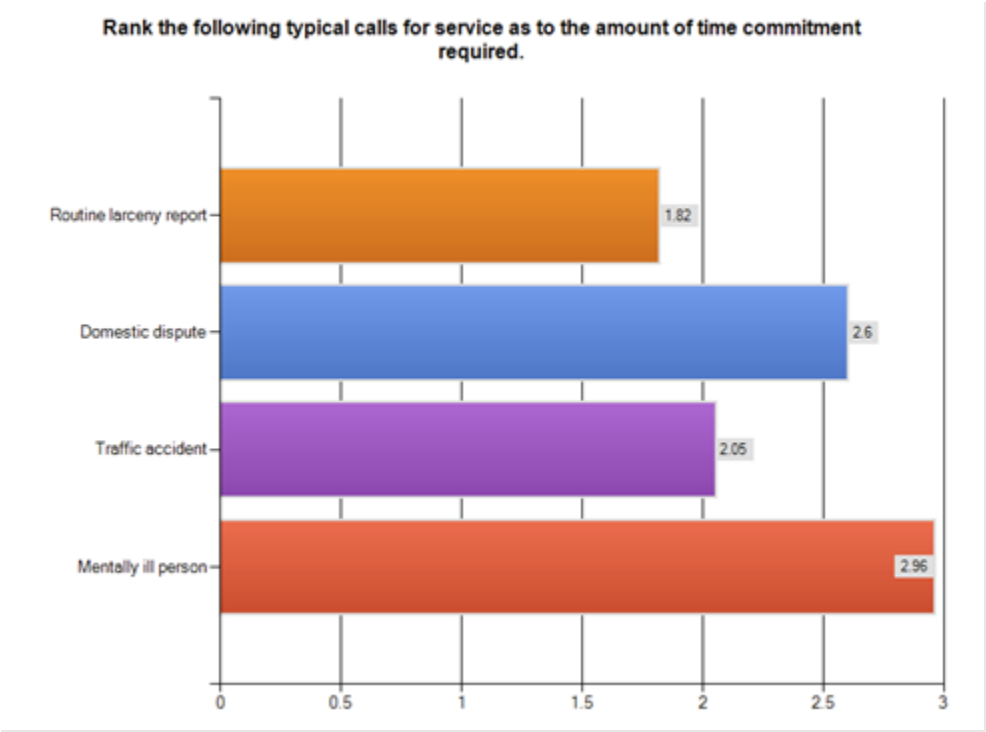

Figure 12. Question 9

Table 11. Question 9

ATTRIBUTE	MINIMAL TIME		ROUTINE TIME		SUBSTANTIAL TIME		EXTENSIVE TIME	
	n	%	N	%	N	%	n	%
Routine Larceny Rpt.	528	25.19%	1421	67.79%	133	6.34%	14	0.67%
Domestic Dispute	61	2.9%	833	39.57%	1144	52.54%	107	5.08%
Traffic Accident	225	10.76%	1552%	74.22%	295	14.11%	19	0.91%
Mentally Ill Person	121	5.83%	412	19.85%	977	47.08%	565	27.232%

Table 12. Question 9

Statistics	Totals
Domestic Dispute	
Mean	2.6
Standard Deviation	0.63
Standard Error	0.01
Median	3.0
Sample (n)	2105
Mentally Ill Person	
Mean	2.96
Standard Deviation	0.84
Standard Error	0.02
Median	3.0
Sample (n)	2075
Routine Larceny Report	
Mean	1.82
Standard Deviation	0.56
Standard Error	0.01
Median	2.0
Sample (n)	2096
Traffic Accidents	
Mean	2.05
Standard Deviation	0.53
Standard Error	0.01
Median	2.0
Sample (n)	2091

While the domestic dispute category collects 52.4 percent (n=1,104) of the responses in the substantial time category in comparison to 47.1 percent (n=977) for the mentally ill person category, it is most interesting that 27.5 percent (n=565) of respondents chose calls involving mental illness as an extensive consumer of law enforcement's man-hour resources. Far greater than any of the other categories, the next nearest within the extensive time category is domestic dispute with only 5.1 percent (n=107) respondents. Routine larceny report and traffic accident each possess less than one percent of the respondents within the extensive category. The respondents' responses to this question clearly indicate that our mentally ill population is a major consumer of law enforcement resources nationally, at a minimum among the law enforcement calls for service types contained within the question. The survey results to this question rate both domestic disputes and calls involving mental illness as high in

consumption of police department resources, with mental illness clearly the most within the extensive time consumption category by a large margin.

When considering this result, one should also take into account the 1994 Department of Justice report entitled *Murders in Families*. That report indicated the following findings regarding untreated mental illness:

- Of spouses killed by spouse: 12.3 percent of defendants had a history of untreated mental illness;
- Of children killed by parent: 15.8 percent of defendants had a history of untreated mental illness;
- Of parents killed by children: 25.1 percent of defendants had a history of untreated mental illness; and
- Of siblings killed by sibling: 17.3 percent of defendants had a history of untreated mental illness (Dawson, Langan, & United States. Bureau of Justice Statistics, 1994).

It is obvious that mental illness has a significant presence in many incidents of domestic disturbances and domestic violence, which would tend to even further increase the representation of mental illness within the results of this question. (See Table 12.) Further research is warranted to determine to what extent mental illness is represented within domestic disturbance calls for service.

In that Question 9 is also an open-ended question, a "word cloud"[12] was created using the *SurveyMonkey* software. The words most frequently appearing are: calls, transport, required, amount, extensive, local hospital and crisis, in that order. (See Figure 13.)

[12] Word cloud: A visual depiction of user generated terms, which are represented by increasing font size in relation to the frequency of the use of the term by different respondents. (SurveyMonkey)

Figure 13. Word Cloud From Participant Responses Regarding Amount of Time Commitment

Listed are several of the 85 written responses as to perception of time commitment; all but a few responses center on the mentally ill population issue:

- Officers simply can't leave a mentally ill person once they determine that a crime has not been committed. They must stay until resources become available to the person. If they simply leave, the mentally ill person may, once again, threaten to harm themselves or again do the act that got the police called in the first place.
- Within a small department additional officers have to be called in when dealing with a mentally ill person. This is a significant amount of time consumed, and a significant financial burden to provide ample man power.
- The process to go through when dealing with a person that is mentally ill is very time consuming. The whole process of a Mental Incapacitation Warrant and the transport to a psychiatric facility after hours takes around eight hours for an officer to deal with.
- Time spent at the hospital sitting w/ EDP is very substantial and requires two officers. We are a small department and often only have two officers working!
- Mentally ill people must first be transported to a local Hospital approximately twenty miles away. The Officer must wait and then make contact with a mental health provider, and then transport that person between one hundred and two hundred miles. The Officer must then wait for the person to be interviewed and then admitted. It is an all day thing.

- Hospital security is minimal which increases amount of officer time at ER for MHL Section 9 transfers. Safety of staff is a concern when no security is available.
- Because of the nature of calls involving mentally ill person the time spent is often extensive. The time committed to stabilizing the call, then assessing the nature of the person's mental illness, followed by evaluating and searching for the type of care, finally in locating the proper facility to take the person consumes more than the routine or substantial time other calls normally require. Additionally, other factors such as the person refusing to go with the officer to a location certainly add to the time.
- Often time patients are arrested under mental hygiene laws and are taken to mental health treatment facilities and the offender beats the officer home and it becomes a repeated scenario until the offender finally injures themselves or someone else.
- Obviously, we are lacking bed space for patients. This has continued to decline since the early 1980's. An officer will spend a great deal of time with a problem/patient and then spend even a greater amount of time locating a mental health professional. Then there is a question of transport once the patient is triage. They (mental health system) lack sufficient funding up and down the line.
- Many times what should be handled in the mental health system elevates into the criminal justice system as the only recourse to put some leverage over the individual and state to provide treatment.
- The reason for the extensive time is due to our rural setting and a three hour or more drive to the nearest mental health care facility. We are obligated to transport.
- Chapter 51 transports. This has a substantial impact on small agencies like ours with one officer on shift. We get stuck transporting patients after the initial placement and diagnosis by emergency medical staff. The facility is in Green Bay and the officer may be at the hospital and out of the area for most of his/her shift. The law has to change in this regard.
- Transports of the subject can be from 30 min. to 6 hrs. Note we are a 4 Officer department with only one on duty at a time.

These comments attest to the burden of the excessive time consumption placed on police departments in dealing with the mentally ill population, thus compromising their ability to address the numerous homeland security concerns that local law enforcement has incurred since September 11, 2001. It would be anticipated that the policy changes to be suggested within this thesis paper would greatly reduce the strain on the criminal justice system created by the deinstitutionalization process.

J. QUESTION 10

"How many officers are typically dispatched for a call involving a non-violent mentally ill person?" Question 10 seeks to quantify the numbers of officers dispatched to a call involving a mentally ill individual. Often the report that the person involved in an incident requiring police interaction is mentally ill, generates the response of additional officers, usually as a safety precaution for both the officer and the mentally ill person, and based upon the likely unpredictability of the mentally ill persons actions. The survey results indicate that 27.4 percent (n=579) of the respondents send one officer to an incident involving a non-violent mentally ill person, while 71.56 percent (n=1,510) respondents typically dispatch two officers, with 0.85 percent (n=18) of the respondents sending three officers and an additional 0.28 percent (n=6) respondents indicating four or more officers are typically dispatched. (See Figure 14 and Table 13.)

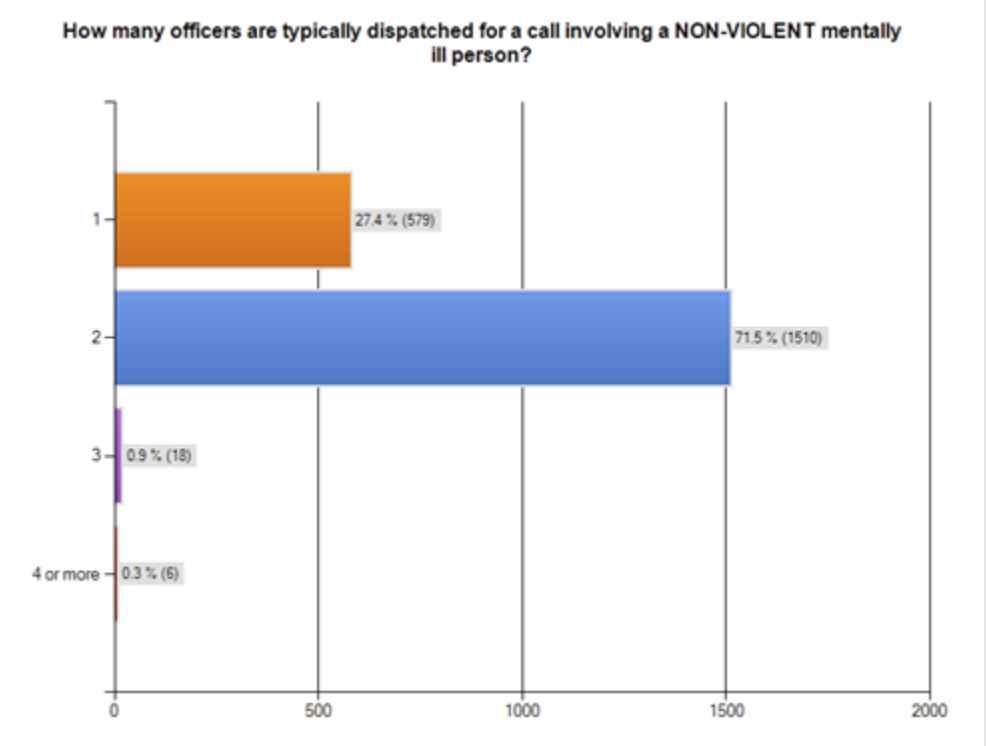

Figure 14. Question 10

Table 13. Question 10

Officers Dispatched Non-Violent M.I.	(n)	%
One	579	27.4%
Two	1510	71.46%
Three	18	0.85%
Four or More	6	0.28%
Sample (n)	**2113**	

K. QUESTION 11

"How many officers are typically dispatched for a call involving a violent mentally ill person?" It is the intention of this question to determine to what extent the addition of violence in combination with the involvement of a mentally ill person alter the number of police officers dispatched an incident. While question 10 indicates that 27.4 percent (n=579) of respondents would dispatch only one officer to a call involving a mentally ill individual that number drops to 2.79 percent (n=59) of the respondents in question 11 as violence is factored into the equation. It is understood that this is most likely true even when removing the mentally ill factor, and considering the violence component alone in any call for service. However, where 71.46 percent (n=1,510) of respondents in question 10 chose two officers for non-violent calls for service that number drops to 44.92 percent (n=951) and the representation for the three and four or more officers dispatched categories increases from less than statically significant in question 10 to 31.6 percent (n=669) and 20.69 percent (n=438) in question 11. The disparity between the responses to the two questions is undoubtedly due in part to the addition of the violence factor, but is heightened by the base factor within both questions of mental illness. This is displayed within the write in responses found within other questions within this survey, such as:

> Officers simply can't leave a mentally ill person once they determine that a crime has not been committed. They must stay until resources become available to the person. If they simply leave, the mentally ill person may, once again, threaten to harm themselves or again do the act that got the police called in the first place.

This response indicates a heightened level of concern on the part of the police officer that the mentally ill person has a greater propensity to return to the acts which caused the initial notification of the police department, and is most likely based upon the unpredictability of the actions of a mentally ill person. (See Figure 15 and Table 14.)

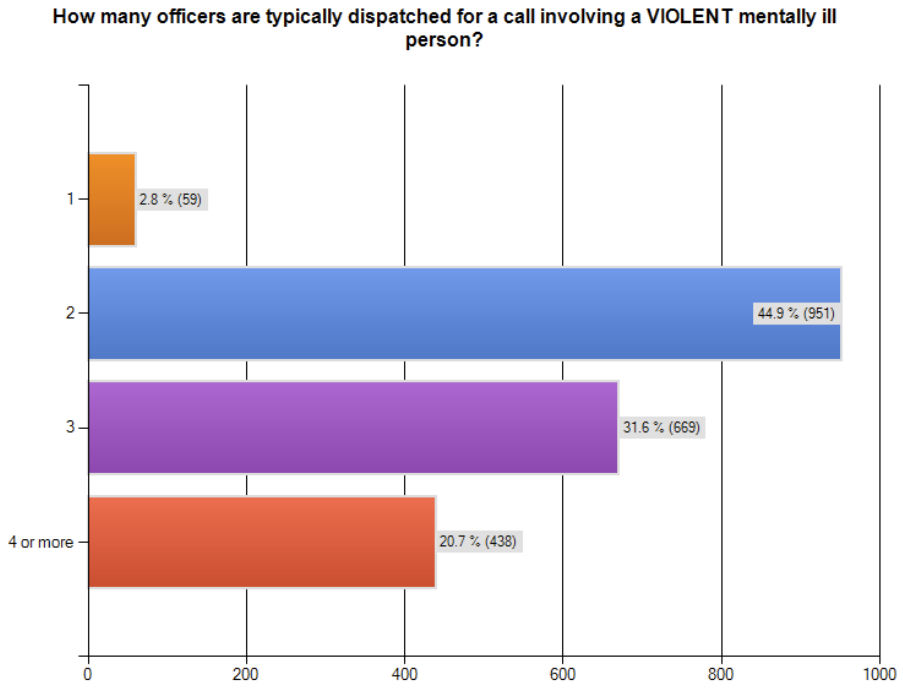

Figure 15. Question 11

Table 14. Question 11

Officers Dispatched Violent M.I.	(n)	%
One	59	2.79%
Two	951	44.92%
Three	669	31.6%
Four or More	438	20.69%
Sample (n)	**2117**	

L. QUESTION 12

"Does your agency mandate the number of officers required to accompany a mentally ill person to a facility for evaluation?" This question seeks to determine if the responding agencies generally imposes a requirement as to the number officer officers required when transporting a mentally ill individual to a facility for evaluation. Of the respondents, 74.35 percent (n=1,565) indicated that they have no such policy, while 25.66 percent (n=540) of the respondents indicated that a policy mandating the number of police officers required to transport a person with a mental illness does exist. (See Figure 16 and Table 15.)

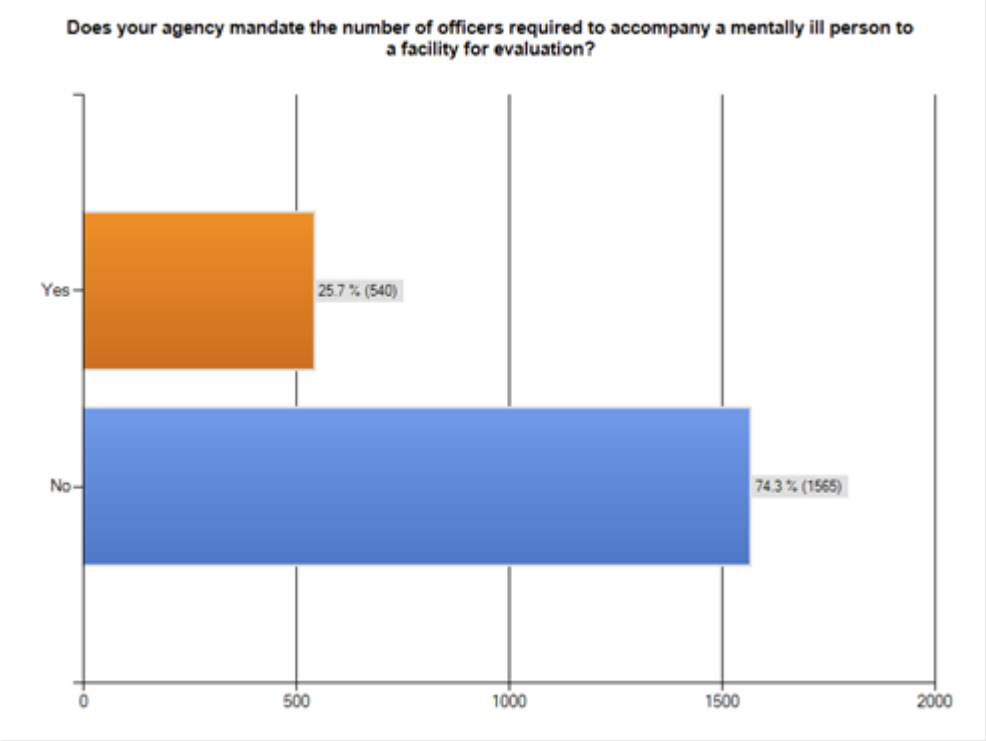

Figure 16. Question 12

Table 15. Question 12

Mandated Transport Policy	(n)	%
Yes	540	25.65%
No	1565	74.35%
Sample (n)	**2105**	

M. QUESTION 13

"When your department does transport an individual with mental illness to a hospital or mental health facility for evaluation, how many officers are required to accompany the individual? This question seeks to determine of those departments that do mandate the numbers of officers required to transport mentally ill persons, exactly how many officers are required. Unlike question 12 this question seeks to quantify the man hours required. It was the author's expectation that the mean number would be no less than two officers however survey results do not indicate that to be the case. Nationally, 63.394 percent (n=1,302) of the respondents indicated that they assign only one police officer for such transports, while considerable 36.32 percent (n=746) of respondents indicated that two officers are required. The author's expectations were predicated upon prior incidents of mentally ill detainees attempting to escape from custody by jumping from moving police vehicles or self inflicting injuries by banging their head during transport, both of which are extremely difficult to manage by a single officer while operating a police vehicle. (See Figure 17 and Table 16.)

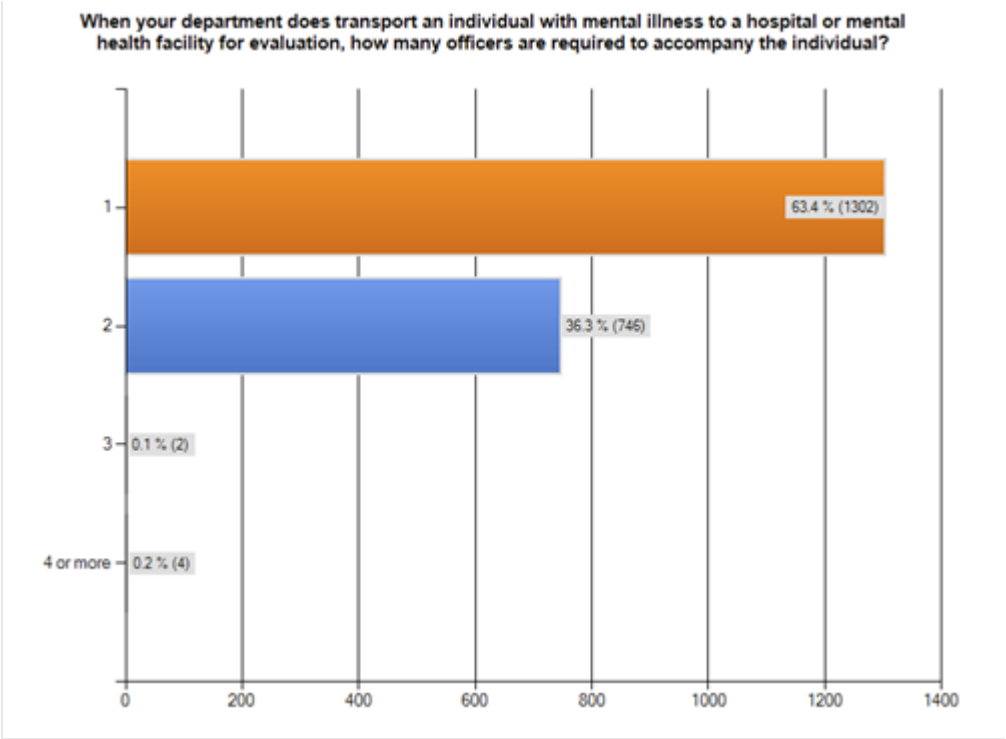

Figure 17. Question 13

Table 16. Question 13

Officers Required for Transport	(n)	%
One	1302	63.39%
Two	746	36.32%
Three	2	0.1%
Four or More	4	0.19%
Sample (n)	**2054**	

N. QUESTION 14

"*What obstacles affect the ability of law enforcement to make referrals for persons with mental illness—check all that apply.*" This question provides some insight as to the perception of senior law enforcement officials as to various obstacles that hinder law enforcement's ability to refer persons with mental illness. A text analysis in the form of a word cloud clearly indicates what issues the respondent group perceives as

prominent among their concerns. Most prevalent among the responses: mental health, facilities, evaluation, bed, hospital, services, referrals and problem. (See Figure 18.)

Figure 18. Word Cloud Created From Participant Responses to Question 14

A vast majority of the responses equaling 76.04 percent (n=1,606) of respondents center on the dangerous to self or others criteria present in many states statutes which would allow police agencies to involuntarily remove a mentally ill individual for emergency psychiatric evaluation. (See Figure 19 and Table 17.) Many states statutes employ the term "imminently dangerousness to self or others." The fact the individual is clearly psychotic, even if extremely so, is seen in many cases as failing to meet that standard. As a result the clearly psychotic person, be he adolescent, middle aged or senior citizen, are left to deteriorate further until such time that he either becomes dangerous or enters the criminal justice system due to either bizarre or anti-social behavior or both. Unfortunately, many times it is the direct family members who reach out to emergency services for assistance with their mentally ill loved one, only to be told that until such time that the dangerous criteria is meet, removal for the purposes of involuntary evaluation is not an option. Not only does this leave the family in a dangerous situation, but the police officer is forced to leave a situation unable to provide help, not only for the family but also for the mentally ill individual. The "Imminently Dangerous" clause is referred to in this open-ended response:

The biggest problem does not lie with law enforcement. The problem is found when citizens can't get assistance due to the 'danger' requirement. When they have nowhere else to turn they call the police to handle the issue. This takes a large amount of time to then pull strings to try and get help for the citizens.

Another respondent writes, "We can get them to the psych unit, but the Drs. let them go due to the 'dangerous to self or others' criteria."

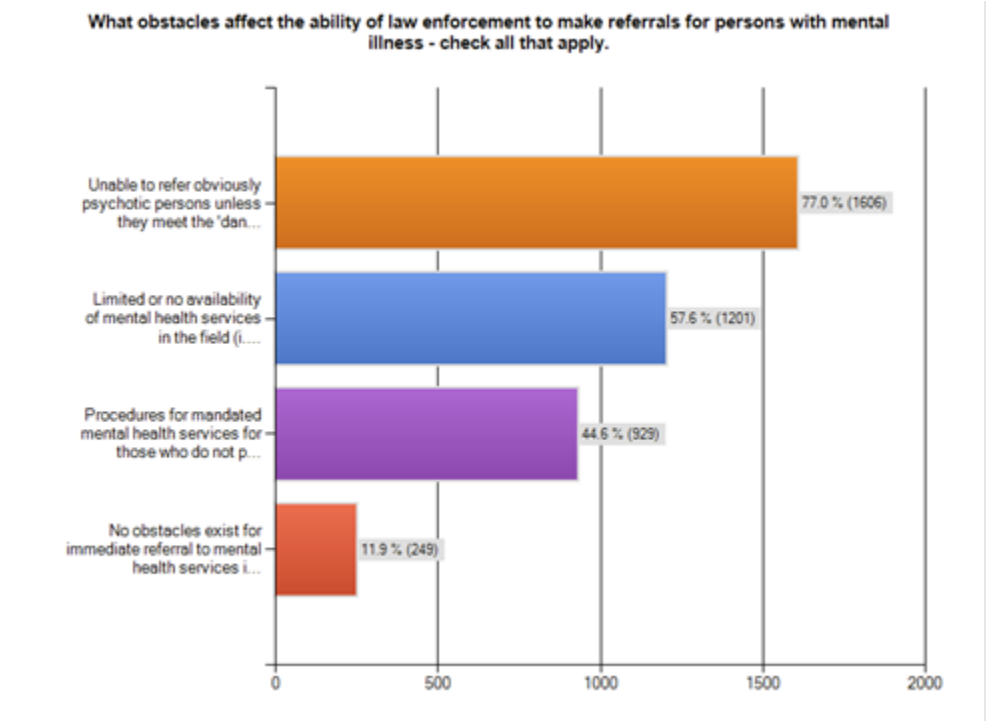

Figure 19. National Results to Question 14

Table 17. National Results Question 14

Obstacles	(n)	%
Dangerousness	1606	77.0%
Limited Services	1201	57.6%
Complex Procedures	929	44.6%
No Obstacles	249	11.9%
Other	162	7.76%
Sample (n)	**2112**	

In many of the 44 states that do have Assisted Outpatient Treatment (AOT) laws, the term "imminently dangerous" is a component of that law, and as such it is a major roadblock in attaining psychiatric care for an individual, even though that individual may be clearly in the throes of a full blown psychotic episode. However, not all states require that individuals be imminently dangerous before involuntary psychiatric evaluation and care. We can best analyze this issue by examining two states with very different wording with regards to involuntary treatment for the purposes of emergency psychiatric care, Massachusetts and Arizona. The following are the criteria within the state of Massachusetts that must be met in determining if a severely mentally ill person is to be hospitalized for the reasons of stabilization. The state of Massachusetts's inpatient laws regarding involuntary hospitalization for reasons of mental illness (Massachusetts's General Laws chapter 123 § 8(a) chapter 123 §1) mandates (1) Danger to self/others or (2) very substantial risk of physical impairment or injury because of inability to protect himself/herself within the community.

In comparison, Arizona's court ordered assisted outpatient treatment laws exemplify what is needed in a comprehensive commitment standard, while Massachusetts pales in comparison. Listed are some of the pertinent sections of the Arizona statute that allow for commitment for treatment without relying solely upon the necessity of imminent danger.

- Arizona Rev. Statute § 36-540 (A): If the court finds by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, ***is persistently or acutely***

disabled or is gravely disabled and in need of treatment, and is either unwilling or unable to accept voluntary treatment . . . .

- Arizona Rev. Statute § 36-501(5). "Danger to others" means that the judgment of a person who has a mental disorder is so impaired that he is ***unable to understand his need for treatment and as a result of his mental disorder his continued behavior can reasonably be expected,*** on the basis of competent medical opinion, to result in serious physical harm.
- Arizona Rev. Statute § 36-501(6). "Danger to self" means:

(a) Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, ***when considered in the light of its context and in light of the individual's previous acts***, it is substantially supportive of an expectation that the threat will be carried out.

(b) Behavior which, as a result of a mental disorder, will, without hospitalization, results in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled.

- Arizona Rev. Statute § 36-501(16). "Gravely disabled" means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs.
- Arizona Rev. Statute § 36-501(33). "Persistently or acutely disabled" means a severe mental disorder that meets all the following criteria:

(a) ***If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality.***

(b) ***Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be***

incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

Arizona's standards in brief: Inpatient and Outpatient: (1) Danger to self/others; (2) in danger from inability to provide basic physical needs; or (3) likely to suffer severe and abnormal mental emotional or physical harm without treatment, likely to benefit from treatment, and substantially impaired capacity to make informed decisions regarding treatment.

It is clear that Arizona's assisted outpatient treatment laws take into account important key aspects crucial in understanding the complexities surrounding the severely mentally ill. Arizona's law allows for consideration of the individual's prior acts. It includes persistent or acutely disabled, while accounting for likely occurrences if not treated to include the substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior or capacity to recognize reality. Most importantly, I believe that it takes into consideration anosognosia and the persons suffering from a lack of ability to understand the existence of their illness.

When responses for question 14 are filtered by state, 70.2 percent (n=33) of Massachusetts respondents indicate the "dangerous to self or others threshold" as the main obstacle in successfully referring obviously psychotic persons for psychiatric care. (See Figure 20 and Table 18.)

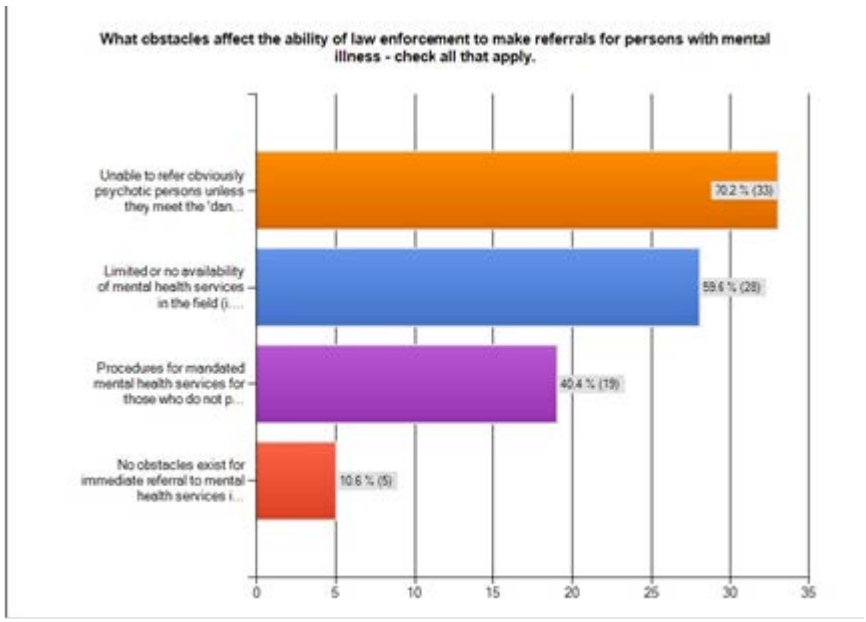

Figure 20. Question 14

Table 18. Massachusetts Filter Response Question 14

Obstacles Mass.	(n)	%
Dangerousness	33	70.02%
Limited Services	28	59.6%
Complex Procedures	19	40.4%
No Obstacles	5	10.6%
Sample (n)	**85**	

Arizona's responses to question 14 are similar to those of Massachusetts with an even higher percentage 83.3 percent of respondents indicating dangerous to self or others threshold as the main obstacle in successfully referring obviously psychotic persons for psychiatric care, among choices provided. (See Figure 21 and Table 19.)

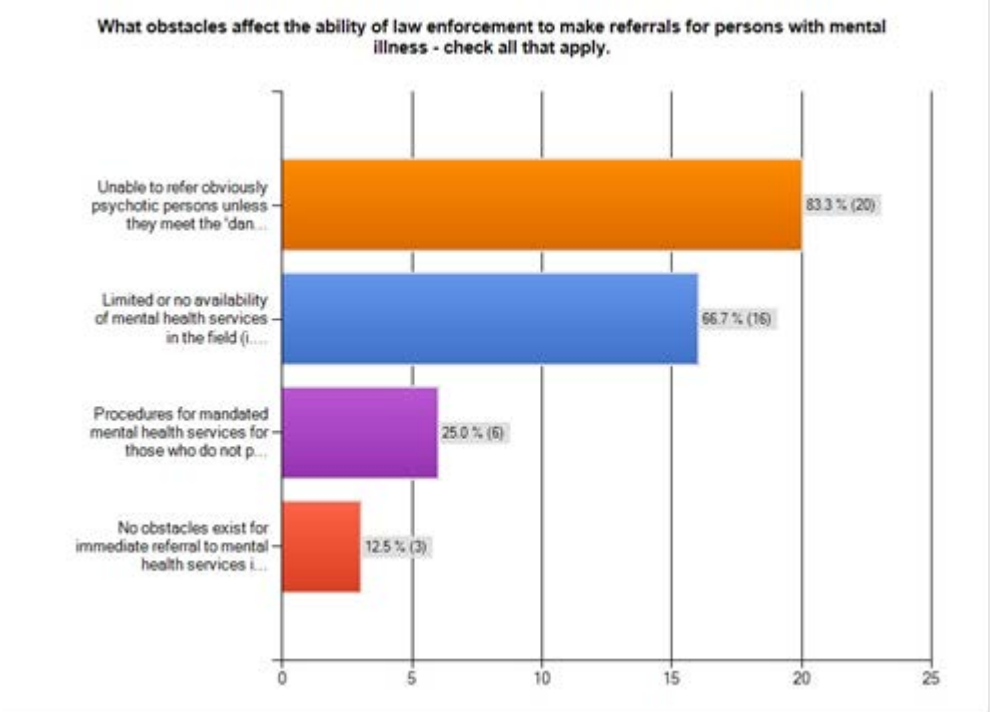

Figure 21. Question 14

Table 19. Arizona Filter Response Question 14

Obstacles Arizona	(n)	%
Dangerousness	20	83.3%
Limited Services	16	66.7%
Complex Procedures	6	25.00%
No Obstacles	3	12.5%
Sample (n)	**45**	

Of respondents from the state of Arizona, 83.3 percent chose dangerous to self or others as the major obstacle affecting the ability of law enforcement to make referrals for persons with mental illness, even though Arizona has one of the most comprehensive standards within the United States today. This anomaly is not exclusive to Arizona, of the few states with exemplary standards; all responses list the imminently dangerous verbiage as a major obstacle. These results are indicative of a dire need for training within states with regard to the requirements of the standards within their respective

states. Further research needs to be conducted to ascertain if this shortcoming in knowledge of the actual standards within those states with model statutes exists not only in Arizona or whether Arizona is representative of the national picture.

The choice, “Resources such as mobile crisis community response teams and community-based outreach services are limited,” was indicated by 56.86 percent (n=1,201) of the respondents. The frustration experienced by patrol officers when responding to calls for service of this nature is exemplified in this comment related to Question 14:

> In the past, if an officer could articulate to the crisis counselor that a mental subject was a danger to himself or others then they would respond and make arrangements for bed space. Now, they rarely come out unless it is an uncontrolled violent person. In some cases, a crisis counselor has asked to speak to the mental subject over the officer's cell phone and "diagnosed' the mental subject based on that short phone conversation. The problem here is that the officer has made observations and noted the comments made by the mental subject. Most officers would not ever release a dangerous person despite whatever diagnosis is made over the phone. So, the mental subject either gets arrested or goes to a local hospital for evaluation. This wastes resources and takes more of the officer's time - all in the name of protecting one's self from liability.

In addition, many responses point to the vast distances severely mentally ill patients need to be transported to the nearest mental health facility. Listed are several responses pertaining to distance of facilities available:

- The closest state mental health facility is approximately 300 miles from my jurisdiction. The closest private mental health facility is 100 miles. The private facility is quite difficult to work with.
- Have to drive 45 miles just for an evaluation with MHMR which ties up two (2) officers for 4-5 hours.
- Our closest inpatient facility is 200 miles
- Physical distance. Facilities are 90 to 400 miles away from this jurisdiction.

The complexity of the procedures surrounding those mentally ill persons who do not yet pose an imminent threat is indicated by 43.99 percent (n=929) of the respondents. This survey response is representative of issues surrounding complexity: “Lots of

services are available but no single point of contact for 'admission' into the system. Requires law enforcement to understand the variety of services available to be able to plug the mentally ill person into the system."

Of the respondents, 11.79 percent (n=249) indicated that no obstacles exist for the immediate referral to mental health services within their communities. One hundred and sixty two respondents chose to enter a written response to the question; those responses are contained within Appendix E.

Examining the issue in the state of California, where the policy change originated is also an interesting study, while most states that do have assisted outpatient treatment laws enact them statewide; California's law was enacted as optional, by county. To date, of California's 58 counties, only Nevada County has fully implemented the 2002 legislation known as Laura's Law. The remaining 56 counties have no law implemented to assist the severely mentally ill at all. It should be noted that California's Nevada County was the county of residence and location of the tragedy that claimed the life of the law's namesake, 19 year old Laura Wilcox. The shooting rampage, by an untreated severely mentally ill man with a history of mental illness, left two dead and three seriously wounded (Treffert, 1981).

It is a very interesting fact that the California State Association of Counties named Nevada County as a recipient of its 2010 "Challenge Award" for their innovation and creativity, releasing this statement:

> In 2008, Nevada County behavioral health officials faced a tough task: convincing some individuals with untreated mental illnesses that they were in need of treatment. The Nevada County Assisted Outpatient Treatment Program offered a unique solution that bridged the gap for people that are dangerous and in need of treatment, but may not be on probation, and are not gravely disabled, or do not meet criteria for emergency involuntary hospitalization. Nevada County was the first California County to fully implement this program, and met with immediate success. Of 22 eligible candidates, 13 met program selection criteria in varying degrees and continue to receive Assisted Outpatient Treatment. Data from the Milestones of Recovery Scale indicates that seven candidates succeeded with recovery, and five others are stable and

> receiving voluntary intensive mental health treatment. Program costs of $80,000 were offset by savings estimated at $203,000, based on decreased hospitalization costs and reduced incarcerations.

Although the California State Association of Counties points to the program as a success, both financially and from a humanitarian viewpoint however while commending Nevada County for its implementation, no other county within the state has implemented Laura's Law.

In a 2002 letter to the Governor, California Justice Harold Shabo stated:

> These persons wander the streets hungry, homeless, and without hope. They cycle through our hospitals and are released with no assured after-care or plan to meet their human needs and, all too often in my experience, wind up in our jails and prisons, not because they are criminals but because there simply is no place for them in our society.

O. QUESTION 15

"What is the average amount of time your officers spend with a mentally ill person, from the onset of the call for service, inclusive of transportation and time in the hospital or mental health facility, waiting for a mental health patient to undergo the initial psychiatric evaluation?" The intent of the question is to quantify nationally on average how much time is spent by law enforcement when responding to a call for service involving a mentally ill person, more specifically when that call requires a medical evaluation. When analyzing the figures and statics with regard to this question, it is interesting that the figures indicate that one to two hours is the most frequently chosen response with 31.5 percent (n=666) of the responses. Further examination reveals that 36.4 percent (n=771) of the respondents indicated that the time spent was between three to more than four hours category. (See Figure 22 and Table 20.) Many of the write-in responses to the open-ended questions indicate that limited bed space and great distances to the nearest mental health facility, as causative factors greatly increasing the consumption of man-hours. This problem exists due not only to the remnants of deinstitutionalization, but also as a result of the continuing reduction of acute care bed space in mental health facilities nationwide (Lamb & Weinberger, 1998).

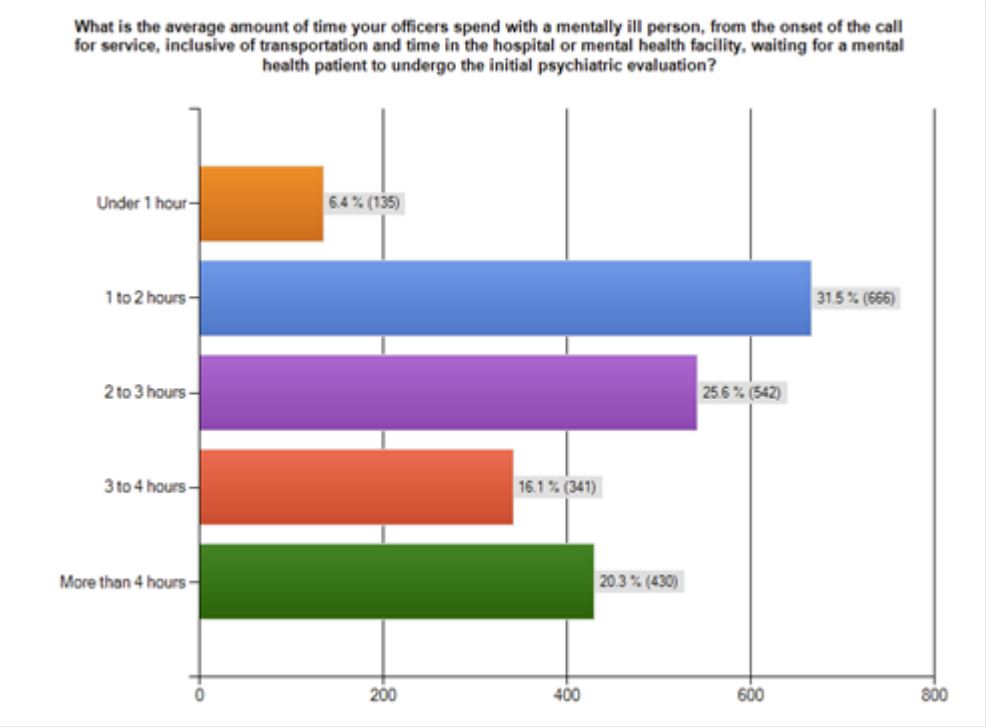

Figure 22. Question 15

Table 20. Question 15

Average Time Spent on M.I.	(n)	%
Under 1Hr.	135	6.38%
One to Two Hrs.	666	31.5%
Two to Three Hrs.	542	25.64%
Three to Four Hrs.	341	16.13%
More than Four Hrs.	430	20.34
Sample (n)	**2114**	

P. QUESTION 16

"In your estimation, what percentage of people who have injured or killed police officers in the line of duty was experiencing mental illness at the time of the incident?" Question 16 asks that the respondent estimate the extent to which he or she believes that mental illness was a factor present during the assault and or murder of on duty police officers. The 0–20 percent category was chosen by 38.05 percent (n=775) of respondents. In comparison 28.91 percent (n=589) respondents chose 21–40 percent (n=589), 19.93 percent (n=406) respondents chose 41–60 percent, 9.82 percent (n=200) of respondents chose 61–80 percent and 3.29 percent (n=67) of respondents chose the 81–100 percent category. More over, 33.04 percent of all responses fall within the combed ranges between 41 to 100 percent categories, with an additional 29.9 percent within the 21–40 percent category. (See Figure 23 and Table 21.)

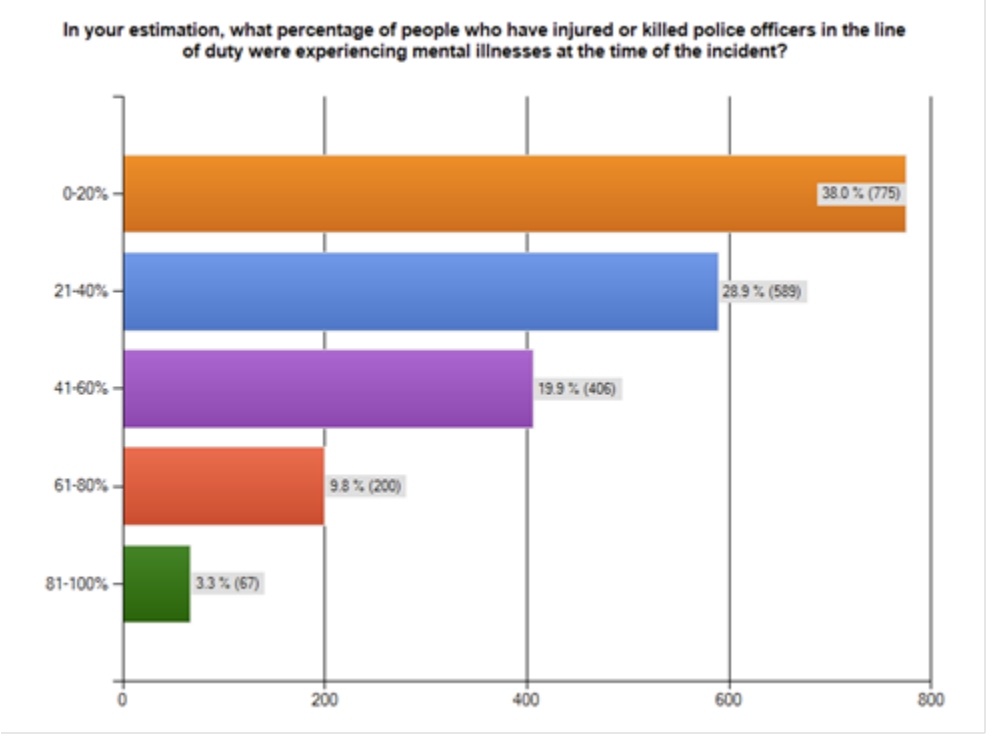

Figure 23. Question 16

Table 21. Question 16

Injured or K.I.A. by M.I.	(n)	%
0 - 20%	775	38.05%
21 - 40%	589	28.91%
41 - 60%	406	19.93%
61 – 80%	200	9.82%
81 – 100%	67	3.29%
Sample (n)	**2037**	

Q. QUESTION 17

"In your estimation, what percentage of your homeless population appears to be mentally ill?" A constant area of concern for municipal law enforcement agencies is the presence of homeless populations. This question seeks the estimation of senior law enforcement officials as to the percentage of mentally ill persons among the communities homeless population. (See Figure 24 and Table 22.)

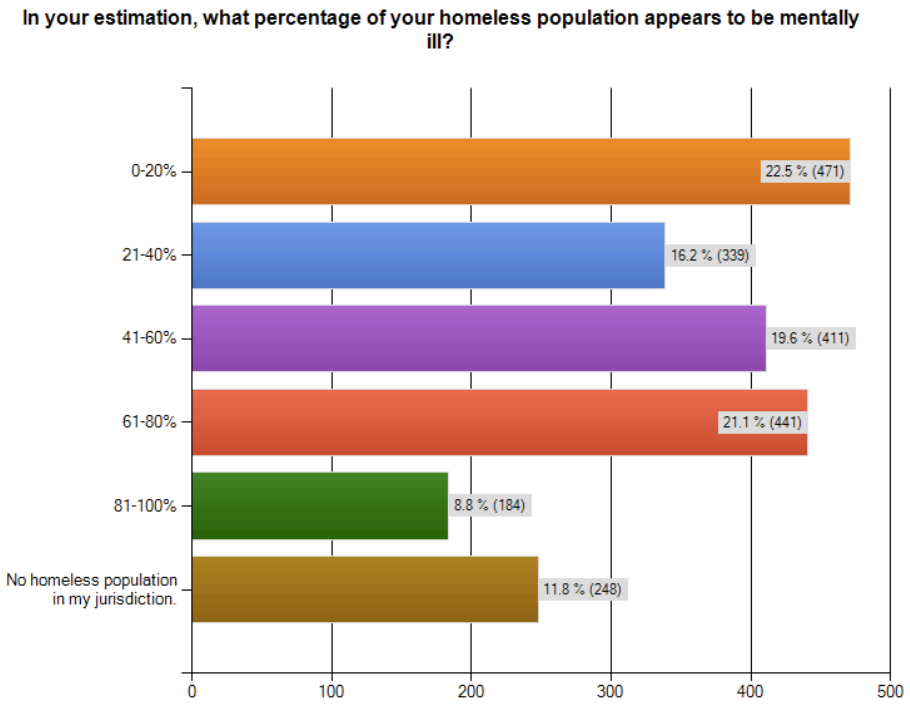

Figure 24. Question 17

Table 22. Question 17

Percentage of Homeless Population M.I.	(n)	%
0 - 20%	471	22.49%
21 - 40%	339	16.19%
41 - 60%	411	19.63%
61 – 80%	441	21.06%
81 – 100%	184	8.79%
No Homeless Population	248	11.84%
Sample (n)	**2094**	

In response to this question, 22.49 percent (n=471) of respondents indicated that from 0–20 percent of their homeless population, in their estimation appear to be suffering

with a mental illness. In addition, 16.19 percent (n=339) of respondents indicated 21–40 percent, 19.63 percent (n=411) of the respondents indicated 41–60%, 21.06% (n=441) respondents indicated 61–80 percent and 8.79 percent (n=184) of respondents indicated 80–100 percent of their homeless population appears to be mentally ill, while 11.84 percent (n=248) of respondents report having no homeless population within their community. Totaling the 21 to 60 percent categories equals 58.85 percent, which is consistent with several studies mentioned earlier within this paper, which indicate reasonably consistent rates among homeless people of one-third to one-half with severe psychiatric disorders (Gillig & McQuistion, 2006). Policy recommendations aimed at proactive treatment programs targeting the severely mentally ill within the homeless population, would have the added benefit of reducing their representation within the homeless population, and thereby reduce the severity of the issues surround this social problem.

R. QUESTION 18

"How long have you been a police officer?" (Demographic question) Knowing how long the respondent has been a police officer allows the survey results to understand the respondent's frame of reference. The survey centers on estimations and observations, both of which become more valuable over longer periods of time. The observations of a law enforcement officer that spans more than 20 years, most certainly holds more credence than those of a law enforcement officer holding the position for less than five years, based if only solely upon their opportunity to have observed the development of the issue over a prolonged period of time. (See Figure 25 and Table 23.)

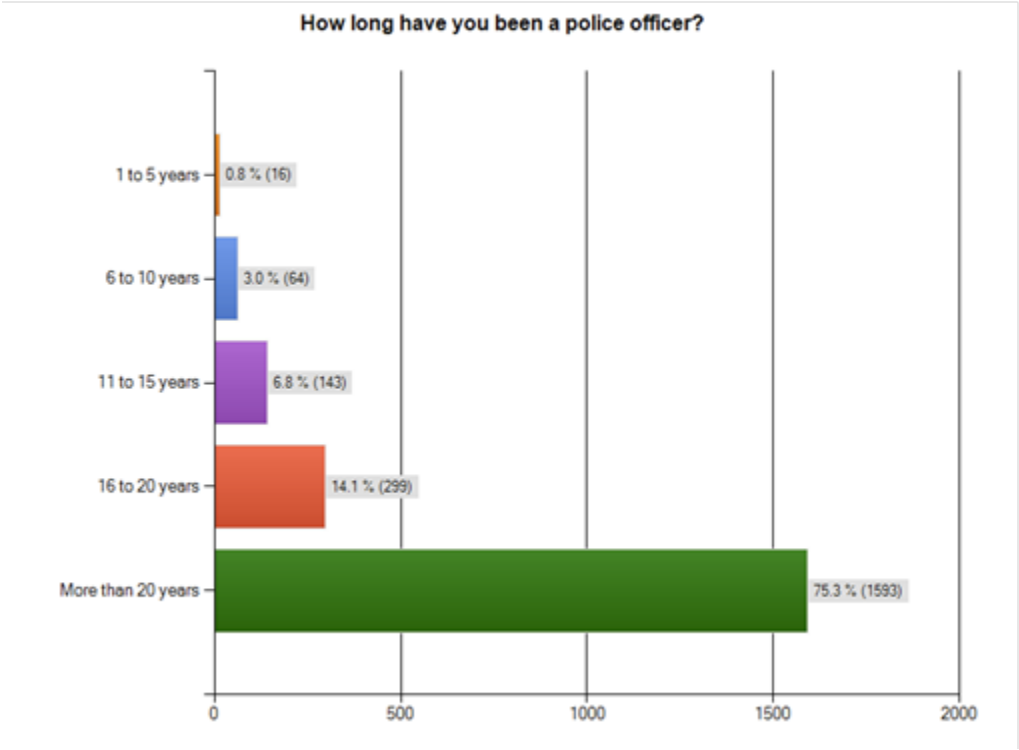

Figure 25. Question 18

Table 23. Question 18

Respondents Length of Service	(n)	%
1 to 5 Years	16	0.76%
6 to 10 Years	64	3.03%
11 to 15 Years	143	6.76%
16 to 20 Years	299	14.14%
More than 20 Years	1,593	75.32%
Sample (n)	2115	

The results of this question clearly place the vast number of respondents within the, employed as a police officer for more than 20 years category, with 75.32 percent (n=1,593) of respondents choosing this option. In addition, 14.14 percent (n= 299) of respondents chose 16 to 20 years as their length of service. The remaining respondents

fall within the one to 15 year range totaling only 10.55 percent (n=223) of respondents. The vast majority of respondents are able to view the issues raised by the survey with the perspective of over 20 years of service to their communities and the profession.

S. QUESTION 19

"Which best describes your agency jurisdiction?" (Demographic question) This, the second demographic question, allows the categorization of respondent's answers by governmental jurisdiction: federal, state, county/parish and local. It was the author's hope that the responses would provide an even sample of statistically significant responses throughout the different jurisdictional categories, indicating the incidence and prevalence of mental health issues throughout various levels of law enforcement. However, that was not the case; an overwhelming response was generated within the local jurisdiction category containing 84.23 percent (n=1779) of the responses. Furthermore, 10.65 percent (n=225) of the responses were generated within the county/parish category with another 4.64 percent (n=98) of responses falling within the state jurisdiction. Only 0.47 percent (n=10) of responses were generated from federal sources. The method of distribution of the survey, via professional associations of police chiefs, clearly targeted the local jurisdictions. The people in the best position to comment on this issue are the same people who comprise the majority of respondents, as the issues addressed in the survey are largely local emergency services issues. Future research should be directed at determining the different ways mental health issues impact law enforcement across jurisdictional levels. (See Figure 26 and Table 24.)

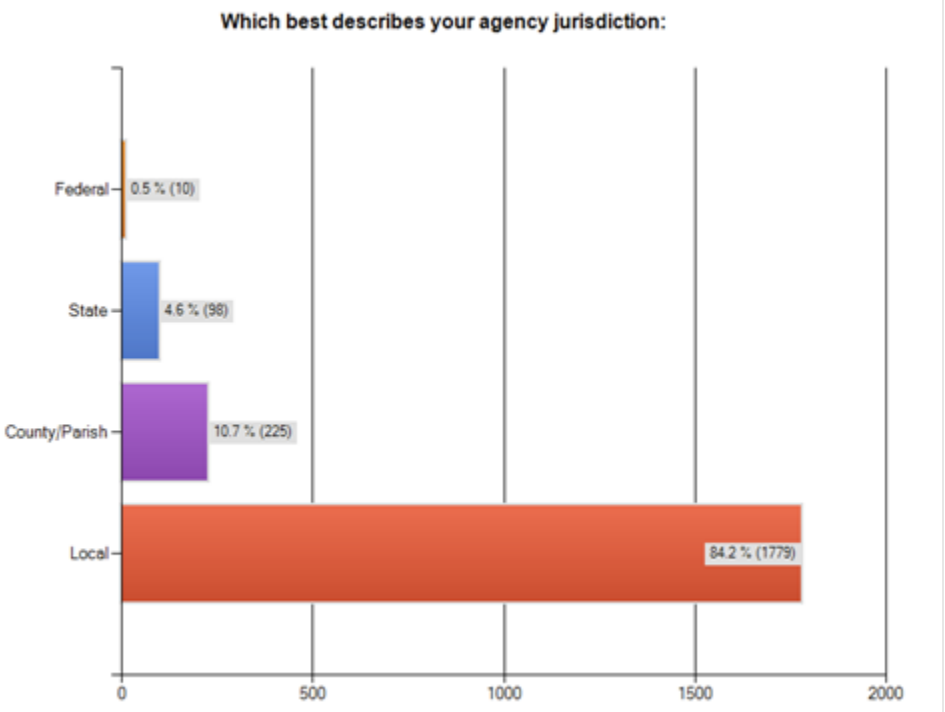

Figure 26. Question 19

Table 24. Question 19

Jurisdiction	(n)	%
Federal	10	0.47%
State	98	4.64%
County/Parish	225	10.65%
Local	1779	84.23%
Sample (n)	**2112**	

T. QUESTION 20

"In which state are you located?" (Demographic question) This question allows for the survey results to be separated by state responses, while simultaneously allowing for examination of responses from police chiefs of all states. The breakdown of responses by state can be found in Appendix F. No bar graph is provided as the choice of

state generates a 100 percent response. Furthermore, 2,111 respondents entered a state response while 295 respondents skipped the question. (See Figure 27.)

20. In which state are you located? Download

	Response Percent	Response Count
State: Show Responses	100.0%	2,111
answered question		2,111
skipped question		295

Figure 27. Question 20

U. QUESTION 21

"Please provide the number of sworn personnel within your agency." (Demographic question) This question seeks to identify the size of the law enforcement agency represented by the respondent. (See Figure 28 and Table 25.)

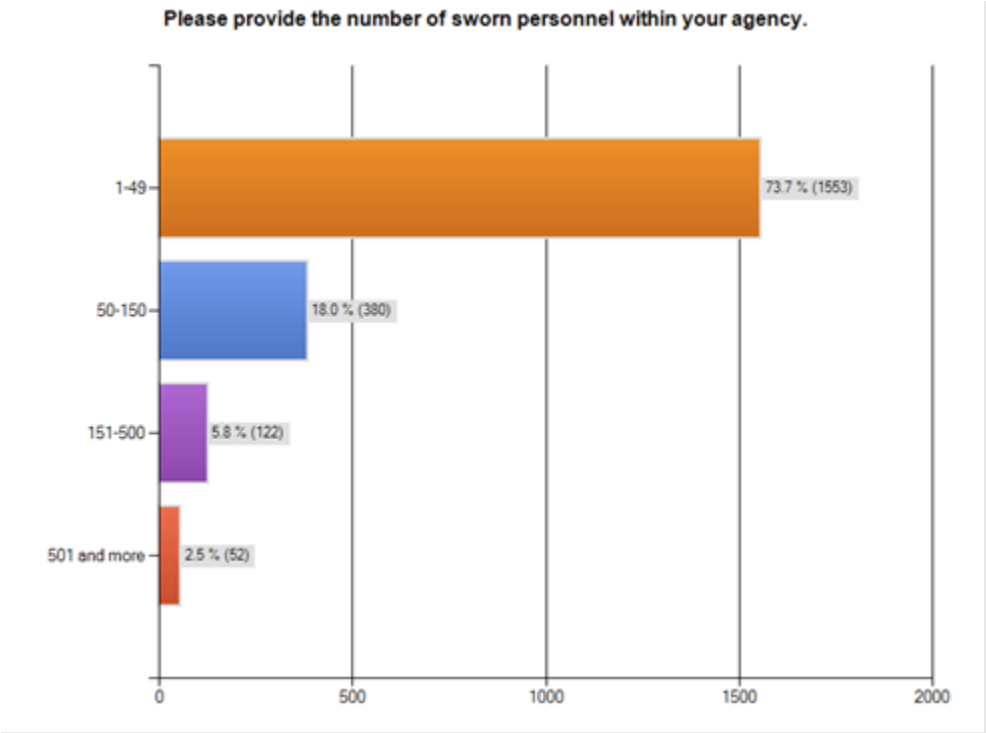

Figure 28. Question 21

Table 25. Question 21

Department Size	(n)	%
1 – 49	1553	73.71%
50 – 150	380	18.03%
151 – 500	122	5.79%
500 and more	52	2.47%
Sample (n)	**2107**	

The results of this survey clearly reflect the structure of law enforcement within the United States, with the vast majority of law enforcement agencies being small to mid-size local police departments. The Bureau of Justice Statistics (BJS) sources for information about local police include the Law Enforcement Management and Administrative Statistics (LEMAS) survey and the Census of State and Local Law Enforcement Agencies (CSLLEA). The Bureau of Justice Statistics also classifies tribal police as local police in BJS data collections.

- In September 2007, an estimated 12,575 local police departments with the equivalent of at least one full-time officer were operating in the U.S.
- In 2007, local police departments had an estimated 601,000 full-time employees, including an estimated 463,000 sworn officers.
- Municipal and township police departments employed an average 2.3 full-time officers per 1,000 residents in 2007. (Bureau of Justice Statistics, 2007)

Although the issues surrounding the unintended consequences of the deinstitutionalization of the severely mentally ill has great effects on law enforcement and the criminal justice system nationwide at all levels of government; its effects are felt by local law enforcement daily.

V. QUESTION 22

"Please provide approximate population served by your department." (Demographic question) This question seeks to determine the size of the communities represented within the survey and to what extent. As indicated in Figure 29 the vast majority of responses, 66.1 percent (n=1,399), were received from agencies whose jurisdictions are in the population range of 2,501 to 50,000 residents. Municipalities with populations over 500,000 accounted for 18.7 percent (n=395) of responses. The remaining 15.2 percent (n=322) of responses were from representatives of agencies with community populations of less than 2,500. Survey results filtered by size of population served can be found within Appendix G. (See Figure 29 and Table 26.)

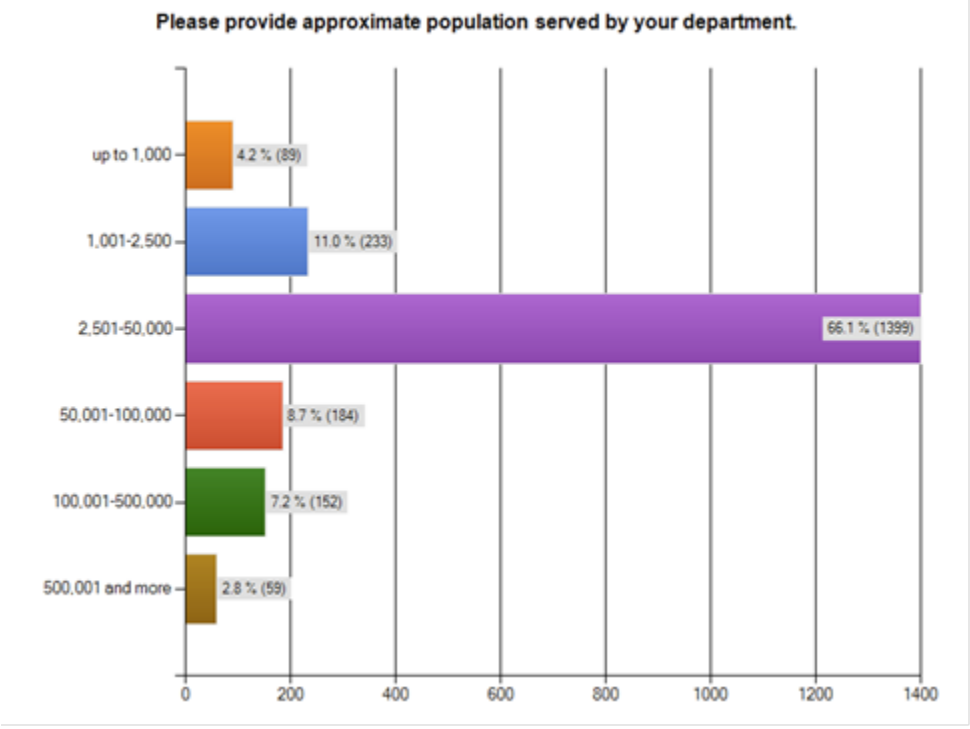

Figure 29. Question 22

Table 26. Question 22

Population	(n)	%
Up to 1,000	89	4.21%
1,001 – 2,500	233	11.01%
2,501 – 60,000	1399	66.11%
50,001 – 100,00	184	8.69%
100,001 – 500,000	152	7.18%
500,001 and more	59	2.79%
Sample (n)	**2116**	

IV. FINAL REVIEW

The final chapter of this thesis presents several policy suggestions to enhance the methods by which our society should handle the severely mentally ill population and thus make law enforcement agencies more effective in handling new homeland security responsibilities. Analysis of the survey has revealed several areas where improvement can be made by gaining a better understanding of the laws that currently exist. Perhaps even more importantly, the survey has identified areas where policy adjustments are urgently needed.

This project sought to answer the following question: Does the current method by which the United States manages its mentally ill population place unreasonable strain upon both our prison system and our law enforcement resources to the point that it adversely affects their respective abilities to focus on homeland security and anti-terrorism activities? The survey, *The Impact of the Mentally Ill Population on Law Enforcement Resources Survey,* has at the very least shown that calls for service involving the severely mentally ill population are a major consumer of law enforcement resources nationwide. The exceptional response to the survey is indicative of a topic of great concern. The survey has indicated that the problem is substantial and has grown over the course of the respondents' careers nationwide.

The literature has shown that as the availability of hospital beds for the severely mentally ill nationwide continues to dwindle, whereas the presence of severely mentally within our prisons, homeless populations and communities continues to rise. Some prisons are now keeping severely mentally ill prisoners after they have completed their sentences, due to a combination of the severity of their illness and a lack of treatment facilities with which they may be discharged to (Leys, 2011). The literature has also indicated that overcrowding within our prison system hinders the implementation of other programs aimed at such things as countering prison radicalization, which has a direct effect on the security of our nation.

From a local law enforcement perspective, since the tragic events of September 11, 2001, municipal law enforcement is now expected to perform a variety of homeland security functions laid out in multiple federal documents (Pelfrey Jr, 2007). The author is a Chief of Police of a mid-sized police department, located 50 miles north of New York City and whose jurisdiction, New Windsor, New York, with a population of approximately 28,000, encompasses a fair amount of critical infrastructure. After analysis of the survey results, the town of New Windsor Police department is representative of the vast majority respondents both in size of department and size of population served. This department operates with a minimum staffing level of three uniformed patrol officers with an average patrol presence of four and on occasion reaches levels of six to seven patrol officers per shift.

A. OPERATION RED EYE

On September 10, 2008 the Federal Bureau of Investigation (FBI) initiated an investigation entitled "Operation Red Eye" and later dubbed by the press as "The Newburgh Four." This investigation spanned nine months and centered on the actions of four local residents who had devised a plan to attack military aircraft at Stewart International Airport in the town of New Windsor and a Jewish Community Center in Bronx, New York. During the investigation many reconnaissance visits were made in and around Stewart International Airport by the suspects. A storage facility within the town of New Windsor was rented by the defendants where they stored weapons, such as a shoulder mounted rocket and plastic explosives for use in suitcase type bombs. As the suspects were all under close surveillance by the FBI, unbeknownst to them, all of the weapons were rendered inert by the FBI. For a period of nine months these suspects made numerous trips to Stewart Airport and to the storage facility within New Windsor, undetected by patrol units. It was not until one week prior to the termination of the investigation that patrol units received a call from the management of the storage facility regarding suspicious activity and numerous visits to the facility, that the town of New Windsor Police Department started its own investigation into the activity of these four men. How many preventable incidents occurred during the course of the investigation of

the “Newburgh Four” where multiple patrol officers, who would normally be conducting preventative patrol of critical infrastructure, were instead responding to calls for service or transporting severely mentally ill persons, as a result of the unintended consequences of the policy change affecting the management of our severely mentally ill population nationwide?

A review of the town of New Windsor Police Department’s records, indicates that during the time frame of the Newburgh Four case, this department responded to approximately 156 calls for service directly involving mentally ill individuals, including nine incidents of suicides or attempted suicides and numerous of calls for service involving disorderly persons of which a good percentage are believed to have involved mentally ill individuals. For a relatively small agency, this issue is a major and, for the most part, a needless, expenditure of resources. Many of these calls also involved emergency medical services as well as emergency room staff.

As we have seen, terrorists are able to reside and operate in small communities throughout the United States for periods of time before they take action (Pelfrey Jr, 2007). Although the satchel bombs created by the “Newburgh Four” were created and stored in the town of New Windsor, they were eventually planted at a Jewish Community Center in the Bronx, New York. The ability of local law enforcement to main constant vigilance in the protection of critical infrastructure, as well as collection human intelligence regarding possible terrorist activity in and around their community is paramount to maintaining a safe community.

The National Strategy for Homeland Security lists as strategic objectives:

- To prevent terrorist attacks within the United States;
- To reduce America’s vulnerability to terrorism, and;
- Minimize the damage and recover from attacks that may occur. (White House 2002)

Large police agencies have the manpower to assign officers to special functions, or specialty units, capable of focusing resources from various branches within the department and address issues that require more directed attention. Mid- to small-sized police departments, which make up the vast majority of police agencies nationwide and

as displayed within the survey results, do not have that luxury. Additional assignments such as those spelled out within the National Strategy for Homeland Security must be squeezed in around the daily assignments of a municipal police department.

The author conducted an interview on June 17, 2010 with Thomas Kean, former co-chairperson of the 9-11 Commission report. During that interview Mr. Kean expressed his belief that the next terror attack upon this country will most likely **not** be discovered by the CIA or the FBI but more likely by the police officers on patrol, who would see or hear something that they recognize as just not right within their community and in turn passes that information up the line (personal communication, Thomas Kean, June 17, 2010) The May 1, 2010 Times Square attempted bombing incident attempted by **Faisal Shahzad** was an example of his point, when a T-shirt vendor notified a police officer that smoke was coming out of the back of a dark-colored Nissan Pathfinder on the southwestern corner of West 45th Street and Broadway.

This project sought to answer the following question: What is the perception of law enforcement administration about the nature and extent of the strain placed upon their resources by the deinstitutionalization of the severely mentally ill? The survey results strongly support the author's position and indicate that the thesis topic is an area of major concern to the law enforcement and criminal justice community as a whole. The literature has shown that more mentally ill persons today are confined in prisons and jails than are patients within mental health treatment facilities. In essence, the policy change that caused the deinstitutionalization of our severely mentally ill population has shifted the care and treatment for our most severely mentally ill population from the medical community to the criminal justice community. This policy change nationwide has created a situation that was not anticipated and in doing so has shifted the burden from the medical system to the criminal justice system which is not best qualified, licensed, equipped or trained to handle this vulnerable population.

This research is extremely important for several reasons. First, this issue is a major consumer of law enforcement resources, often tying up two or more officers at once for extended periods of time on a regular basis. Officers regularly encounter the severely mentally ill as perpetrators of violent acts, but also as a large component of the

homeless population and as a large percentage of the crime victim population (Teplin et al., 2005). Second, this problem has far reaching effects, not only on law enforcement but throughout the criminal justice system as a whole, to include police, courts, jails and prisons, probation and parole. There is also an important humanitarian and social perspective associated with the topic of the severely mentally ill, almost no one advocates for these ill persons who are too ill to advocate for themselves.

The social issues that this paper examines are all major issues that either arose from or were exacerbated as a result of the unintended consequences of the policy change known as deinstitutionalization. Methods exist that would lessen the extent of these consequences, reduce the consumption of law enforcement resources, ease existing prison overcrowding of the most high maintenance prisoners, ensure that the most dangerous mentally ill persons are monitored and cared for and reduce the mentally ill subset of the nation's homeless population.

B. POLICY RECOMMENDATIONS

A 2003 Columbia University study indicated without question that the use of AOT laws would have the required effect of reducing the current strain placed upon both the corrections systems and law enforcement resources. The study found that court-ordered assisted outpatient treatment patients were four times less likely to become violent than those in a control group, as well as finding:

- 77 percent reduction in psychiatric hospitalizations
- 86 percent reduction in homelessness
- 83 percent reduction in arrests
- 86 percent reduction in incarceration
- 67 percent reduction in poor medication compliance
- Significant reductions in harmful behaviors, such as harm to self (45 percent reduction) and harm to others (44 percent reduction) (Olfson, Marcus, & Doshi, 2010).

Patient responses:

- 75 percent reported AOT helped to gain control over their lives.
- 81 percent reported AOT helped them to get well and stay well.
- 90 percent reported AOT made them more likely to keep appointments and to take medication. (Owen et al., 2009)

Under more widespread AOT legislation law enforcement, especially small- to medium-sized municipal police departments would require fewer resources to address recurring issues with the mentally ill, and be able to allocate more resources to address ongoing homeland security issues including preventive surveillance of critical infrastructure. The survey in this research was aimed at gaining insight into the importance of the issue from a law enforcement administrator's perspective nationwide, and that the results clearly show that it has.

C. SUMMARY OF RECOMMENDATIONS

1. Multi-disciplinary training of emergency services personnel must be undertaken in each state. It is imperative that law enforcement, fire services, emergency medical services, as well as emergency intake physicians and judges understand exactly the options available to them in dealing with this vulnerable population, especially in those states where laws exist that would allow commitment to an assisted outpatient treatment program without the strictly defined prerequisite of being "imminently dangerous." This is a recommendation that can be implemented today, as the precedent exists in some states. As the survey indicated, officers in states where dangerousness is not the only admission factor need to understand the "need for treatment standard" and make referrals based upon that standard, before violence ensues.
2. Federal guidelines should be established mandating court-ordered assisted outpatient treatment programs in every state. Wording comparable to that which appears within the Arizona's treatment laws should be standardized nationally so that law enforcement, physicians, and families are not forced to wait until the dangerous level is reached. The recommended change in the laws should include a "need for treatment standard" rather than relying sole upon "dangerous to self or others." Such laws would eliminate the need to wait until violence is threatened or perpetrated before taking action, providing for a safer community. Without a nationally governed framework severely mentally ill persons would be able to move from state to state with no monitoring of their current mental health status. Currently, here in New York State court orders for assisted outpatient treatment

stop as the patient crosses a county line, often meaning that a person adjudicated as imminently dangerous moves into a neighboring county unbeknownst to the new county's mental health officials.

3. States should enact new assisted outpatient treatment laws incorporating within those laws the revised standards. Federal funding should be tied to each state's cooperation in effectively implementing and monitoring the AOT laws within their state. Currently few states actually use the AOT laws that are already in place.

4. For the severely mentally ill population who have a past record of violence when not in treatment, regular supervision ensuring compliance with treatment needs to be conducted and overseen by each state's department of mental health.

5. A registry similar to the child abuse hotline system should be put in place including a mandatory reporter system, composed of professionals such as:
   - Social workers
   - Teachers and other school personnel
   - Physicians and other health care workers
   - Law enforcement officers

These professionals would be required to notify the state office of mental health upon contact with an obviously psychotic person who is either exhibiting signs of possible harm to himself or others or is in obvious need of psychiatric assistance. A mandated reporter system may have helped to prevent the January 8, 2011 Tucson mass shooting of 14 persons, including United States Representative Gabrielle Giffords and the fatal wounding in the same incident of six others including United States District Court Chief Justice John Roll. Although the shooter, Mr. Jared Lee Loughner, had exhibited psychotic behavior and was described as dangerous, even to the point that his college expelled him and refused readmission until after he had received a psychiatric care, no policy existed that would have required his professors to report their concerns to the office of mental health (New York Times, 2011).

This research shows that the implementation of the suggested policy changes would:

- Increase public safety;
- Reduce the homeless population;
- Reduce the prison population;

- Reduce frequency of arrest of severely mentally ill;
- Reduce frequency of severely mentally ill as crime victims;
- Reduce the frequency of hospitalizations of mentally ill;
- Assist the families of severely mentally ill persons in seeking help for their severely mentally ill loved one.

A reduction in the severely mentally ill populations' presence within the social issues listed above by the enactment of long-term solutions to assist this portion of the community, would reduce or eliminate the revolving door, "catch and release" current practice as well as decrease the financial strain on local authorities. Without monitoring and treating this extremely volatile yet relatively small subset of our mentally ill community, we endanger not only ourselves but the mentally ill population as well. Unfortunately, prisons housing mentally ill subjects, who have frequent outbursts requiring increased manpower to manage, has taken time and resources away from the programs that are addressing prison radicalization which in turn has a significant impact on our national security. Police patrols are pulled from monitoring critical infrastructure and speaking to business owners and the public regarding programs such as "See Something Say Something" in order to transport known, yet untreated psychotic individuals to mental health facilities for yet another evaluation. This problem has reached crisis levels within the United States and requires national action to immediately resolve.

APPENDIX A. IACP LETTER OF ENDORSEMENT

International Association of Chiefs of Police
515 North Washington Street
Alexandria, VA 22314-2357
Phone: 703-836-6767; 1-800-THE IACP
Fax: 703-836-4543
Web: www.theiacp.org

President
Mark A. Marshall
Chief of Police
Smithfield Police Department
Smithfield, VA

Immediate Past President
Michael J. Carroll
Chief of Police
West Goshen Township Police
West Goshen, PA

First Vice President
Walter A. McNeil
Secretary, Department of Corrections
Tallahassee, FL

Second Vice President
Craig T. Steckler
Chief of Police
Fremont Police Department
Fremont, CA

Third Vice President
Yousry "Yost" Zakhary, Director
Woodway Department of Public Safety
Woodway, TX

Fourth Vice President
Richard Beary
Chief of Police
University of Central Florida
Orlando, FL

Vice President at Large
Chief Patrick Foley
Douglas Police Department
Douglas, MA

Vice President at Large
Patty Jaye Garrett Patterson
Chief of Police
Sumter Police Department
Sumter, SC

International Vice President
D.G. (David) Beer
Pearson Peacekeeping Centre
Ottawa, Ontario, Canada

Vice President-Treasurer
Carl R. Wolf
Chief of Police
Hazelwood Police Department
Hazelwood, MO

General Chair Division of State Associations of Chiefs of Police
Kent Barker
Chief of Police
Tualatin Police Department
Tualatin, OR

General Chair Division of State and Provincial Police
John R. Batiste
Chief
Washington State Patrol
Olympia, Washington

Parliamentarian
Philip A. Broadfoot
Chief of Police
Danville Police Department
Danville, VA

Executive Director
Daniel N. Rosenblatt
Alexandria, VA

Deputy Executive Director
Chief of Staff
James W. McMahon
Alexandria, VA

January 27, 2011

Chief Michael Biasotti
New Windsor Police Department
U.S. Naval Postgraduate School
1 University Way
Monterey, California 93943

Dear Chief Biasotti,

After speaking with Mark Spawn, Director of Research, Development and Training with the New York State Association of Chiefs of Police, I am pleased to be able to assist you as a member of the International Association of Chiefs of Police with your research project. As the Manager for the Division of State Associations of Chiefs of Police, I will distribute the survey link for the "Impact of Mental Illness on Law Enforcement Resources" project to the various state associations. The executive directors will be asked to distribute the survey to their members at their discretion.

I look forward to hearing more about the study and learning what types of responses you receive.

Sincerely,

Erin Vermilye
SACOP Manager

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX B. THE SURVEY

The Impact of the Mentally Ill Population on Law Enforcement Resources

The Impact of the Mentally Ill Population on Law Enforcement Resources

The focus of this research is to record the perceptions of law enforcement officials regarding mentally ill people with whom your agencies come into contact. While the results of the survey will be published, no agency, individual or identifiable information is collected. All responses are anonymous. In order to promise anonymity, there will be no follow-up requests for completion of this survey, so we request your prompt attention so that your departments' data can be included in the analysis.

This topic is an important one, however, reliable data is scarce. With your input a better understanding of the issue can be measured, which will allow a better understanding of the scope of the issue. The survey consists of 21 multiple choice questions which should take about five minutes to complete.

1. I agree to participate in this survey.

- ◯ Yes
- ◯ No

THE IMPACT OF THE MENTALLY ILL POPULATION ON LAW ENFORCEMENT RESOURCES

2. What percentage of your officers' time is spent dealing with the mentally ill?

[ ]

3. From your observations has there been an increase in the mentally ill population over the length of your career?

- ◯ Yes
- ◯ Has remained the same
- ◯ No

4. From your observations, has there been an increase in suicides and suicide attempts in your jurisdiction over the length of your career?

- ◯ Yes
- ◯ Has remained about the same
- ◯ No

5. From your observations, has there been an increase in the number of mentally ill detainees/prisoners requiring more direct supervision over the length of your career?

- ◯ Yes
- ◯ Has remained the same
- ◯ No

6. From your observations what percentage of your department's time is spent on calls for service or other activities involving individuals with mental illness?

[ ]

The Impact of the Mentally Ill Population on Law Enforcement Resources

7. How has the amount of time that your department spent on calls for service involving individuals with mental illness changed over the length of your career?

- ◯ Decreased
- ◯ Increased
- ◯ Substantially decreased
- ◯ Substantially increased
- ◯ Stayed the same

8. If there is an increase in your jurisdiction regarding calls for service involving individuals with mental illness what do you attribute the increase in calls to? (select all that apply)

- ☐ Public's inability to effectively refer mentally ill persons into mental health treatment programs.
- ☐ More persons released from inpatient mental health facilities into the community.
- ☐ Increased awareness on part of police, of persons with psychiatric disorders.
- ☐ Increased number of persons diagnosed with psychiactric disorders.
- ☐ Increased amount of categories of possible diagnoses of psychiatric disorders.
- ☐ Increase of public sensitivity toward persons with psychiatric disorders.
- ☐ Other (please specify)

9. Rank the following typical calls for service as to the amount of time commitment required.

	Minimal time	Routine time	Substantial time	Extensive time
Routine larceny report	◯	◯	◯	◯
Domestic dispute	◯	◯	◯	◯
Traffic accident	◯	◯	◯	◯
Mentally ill person	◯	◯	◯	◯

Other (please specify)

10. How many officers are typically dispatched for a call involving a NON-VIOLENT mentally ill person?

The Impact of the Mentally Ill Population on Law Enforcement Resources

11. How many officers are typically dispatched for a call involving a VIOLENT mentally ill person?

12. Does your agency mandate the number of officers required to accompany a mentally ill person to a facility for evaluation?

- ◯ Yes
- ◯ No

13. When your department does transport an individual with mental illness to a hospital or mental health facility for evaluation, how many officers are required to accompany the individual?

14. What obstacles affect the ability of law enforcement to make referrals for persons with mental illness - check all that apply.

- ☐ Unable to refer obviously psychotic persons unless they meet the 'dangerous to self or others' criteria.
- ☐ Limited or no availability of mental health services in the field (i.e. mobile crisis, community response team, community-based services, outreach services, etc.).
- ☐ Procedures for mandated mental health services for those who do not pose an imminent threat are too complex.
- ☐ No obstacles exist for immediate referral to mental health services in my community.

Other (please specify)

15. What is the average amount of time your officers spend with a mentally ill person, from the onset of the call for service, inclusive of transportation and time in the hospital or mental health facility, waiting for a mental health patient to undergo the initial psychiatric evaluation?

16. In your estimation, what percentage of people who have injured or killed police officers in the line of duty were experiencing mental illnesses at the time of the incident?

17. In your estimation, what percentage of your homeless population appears to be mentally ill?

The Impact of the Mentally Ill Population on Law Enforcement Resources

18. How long have you been a police officer?

19. Which best describes your agency jurisdiction:

20. In which state are you located?

State:

21. Please provide the number of sworn personnel within your agency.

22. Please provide approximate population served by your department.

APPENDIX C. WRITTEN RESPONSES TO OPEN ENDED QUESTION #8

College campuses seem to be dealing with more severely ill students and more medicated students who's needs strain our systems capacity for services.

Increase of mentally ill persons engaging in mainstream activities of society

A large number of EDPs who are sent for Mental Health evaluations are released/returned to the street quickly.

The system is broke. When you bring a Mental Health Patient to the Hospital and they beat the ambulance home, something is wrong!

The stresses of contemporary life such as loss of jobs, increased divorce rate, lack of jobs and other factors are impacting on the general welfare and mental health of the nation. This national dilemmas is exacerbated by the fact ever growing numbers of people are being denied access to mental health services and highly effective medications. The compilation of these factors have caused a marked increase in domestic violence, homelessness, depression, suicidal thoughts, abnormal behaviors in public, self destructive behaviors, increased alcohol and drug use, violence and many other behaviors that are destructive to the individual and society as a whole. Police being the first to be called for emergencies consequently encounter ever increasing numbers of people suffering from varying kinds of mental illness and the difficult and often dangerous situations these people have caused, including self destructive behaviors. These encounters often expend enormous amounts of police manpower and resources to resolve and frequently result in injuries and collateral legal issues for the officers and their respective municipalities as well.

Patients who have no medication or refuse to take prescribed medications, resulting in increased incidents of inappropriate behavior that requires police interventions.

Increased stress in peoples lives; most often mentally ill persons stop taking medications as they feel they don't need them anymore.

Evaluation process at emergency room relies too much on patient answers. Need more cooperation with those providing mental health assistance and emergency room to better diagnose patient.

Lack of treatment facilities.

Seems to be a higher incidence of mental illness in the general population.

No increase.

Lack of appropriate treatment and funding for those with mental illness.

Increased complexity in everyday life causing distress to individuals and leading to disorders.

We need treatment facilities. Jails are not the place for the mentally ill.

Increase in facilities dealing with mentally ill with inappropriate amount of supervision of the facility.

The distance to treatment centers and the frequent lack of beds, necessitating transport to greater distances.

We do not specifically classify calls for service as involving the mentally ill. An assault by a disturbed person is dispatched as an assault. It is impossible to determine specifics.

No noticeable increase is noted.

Mental illness evaluation centers are using the Police department to transport their patients to secure facilities which often takes us 60 to 90 minutes per transport.

Failure of the mental health system to effectively deal with and house the mentally ill.

The system being overloaded and resulting early release.

State laws requiring police to detain and transport mentally ill subjects to in-patient facilities per a doctor's recommendation.

People with mental illnesses who also self medicate with alcohol and/or illegal drugs; failure to stay on prescribed medications or failure to find effective treatment; also inability to stay employed due to mental disorders.

Lack of mental health resources, revolving door treatment, dependence on patients using the honor system in taking or not taking their medications.

Impact of the economy that impacts individuals who lose their support systems through loss of employment and availability of psychological services.

We have transitional housing for mentally disabled persons. The county Behavioral Health Department will be locating its headquarters in our city. We also have a Veterans transition center and Veterans medical clinic and many of their clients/patients are dealing with mental health issues

Population has more than doubled in the last 15 years. Our jail system provides more bed space for mentally ill subjects than the local state services. Law enforcement (including our enforcement operations) recognize the potential for individuals to access these services if the subject is booked for a crime, particularly when other treatment resources are unavailable.

Economic downturn has increased cases of severe depression, alcoholism and drug use

A lack of interest and/or response by immediate family members in helping with the problem. Another problem is that the mentally ill person has no immediate family (that is, their parents have passed away and there are no children living or known).

Increased substance use that in turn results in early onset of some individuals to reveal bipolarism [sic] or other mental health illness.

Psychiatric problems from drug use.

Conflict between mental illness service providers and LE on proper protocol.

It seems as if mental illness is more prevalent than 20 or 30 years ago.

Meth related Psychosis.

Increased drug use.

In ability for family's to deal with the mental health person and put the burden on government who has little ability or resources to deal with this sufficiently so the police and Jail are left with no choice except to deal with this issue daily and then in the jail with little support.

Reduced state and local funding to mental health treatment.

Increase in the prescribing of psychotropic drugs - increase of combining psychotropic drugs with illegal drugs/alcohol.

I have not seen an increase, however, from what we have experienced it would most like be the public's knowledge regarding referring mentally ill persons into a treatment program.

No resources to help the mentally ill.

Lack of services for mentally ill.

Economy and loss of jobs and marriages associated with the economy has increased the number of calls related to mental illness.

Decreased funding of social service programs and mental health facilities.

Lack of funding for mental health services. Recent budget cuts make police the only available option.

Lack of after-hours mental health professionals to respond and relieve first-responding police officers who are on-scene with those with mental health issues.

Lack of programs.

Unemployment, depression regarding job loss.

Prescription drug abuse.

With the use of cell phones the mentally deficient subject makes phone calls or sends text messages threatening to harm themselves. The calls are usually made to a 3rd party rather than the Police.

Increased Drug use, increased depression, very poor economic issues, homelessness, etc.

There has been a significant increase in persons diagnosed with mental illness. Diagnosis is often by check list and not by a timely one-on-one with a professional. Medicines are given over long periods of time with no follow-up or monitoring of physical condition or reactions to medications. Too often it seems that the problem is lack of monitoring of the patient and a severe reaction over time to the drug.

Officer CIT training has increased awareness of problem. Public and Mental health's failure to recognize and commit recourses to this problem, especially the mental health situation in jail, has resulted in 40 percent of jail population being treated with mental health drugs.

Reduced Funding for Mental Health Facilities closing and individuals released to the street.

Lack of mental health resources due to lack of funding. Two separate mental health treatment facilities have closed their doors within the last two years.

The mental health system fails to a) admit patients that need help and b) retain patients brought in for help by law enforcement. This is all based upon insurance/money which is the bottom line in this country. I would hope we could revamp this problem as there are many dedicated mental health professionals in this country.

Lack of intervention resources.

Greatly Increased medication of young adults. Young adults going off their medications or misusing the medications.

Increased drug use leading to mental health issues.

Work in a small jurisdiction with very limited resources for the mentally ill. The only local mental health treatment facility will only respond AFTER it receives a call

from the hospital, and the local hospital has only 1 bed for psych patients. The other alternative is jail, after they meet the criteria of a danger to themselves or others, and the County Attorney approves. The police are left to deal with the problem.

Severe budget cuts at the State level in Mental Health Resources.

People turning to illegal and legal prescription medication for every illness. Many people cannot cope with the reality of the economy. Losing their homes/family/jobs and turn to drugs as an escape.

The number of veterans from current conflicts returning with multiple psychiatric disorders. Also, overburdened criminal justice and mental health systems who cannot handle the 360 care needed to stabilize a person.

I think more people claim to have a mental illness as a way to receive benefits from the government.

Methamphetamine and other historical drug abuse.

Mental health not dealing correctly or having the ability to deal correctly with the problems. Too many repeats.

Coming from different jurisdiction.

I worked at the University of Virginia prior Police Department prior to arriving at the Richmond Airport. UVA being a level one trauma center experienced a host of mental health cases and also a mental health unit where various localities delivered people in crisis for observation or otherwise.

Believe the effects of long term or post-use of illegal drugs is beginning to tell its tale.

No notable increase.

Back in the 1970s, when we dealt with a mentally ill person, we generally did not fear bodily injury with weapons. Now we do, and I believe the public, and the families of the mentally ill, fear this also and that is why they call the police to handle what would not have been a police matter 35 years ago.

I am Sheriff of a small rural county. A company started a halfway house for people with mental health disables. The company is being paid to supervise the patients but that fail to do so. My deputies end up having to deal with the patients.

Lack of bed space and State resources are forcing local law enforcement to maintain physical custody or control for longer periods of time. When bed space is available, state law requires local law enforcement to transport to a facility that may be more than 50 miles away. These duties used to be the sole responsibility of the sheriffs' departments. It is a civil matter - not a criminal matter—yet they have put the responsibility on law enforcement.

Inability of doctors/family to keep mentally ill persons on a regular course of prescribed medication.

The implementation of a civilian mobile crisis team and crisis intervention team training for certain officers.

Early release from emergency petitions.

We are a new department in the area with enhanced service to our citizens.

It has remained about the same, however, I think mental illness is a broad category.

Change in law regarding 72-hour holds. Doctors are required to release the patient when there condition stabilizes, even if only a couple of hours have past. Mentally ill are being released back into public with no mandatory follow-up to insure that they have remained stable or are taking medications.

Fewer mental health resources for mentally ill persons, eventually causing them to be handled by the criminal justice system.

Lack of Quality LOCAL Resources

We have seen a huge increase in the number of parents who want to "commit" their children and call local law enforcement to assist with this.

During these stressful times with the economy there are more people that are suffering from mental illnesses. Many are drug or alcohol induced illnesses.

The abuse of prescription drugs has increased and I think this has had an effect with the increase of mental illness. The addiction of meth likely contributes as well.

The State's apparent inability to provide comprehensive treatment and facilities.

Drug induced psychosis both temporary and permanent as a side affect of use.

Increase in drug and alcohol abuse.

Magistrates and Dr.'s not screening properly.

Lack of or cut back of funds for indigent people.

The closure of mental health facilities and the main-streaming of mentally ill persons a couple of decades ago really impacted jails and police.

Recent war(s) have dramatically increased psychiatric issues amongst our veterans.

Failure of mental health personnel to do their jobs.

Chemical (Alcohol/Drugs) caused issues.

Legislation that guarantees mentally ill people who are not currently a danger to themselves or others to be in society without proper follow up regarding them taking their medications.

Lack of referral resources for the mentally ill.

With resources closing, they are dumped in our city to care for.

Lack of community mental health resources.

A secure residential treatment facility for persons released from the state mental hospital for criminal activity (but for a finding of mental illness) has been constructed in my city.

CIT Training at this department.

Our jurisdiction has a homeless shelter and many are “sent” here by “they” from across the County. Once in our jurisdiction, they tend to tie up some time - sometimes only after their arrival, sometimes on a regular basis.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX D. WRITTEN RESPONSES TO OPEN ENDED QUESTION #9

What has helped us is having a CPEP (Community psychiatric program) unit at a local hospital. Most of the time patrol ofc's [sic] are able to drop off the EDP without having to guard them like we used to have to do. The overall #s of EDPs seems to be growing however.

Traffic and parking enforcement.

Mentally ill persons tend to use police services and individual officers in particular when other professional services are not available. It's not unusual for a person in crisis to be told the next available date is 4-weeks out.

Time spent at the hospital sitting w/ EDP is very substantial and requires two officers. We are a small department and often only have two officers working!

Hospital security minimal which increases amount of officer time at ER for MHL Section 9 transfers. Safety of staff a concern when no security is available.

Because of the nature of calls involving mental ill person the time spent is often extensive. The time committed to stabilizing the call, then assessing the nature of the person's mental illness, followed by evaluating and searching for the type of care, finally in locating the proper facility to take the person consumes more than the routine or substantial time other calls normally require. Additionally, other factors such as the person refusing to go with the officer to a location certainly adds to the time.

Extensive if applying for Title 36 commit.

Other non-criminal calls for service--public assists, disturbances, traffic complaints, etc.

In California, it is very difficult to house someone who is a danger to themselves or others. These calls tie up officers for hours.

This respondent is the chief of a small city (20,000 pop). My officers spent no less than 2 hours every day (24/7) on our mentally challenged homeless population.

Often times patients are arrested under mental Hygiene laws and are taken to mental health treatment facilities and the offender beats the officer home and it becomes a repeated scenario until the offender finally injures themselves or some one else

We have a certified medical clinician that drives with our officers and respond to these types of calls.

Mentally ill persons threatening to harm themselves usually requires an evaluation by mental health. This ties up the officer until that is completed.

We have no local treatment facility we must transport at least one hour one way

Obviously, we are lacking bed space for patients. This has continued to decline since the early 1980's. An officer will spend a great deal of time with a problem/patient and then spend even a greater amount of time locating a mental health professional. Then there is a question of transport once the patient is triage. They (mental health system) lack sufficient funding up and down the line.

The Mentally ill have become a regular part of policing and require specialized training. The use of non-lethal devices are prohibited in many circumstances.

We have a fairly good system to which mentally ill persons can fairly quickly be taken to one of the local hospitals for treatment and mental health lodging. The problem is; often there is no room at the Inn and persons are triaged, told to take their medication and released resulting in the department often dealing with them again in short order.

Sexual contact between mentally ill individuals who are not able to give consent. The contact is often reported by case workers or live-in supervisors.

The amount of time an officer spends with a mentally ill subject has increased dramatically. We now spend an average of 8-10 hours on a mental case.

Question is vague and difficult to answer without doing a time analysis for the agency.

At the airport, only an occasional encounter; however at UVA, Officers can spend shift after shift babysitting a person in crisis, especially if there was no bed available.

Substance abuse, including alcohol-substantial time

Many times what should be handled in mental healthy system elevates in to criminal justice system as the only recourse to put some leverage over the individual and state to provide treatment

Court process only.

Have spent up to eight hours with a suicidal mental person awaiting to be released.

This obviously depends on the type of call.

Between coordinating with Human Services (now for “permission” to take someone into protective service), medical clearances required by jail or mental health facility, and overall time required to gather information.

For mentally ill persons, now routine time is up from a few years ago.

A substantial amount of time is spent on each call because of lack of services after hours which creates a lot of additional hours of care by officers in stead on trained mental health works.

Traffic accidents can use a lot of time if they are serious or alcohol involved.

The reason for the extensive time is due to our rural setting and a three hour or more drive to the nearest mental health care facility. We are obligated to transport.

Great amount of overtime being spent, as why we babysit a mentally ill person, (as required) we must replace officer with overtime cost.

Transportation to the proper facility and the wait at the local hospital can take as much as 5 to 7 hours just to get the patient accepted into a BHU.

Routine staffing must be supplemented for mental health calls requiring detentions due to facility and transportation requirements.

We have a limited ability to streamline the processes use in Domestic Abuse and Mentally Ill calls for service and response.

Calls for service account for a majority of our time.

Index crimes-extensive response and investigation time.

Assaults involving the mental ill.

Mental illness calls—overall require substantial amount of time and can typically run into an extensive amount of time.

Chapter 51 transports. This has a substantial impact on small agencies like ours with one officer on shift. We get stuck transporting patients after the initial placement and diagnosis by emergency medical staff. The facility is in Green Bay and the officer may be at the hospital and out of the area for most of his/her shift. The law has to change in this regard.

If the person with mental problems has to be hospitalized, the call takes extensive time, including travel to the out of town hospital and later court time which is out of town.

This is a serious issue where officers take mentally ill persons into protective custody and transport them to the local ER. From there the mental health facility is contacted by the ER doctor. The officer(s) must wait for a mental health worker to either respond or call which takes an extensive amount of time.

These types of calls take a lot of officer time. Normally when the person is contacted or located the officer has to spend time trying to get information or identify who the person is and then figure out if the person needs to be taken into custody for protection or released, The who process at times is very time consuming.

A great deal of time is consumed trying to “plug” a person into a resource that in good judgment can not be released. The “hoops” to access available resources are very consuming (IF you can find a resource fitting).

We have several officers trained as members of our Crisis Intervention Team, they sometimes spend more time; however, the results are also much better.

We primarily investigate workers' compensation fraud and also handle security for the Workers' Compensation Board's hearings. Additional time is being spent handling

situations involving injured employees who have developed psychiatric problems over the course of their claims and become disruptive and threatening.

We have a Crisis Intervention Team (CIT) system in place, in partnership, involving mental health providers and local emergency rooms (based on Memphis CIT model).

Improved health care has had an unexpected impact on the length of life associated with the mentally ill in effect, increasing the percentage of mentally ill within the population. This is also observed in the increased number of Alzheimer patients.

I say routine time. The actual calls do not take very long. Especially if your dept participates in a CIT program and you have very well trained officers. However, on occasion, getting a mental ill person some assistance can take some time due to work load of treatment facilities.

Our community works very closely with our mental health providers which helps reduce the amount time Law Enforcement is tied up on mental health calls. Valero instituted a Mobil Response to Law Enforcement which has drastically reduced the amount of time spent on mental health calls from 1700–0800 hours.

“Typical” calls involving mentally ill persons requires no more time than other types calls. However, there are more "atypical" calls, requiring more time.

Public intox.[sic]/vagrant; homeless/panhandling.

Transports of the subject can be from 30 min to 6 hrs Note we are a 4 Officer department with only one on duty at a time.

We have over an hour travel time if we transport a mental patient to the hospital. It is significantly longer if that person is also going to be arrested.

Driving complaints called in by cell phones.

Homeless- trespassers.

Mentally ill persons can take 8 hours or more to resolve as our county has only 1 hospital that serves as a triage center.

Public Intoxication calls have increased.

Officers pick up problem individuals don’t know what to do with them, Coroner called order of protective custody issued officer then has to transport, etc. time consuming.

Officers simply can't leave a mentally ill person once they determine that a crime has not been committed. They must stay until resources become available to the person. If they simply leave, the mentally ill person may, once again, threaten to harm themselves or again do the act that got the police called in the first place.

It takes more resources and time on small departments that are already over extended.

Within a small department additional officers have to be called in when dealing with a mentally ill person. This is a significant amount of time consumed, and financial burden to provide ample manpower.

We spend a LOT of time waiting for medical clearance or transport to a facility. The actual time to take someone into custody is not usually that great. It's the waiting.

Gang and graffiti calls Public Intoxication calls, some of which may be a result of the mentally ill.

The process the go through when dealing with a person that is mentally ill is very time consuming. The whole process of a Mental Incapacitation Warrant and the transport to a psychiatric facility after hours takes around 8 hours for an officer to deal with.

When Volunteer Crisis Unit is available, officers' time commitments drop dramatically as The Crisis Unit handles transport and commitment actions.

For the mentally ill, if the person is in fact ill, it takes an extensive amount of time.

With less beds in the state, and the distance for travel for a bed, we are seeing extensive time frames with travel and the wait.

On average our Department spends 6.75 hours per Emergency Detention Order.

Excessive time if placement is required (typically about half the calls) Substantial time if not.

Families do not seem to be interested in assisting with these mental health issues and want local law enforcement to handle.

Substantial time spent on juveniles that are diagnosed with mental illness and assisting them and their families try to find an agency that can and will assist them. Department of Human Services is basically a band aid treatment for these young ill people.

Normally we spend up to 3 hours dealing with a person who claims to be mentally ill. this is from the time we transport to the hospital, stay with them in the ER, doctor examination, and referral by a judge or a release.

We are required by the code to take them to the hospital if we believe they are a danger to themselves or someone else. Once we have them there, it seem to take hours before they are actually "committed" or until they find a place to put them in.

I believe that a lot of our calls dealing with some of the public appear that they have some kind of mental issues and we would not be dealing with them if they would get help or just grown up and act their ages. Some people need pills to help themselves and they do not even know that they need the help.

Routine time per call, but more calls for service.

Medical evaluation, mental hearing and committal process, transport to available bed space.

Substantial time being an hour or two so if your definition is different you may need to put my responses in the extensive time if that covers 1 or more hours, not sure of your definition of substantial and extensive.

Most of the calls that I deal with is either suspicious people in either high burglary/entering auto areas, or people behind others that might possibly be driving under the influence.

Waiting for a Mental Health Gate Keeper to evaluate the person needing treatment. This can be a one hour wait to up to a four plus hour wait.

IF EOD is done time spent with transportation is increased 4 hrs for 2 officers assigned. 8 man hours at the least.

Our officers spend hours waiting in the hospital for Edwin Fair to arrive and then another hour for the evaluation. Officers then transport to hospitals from OKC, Norman or recently Ft Supply taking NO LESS THAN 8 hrs for a mental health call. This then takes the only officer on duty away from the city for a whole shift or more and requires calling in an off duty officer.

Mentally ill people must first be transported to a local Hospital approximately twenty miles away. The Officer must wait and then make contact with a mental health provider, and then transport that person between one hundred and two hundred miles. The Officer must then wait for the person to be interviewed and then admitted. It is a all day thing.

It takes Edwin fair sometimes 4 to 6 hours to arrive at our local hospital. This is time that officers are tied up tending to mental health issues.

APPENDIX E. WRITTEN RESPONSES TO OPEN ENDED QUESTION #14

We have access to the County Psych unit for people who meet the criteria for being admitted, but for those who don't, we, as most law enforcement have no other immediate mental health facilities or professionals available.

We have a paid paramedic that deals with these situations.

Unwillingness of hospital staff to detain and evaluate.

Lack of (reduced) funding for services for those with mental illness.

Status of the facility - may require transport to a facility with an available bed.

No standard procedures state wide to deal with these problems. It is dealt with differently in every jurisdiction.

Our community, Santa Clara County, CA, provides voluntary access for people short of “danger to self, etc.”

Excessive standby time waiting for evaluation.

I've been a police officer for 37 years in 3 agencies (LAPD), So Pasadena, CA, and Mammoth Lakes, CA. In California funding for mentally ill patients has dramatically decreased over this time resulting in people that should be institutionalized or at least getting competent out-patient care, living in society. Many of them choose to be homeless. I don't have a homeless population in

Mammoth Lakes (8000 foot elevation ski resort), but I would estimate that 80% of the homeless in Los Angeles are mentally ill. Failure to adequately fund mental health programs is resulting in the needless deaths of the mentally ill and unnecessary crimes against the rest of the population.

Mental health releases the patient within hours and we deal with the same problem again and again.

There are plans and criteria in place but in a large geographic rural area the services can be few and far between.

Although referrals are easily made, the voluntary involvement of the mental health patient is necessary. If they are not voluntary, and not a danger to themselves there is little that can be done with them.

Intoxication levels of mentally ill. Mental Health case workers will not evaluate people until they are sober. There are no secure facilities for those waiting to get sober.

Use of alcohol by many.

Form preparation and witness appearances for next-day Mental Health Court Proceedings.

Limited number of beds in mental health facilities due to budget cuts.

The evaluated persons usually have been consuming alcohol which will alter the criteria to complete a report evaluation.

Law Enforcement “Is not Qualified.” Must have Mental Health Agency interview, screen, make arrangements for commitment, ect. Law Enforcement must “Stand By.”

No mental health treatment facility or resources available in my county (Douglas County, Oregon).

This is not necessarily an obstacle as much as a non-solution.

The only obstacle that exists--and it's a big exception—is that when the mentally ill person is not dangerous to self or others, we have resources to refer him/her to, but they often will not accept those resources.

The obstacle we most often face is unavailability of bed space for individuals.

We are a University Police agency and have more resources than most because of the on-campus counseling center.

No problem referring them but the problem is fining beds or places that will treat them.

Mobile services exist to deal with MH clients. However, the MH system is overloaded and only those most critical get admitted. Chronic MH clients remain on the street.

Generally a very long wait for acceptance to treatment facility.

Takes to long to release to the center.

Bed availability for the person in-crisis!

Only restriction is after hours assistance; only will evaluate those who are an threat to self or others.

Many of our officers are trained in Crisis Intervention and are more prepared to help with Mobile Crisis and other services.

In the past, if an officer could articulate to the crisis counselor that a mental subject was a danger to himself or others then they would respond and make arrangements for bed space. Now, they rarely come out unless it is an uncontrolled violent person. In some cases, a crisis counselor has asked to speak to the mental subject over the officer's cell phone and "diagnosed' the mental subject based on that short phone conversation. The problem here is that the officer has made observations and noted the comments made by the mental subject. Most officers would not ever release a dangerous person despite whatever diagnosis is made over the phone. So, the mental subject either gets arrested or goes to a local hospital for evaluation. This wastes resources and takes more of the officer's time—all in the name of protecting one's self from liability.

After hours and on weekends, referrals are non-existent unless there is a crisis.

Limited or no availability of mental health services in the jail facility.

We are currently in the process of forming a CIT council and are sending officers to training to deal with those individuals in mental crisis.

Should streamline process to take person to mental health for evals [sic].

I don't want to imply that we have no obstacles, but we are pretty fortunate in our area to have a number of resources on which to rely for help. Obviously the gravity of the situation dictates the type of support we need.

Federal law enforcement agencies do not have the imminent danger authority and thus cannot legally detain psychotic persons under the state statue. Must wait for local law enforcement to be dispatched, arrive and take action.

BAC level—if above a .08 BAC they will not evaluate.

In Nevada, the Sheriff is required to transport mentally ill subjects to the State hospitals. These trips can take 5–8 hours one way due to the great distances we have to travel.

We have a lot of mental health patients walking away from health services because of the length of time it takes to complete an evaluation or find a bed in a mental health facility. Most of the time the patient is under the influence of drugs or alcohol, which takes and extraordinary amount of time for detox [sic] before the evaluation—this causes a lot of anxiety to the patient and they become a larger time constraint to the police department.

When subjects suffering from mental illness are confronted by L.E. in the community if they have been abusing alcohol or illegal drugs most mental health practitioner will not assess these individuals regardless of behavior or symptoms until they are “sober.” This requires prolonged periods of police officers and jails having to hold these individuals or protect them in medical facilities until mental health practitioners provide an assessment.

Hospital is located in neighboring town. Not in our town. As is the local mental health agency that covers our catchment area.

Mental Health facilities are overwhelmed. Police take persons in to a facility based upon troubling behavior. They are often released before the officer can finish the report.

Uncooperative Emergency Department at the local hospital.

We refer them to facilities such as Emergency Mental Health (EMH) because they attempt to commit suicide and then for whatever reason are let out 6–12 hours later. I have questioned this as a Police Chief and have been told that it is difficult to predict if a person will actually ever commit suicide. What the hell do we bother bringing them to the hospital for then. I could say the same thing in their living room and save the trip to the hospital...

Lack of public facilities to treat person who do not have insurance.

Lack of room at mental health facilities.

No procedural obstacles but much time needs to be devoted to these referrals.

The biggest problem does not lie with law enforcement. The problem is found when citizens can't get assistance due to the “danger” requirement. When they have no where else to turn they call the police to handle the issue. This takes a large amount of time to then pull strings to try and get help for the citizens.

Our system here requires a medical evaluation before acceptance, consequently its easier to arrest and put into jail since they don’t need a medical / physical exam prior to acceptance.

What normally happens is we spend time with the individual until they have calmed down and can be let go. We end up being the mental health service.

Physical distance. Facilities are 90 to 400 miles away from this jurisdiction.

We are in contact w/ a mobile crisis team or a mental health facility at the time of the call and intervention are started immediately.

Very difficult to get mental health officials to listen to you while you are in the field.

Catch and release attitude of MH professionals, i.e. anti-suicide contracts, promise not to do it again, etc.

Limited number of in-patient beds available for those who do meet the “dangerous to self criteria.”

These people are often released simply because there is no bed available.

When issues come about, we are able to notify a professional in the city about the case at hand.

The evaluation process is too cumbersome and lengthy. The local hospital contracts the service to a local provider and the wait time on top of the evaluation time to the final decision is considerable—often with no results.

We have a policy that we need to contact mobile crisis worker who then assists in the evaluation, especially important on the threat to commit suicide, not an actual attempt. If there is an actual attempt, dispatch will connect us with the MCW and they will OK Chapter over the phone.

New requirement in State for Human Services "approval" to take someone into protective custody.

All too often these individual beat us back home backs the criteria is not met by the time a doctors arrives at the hospital to treat or see the individual because they have had time to calm down or they know the buzz words the doctors are looking for to release them quickly.

Licensed hospitals unwilling to accept the patient.

Lack of beds is key. This results in fast release, even when there is substantial reason to hold. Fast release equates to no effective intervention and a high likelihood of seeing that person again.

Person not evaluated if under the influence of alcohol or other drug.

What to do with these subjects after hrs (when treatment facilities close) is the issue.

Health agencies that fail to want to get involved, or only do so when it is convenient to them.

If intoxicated or on narcotics they must be cleared before they will admit them into a mental health facility to ensure that is not the cause of their irrational behavior.

Wisconsin's state statute is very vague in the responsibilities of law enforcement and the service providers.

Unless an “emergency” exists the time between referral and assistance is too great and often escalates to the level of emergency before assistance can be offered.

Minimal in-patient stays in state facilities.

Our jurisdiction is extremely rural. If a person requires in-patient treatment, then it is a four hour drive to the hospital, and our ambulance service will not transport. Given that most evaluations take 2 hours at a minimum that leaves an officer out of service for a minimum of 10 hours. Because we have only 8 officers including the Chief, it also means calling someone in on their days off to make the transport.

The number of placement beds available to Law Enforcement is limited. Many people are evaluated in our crisis center, found to need assistance and then there is no place for them to go. I'm not sure if this is just a Colorado issue or not. I suspect not.

Statutory requirements are placed on Law Enforcement, limiting discretion. Distance from a Rural Community to the Point of Service.

Lack of mental health professionals ability or willingness to assist with calls for service involving mentally ill subjects especially after hours.

If client does not meet target populations or have insurance no help available.

I would state that in most cases we receive timely assistance. However we are a small agency and manpower is immediately and seriously drained especially if the people exhibit and kind of combativeness.

County-wide Crisis Outreach Team centered out of local hospital.

We do refer but they are released within an hour or so in most cases.

Lack of inpatient beds at mental health facilities.

The state of Ms does not have a law enforcement committal law. The commitment must be done by a blood relative and a medical doctor through Chancery Court.

Immediate referrals are typically driven by an emergency need—and cared for at that time. The problem is the assistance provided is limited in duration—just long enough for an episode to subside—address with medication.

Although my jurisdiction (NH) has a mental health court there is not currently a pre-arrest diversion to a treatment center, which I feel is needed for minor criminal offenses committed by people with mental illness.

State laws outdated.

The obstacles usually are determined by the time of day the referrals are made.

Some of those who are taken into custody have been released back onto the street by Mental Health workers.

We are very fortunate that our Dept. of Community Programs will send a worker to the hospital and meet with the Officer and patient to evaluate the person. We have established a safe house for many of these people who don't need a full blown trip to a mental health facility but need someone to sit down with them and develop a plan and work with to help them thru their problems. Our county has been able to save a lot of money and our time with this program.

Refusal of mental health to work with persons who have a substance abuse issues. no help for the dual diagnosis patient.

Referrals can be made, however unless the person is an immediate threat to himself or others, the person usually is on a volunteer basis.

After forming the Crisis Intervention Team local facilities found out we knew the regulations related to their responsibilities and they started working with us. There are still some obstacles related to some E.R. doctors, for those we that are not a danger to themselves or others there are limited beds available and the state continues to cut funding to the support agencies.

Lack of facilities that have a place to house and treat mental patient.

Lack of mental health treatment funding.

Must be evaluated by an E. R. doctor for referral or at the request of a family member to a judge i.e. by a relative to a probate judge.

While no obstacles exist, referring to mental health services does little to protect the public safety. Mental health professional simply coaxed the client into taking their medications while at the facility and then sends them back home. Often times we will just have to deal with them again the next day.

We do not transport. We turn these cases over to local authorities after initial response.

Our County has a Crisis Intervention Team set up using the Memphis Model that has really streamlined the process.

We have the knowledge, training, and ability to respond.

Sometimes facilities are short on staff and an officer will have to wait. Can be frustrating but for the most part we find great cooperation.

I can say because of the cooperation and the Mobil Response to Law Enforcement we really don't have any obstacles that prevent the agency from getting the consumer the treatment they need.

We do not transport and typically call on local law enforcement to assist

Lots of services are available but no single point of contact for "admission" into the system. Requires law enforcement to understand the variety of services available to be able to plug the mentally ill person into the system.

Some locations won't accept mentally ill persons under influence drugs or alcohol.

Organic brain injury patients not considered mental health cases: blurring availability of resources and long term placement.

We have referral services available which are pretty good and responsive.

We must call a metal health case worker, for to OK to commit or county will not pay for it…they will listen to what we have to say...but its there call and they find a bed for the person.

No support from the mental heath doctors. You take them into the hospital and it takes 4-6 hrs to admit to the ward if you are able to at all.

New law in WI Leaving the final say as to performing a mental health commitment to the department of human services, vice law enforcement (which was the norm for that past 30 years).

Mental Health (legitimately) will not assess a person who is under the influence of alcohol or drugs. This often requires an officer(s) to guard the patient until they are sober and mental health can then evaluate.

The time involved in making the referrals and having to stay with them.

Local hospital on diversion and finding alternate.

Our jurisdiction gives the medical professional the ability to release the person after determining they are not dangerous to self or others. This has caused problems in rare situation when they make a bad call.

Age, Finding Mental health services for a juvenile in the area is difficult. Adult sites won't accept juveniles.

Mental Health Services will not evaluate individual if they have used alcohol or drugs. We have no where to go with the EDP at that point.

Hospitalization must be the “least restrictive alternative,” which is a very high standard to meet.

During non-duty hours the mental health professionals operate on an “on-call” basis. Most time there is an extremely slow response.

Inability to locate a judge for emergency order.

HEPA laws.

In my area two sheriffs deputies are also coroners agents and are authorized to evaluate for orders of protective custody, very useful!

Intoxicated subjects are not admitted to a mental facility regardless of their history or mental illness.

Police seem to be the only resource that is mandated to be trained and deal with these individuals in the field, usually because there is a disturbance that prompt the call for these individuals. However, EMS, local hospitals, etc, are not required the same level of participation in the de-escalation of a mental event as the police are.

MHMR has to send out a field rep to evaluate the person which requires an extensive waiting period for their arrival.

Our closest inpatient facility is 200 miles.

Distance to nearest mental health care facility is a burden.

Many mental health care responders have become accustomed to many patients who are not really mentally ill- but feel like they are in a crisis because they don't want to deal with life in general. This is a difficult class of individual to deal with. They aren't mentally ill—but they consume public services at an alarming rate leaving fewer resources for legitimate cases.

Have to drive 45 miles just for an evaluation with MHMR which ties up two (2) officers for 4–5 hours.

We do not have a difficulty getting a community crisis response person such as MH-MR but it does take time and we do have to babysit at the hospital or take the time to complete commitment paperwork.

MHMR often dumps their responsibilities upon police, i.e. we have a male who calls at least 3 times per week and tells the dispatchers he needs an officer to bring him cigarettes. When we refuse, he threatens to kill himself. MHMR will not address the issues with him rather MHMR tells the police that "we" need to go talk to him.

MHMR refusal to come out and evaluate person in a short amount of time, 3–4 hours is to long.

No mandate for mental health services to accept a person brought in by law enforcement unless they are willing to self commit. To get a commitment there has to be a plan in place to harm themselves or others and the mental health officer has to work out a hold and make sure there is a bed free. There are far too many people who are off their medication for a number of reasons encounter by law enforcement and in need of assistance getting back on track.

The closest state mental health facility is approximately 300 miles from my jurisdiction. The closest private mental health facility is 100 miles. The private facility is quite difficult to work with.

Hospital and mental health facility readily available.

As a school-based law enforcement agency, many our student population with mental health or related conditions are often managed through educational need procedures. Students or individuals who are a danger to themselves or others are referred to Mental Health Officers or referred for evaluation.

We can get them to the psych unit, but the Drs let them go due to the “dangerous to self or others” criteria.

Due to State budget cuts over the years the number of Mental Health facilities has been decreased while the cost to operate these facilities has steadily increased. There area not enough spaces available for those in a mental health crisis. Private facilities will often deny care if the person is violent which means they end up in the jail system.

This problem is greatly exacerbated by drugs. Is the patient mentally ill, or simply chemically dependent? How can we differentiate the two, and why should we have to?

A 9-5 “come to my office” orientation by care providers; no mental health resources respond to the home or street in our community.

In Hennepin County resources are stretched, but available. It is not an exact science and people with mental illness have great range of symptoms. There is also due process for them, so some who really should take advantage of mental health services opt not to.

No juvenile facility in region.

The whole process is too. Takes too long to have the patient evaluated. Takes to long to have the committal paper file with the court. Takes too long to find a facility. Takes too long to have the paper obtained once a judge signs it. Then when the individual makes it to the next facility we get to go through the same thing and length of time on the other end. On average it takes approx 10 hours. With a small department we have 2 or 3 people working. Basically one of my officers is tied up in this process and I have another officer at time working without backup.

We are a small department and often only have one officer on duty at a time. This is VERY dangerous to have only one officer handle a mental health case. When possible, we have more officers respond.

The service that used to assist us and who we could always refer clients to was DHS. That is no longer an option.

We have a hospital in our town that we transport the mentally ill to.

Legal restrictions for necessary exchange of information regarding mentally ill prone to crisis. There is no database for caregiver, family members, trusted friend, etc to help officers get the person to a safe environment.

If they have no way to pay for services they are let go.

There are no services available in our area to person without medical insurance if they are not an immediate threat.

Also on a different note, we need to stop having the police be the one's who transport the mental subjects to the Mental Health Hospitals, because if they have any kind of medical issue on the way to same, then we the police are not equipped to handle any health issues that may come up during the transporting of these mental subjects. It could be a law suit just waiting to happen. Thank God we have not had any in Delaware at this time that I know of.

In the State of Wisconsin Law Enforcement no longer possesses the ability to directly commit under Emergency Detention. That ability was taken away by law and now rests with the County Mental Health Services for the County and there seems to be a difference in opinion as to who should be committed.

Small agencies do not have manpower to transport, sit at the hospital while medical clearance is obtained.

Despite the fact that the stated position of the government and other organizations (employers, etc.) is that people who obtain assistance for mental illness will not have that held against them in the future, those same organizations do, in fact, hold treatment for mental illness against those persons, resulting in a reluctance of anyone to become involved in mandating treatment for anything other than an extreme emergency.

Time spend on medical eval [sic] and finding bed space.

The problems are not so much the obstacles but rather when we get them to the hospital we have to sit with them, depending on the incident that occurred, and we have a limited about of officers on duty. And once they are committed, there is a matter of time before they are released and we end of dealing with them again in another situation.

Limited mental health/hospitals locally which requires officer time to transport to a facility quite a distance away.

Waiting for the Mental Health Gate Keep to arrive at the hospital this can be a one hour wait all the way up to four plus hours. Then have to wait for the person to be found to be medically fit for transport to a mental health facility. Then have to wait for the Gate Keeper to locate a mental health facility to take the person, this can be 45 miles away, up to over 200 miles away. In some cases even transport out of state.

We use red rock, they are very efficient.

State budget cuts have reduced bed space available.

We are generally only a taxi cab who also has to return to the facility and pick the subject up for a court hearing when required.

The immediate referral only applies when an individual is a threat to their self or others. It does not apply to individuals who are obviously in need of treatment but have not threaten either to harm themselves or others.

The local mental health professionals do not communicate much with law enforcement and do not have any liaisons who mediate between police and MH professionals. Police feel as though we are profiled as a bunch of mean people with guns and badges.

May be referred but usually immediately release.

In our jurisdiction our paramedic unit transports all mentally ill people we have placed on an emergency hold.

Crises Intervention Training has assisted Law Enforcement with the ability to Baker Act mentally ill person(s). There are still times that we are unable to Baker Act people unless they meet the criteria. We need clarification on voluntary vs. involuntary.

No referrals for intoxicated persons in need of mental health help. Officers have to set and guard the person until they are sober before the mental health professional will do any evaluation. Usually 6–10 hours for that officer to be off the call rotation for the department before any mental health help for the person.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX F. RESULTS BY STATE (HYPERLINK)

Appendix F can be accessed by clicking here.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX G. RESULTS BY POPULATION (HYPERLINK)

Appendix G can be accessed by clicking here.

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF REFERENCES

Abramsky, S. & Fellner, J. (2003, October). *Ill-equipped: US prisons and offenders with mental illness*. New York: Human Rights Watch.

Amador, X. F., & Gorman, J. M. (1998). Psychopathologic domains and insight in schizophrenia. *Psychiatric Clinics of North America, 21*(1), 27–42.

Bachrach, L. L. (1976). Deinstitutionalization: An analytical review and sociological perspective. (Stock No. 017-024-00530-4). Washington, DC: Government Printing Office.

Bloom, J. D., Krishnan, B., & Lockey, C. (2008). The majority of inpatient psychiatric beds should not be appropriated by the forensic system. *Journal of the American Academy of Psychiatry and the Law Online, 36*(4), 438.

Burti, L. (2001). Italian psychiatric reform 20 plus years after. *Acta Psychiatrica Scandinavica, 104*, 41–46.

Bonovitz, J. C., & Bonovitz, J. S. (1981). Diversion of the mentally ill into the criminal justice system: The police intervention perspective. *American Journal of Psychiatry, 138*(7), 973.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J., Johnson, S., & Shore, M. F. (1981). Overview: Deinstitutionalization of psychiatric patients, a critical review of outcome studies. *American Journal of Psychiatry, 138*(6), 736.

Breakey, W. R., Fischer, P. J., Kramer, M., Nestadt, G., Romanoski, A. J., Ross, A., & Stine, O. C. (1989). Health and mental health problems of homeless men and women in Baltimore. *JAMA, 262*(10), 1352.

Cilluffo, F. J., Cardash, S. L., & Whitehead, A. J. (2006). Radicalization: Behind bars and beyond borders. *Brown Journal of World Affairs 13*(2), 113.

Clark, R. E., Ricketts, S. K., & McHugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services, 50*(5), 641.

Dawson, J. M., Langan, P. A., & United States. Bureau of Justice Statistics. (1994). *Murder in families*. Washington, DC: US Dept. of Justice, Office of Justice Programs, Bureau of Justice Statistics.

De Girolamo, G., Picardi, A., Santone, G., Falloon, I., Morosini, P., Fioritti, A., & Micciolo, R. (2005). The severely mentally ill in residential facilities: A national survey in Italy. *Psychological Medicine, 35*(03), 421–431.

Dini M., & Jerusum S. Sacco. (1988). Matto-follie d'Italia, l'assistenza psichiatrica a dieci anni dalla 180. *Europeo, 30*: 225–36.

Dowty, D. (2011, May 18). Cops shoot armed mentally-ill man 8 times after he set fire to his home, threatened firefighters. *The Post Standard*. Retrieved February 22, 2011 from, http://www.syracuse.com/news/index.ssf/2011/05/benjamin_campione.html

Economist. (2010, July 22). Briefing rough Justice in America, too many laws, too many prisoners.

Ennis, B. J. (1972). Prisoners of psychiatry: Mental patients, psychiatrists, and the law. New York: Harcourt Brace Jovanovich.

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression analysis. *PLoS Med, 5*(12): e237. doi:10.1371/journal.pmed.0050237

Ferracutti F. Seventh criminalological colloquium, secretariat memorandum. Strasbourg: World Health Organization. 1885:55–69.

Gatti U. Seventh criminalological colloquium, secretariat memorandum. Strasbourg: WHO, 1885:72(a,b).

Ghaemi, S. N., & Rosenquist, K. J. (2004). Is insight in mania state-dependent?: A meta-analysis. *The Journal of Nervous and Mental Disease, 192*(11), 771.

Gillig, P. M., & McQuistion, H. L. (2006). *Clinical guide to the treatment of the mentally ill homeless person*. New York: American Psychiatric Publishing, Inc.

Grinfeld, M. (1993, July). Report focuses on jailed mentally ill. *Psychiatric Times*.

Gutierrez, F. J. (1996). Who is watching big brother when big brother is watching mental health professionals: A call for the evaluation of mental health advocacy programs. *Law & Psychology Review, 20*, 57.

Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services, 49*(4), 483.

Leys, T. (2011, February 22). *Prisons chief: Mental health reform could save money*. Retrieved March 30, 2011, from http://blogs.desmoinesregister.com/dmr/index.php/2011/02/22/prisons-chief-mental-health-reform-could-save-money/

Liptak, A. (2008, April 24). Inmate count in US dwarfs other nations. *The New York Times*.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909.

Morales, M., & Lauinger, J. (2010, November 21). Cops shoot armed mentally-ill man 8 times after he set fire to his home, threatened firefighters. *NY Daily News*. Retrieved February 22, 2011, from http://www.nydailynews.com/ny_local/2010/11/21/2010-11-21_cops_shoot_armed_mentallyill_man_8_times_after_he_set_fire_to_his_home_threatene.html

McNiel, D. E. (1994). Hallucinations and violence. In J. Monahan & H. J. Steadman (Eds.), *Violence and Mental Disorder: Developments in Risk Assessment*. Chicago: Chicago University Press.

Mechanic, D., & Rochefort, D. A. (1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology, 16*, 301–327.

New York Times (2011, January 9). *The Arizona Shooting and What Lead Up to It*. Retrieved April 10, 2011, from http://www.nytimes.com/interactive/2011/01/09/us/reconstruct-graphic.html

Nieves, E (2010, February 20). San Francisco hires social workers for homeless. *Associated Press*. Retrieved April 10, 2011, from http://www.signonsandiego.com/news/2010/feb/20/san-fran-library-hires-social-worker-for-homeless/

O'Sullivan, M. (2009). Criminalizing the mentally ill. *America, 166*(1), 8–13.

Owen, G. S., David, A. S., Hayward, P., Richardson, G., Szmukler, G., & Hotopf, M. (2009). Retrospective views of psychiatric in-patients regaining mental capacity. *The British Journal of Psychiatry, 195*(5), 403.

Olfson, M., Marcus, S.C., & Doshi, J. A. (2010). Continuity of care after inpatient discharge of patients with schizophrenia in the medicaid program: A retrospective longitudinal cohort analysis. *The Journal of Clinical Psychiatry, 71*(7), 831–838.

Parker, J. S. (1988). Criminal sentencing policy for organizations: The unifying approach of optimal penalties. *American Criminal Law Review, 26*, 513.

Pelfrey Jr, W. V. (2007). Local law enforcement terrorism prevention efforts: A state level case study. *Journal of Criminal Justice, 35*(3), 313–321.

Penrose, L. S. (1939). Mental disease and crime: Outline of a comparative study of European statistics. *British Journal of Medical Psychology,* 18, 1–15.

Perlin, M. L. (2003). Therapeutic jurisprudence and outpatient commitment law: Kendra's law as case study. *Psychology, Public Policy, and Law, 9*(1–2), 183.

Quanbeck, C., Frye, M., & Altshuler, L. (2003). Mania and the law in California: Understanding the criminalization of the mentally ill. *American Journal of Psychiatry, 160*(7), 1245.

Reaves, B. A. (2010, December 2). *Local Police Departments, 2007*. Bureau of Justice Statistics NCJ 231174. Retrieved April 10, 2011, from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1750

Reuland, M. M. (2005). *A guide to implementing police-based diversion programs for people with mental illness*. Atlanta: National GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.

Robins, L. N., & Regier, D. A. (1991). *Psychiatric disorders in America: The epidemiologic catchment area study*. New York: Free Press.

Saillant, F., & Genest, S. (2007). *Medical anthropology: Regional perspectives and shared concerns*. Hoboken, NJ: Blackwell.

Richard Schickel. (n.d.). Richard Schickel Quotes. Retrieved Tue February 15 05:43:14 2011, from http://www.great-quotes.com/quote/375550

Schonlau, M., Fricker, R. D., & Elliott, M. N. (2002). *Conducting research surveys via e-mail and the web*. Santa Monica: CA: RAND Corporation.

Shore, D., Filson, C. R., & Rae, D. S. (1990). Violent crime arrest rates of white house case subjects and matched control subjects. *American Journal of Psychiatry, 147*(6), 746.

Stephan, J. J., Karberg, J. C., & United States. Bureau of Justice Statistics. (2003). *Census of state and federal correctional facilities, 2000*. Washington, DC: US Dept. of Justice, Office of Justice Programs, Bureau of Justice Statistics.

SurveyMonkey. Cloud View. Retrieved April 1, 2011, from http://help.surveymonkey.com/app/answers/detail/a_id/4500/kw/tag%20cloud/session/L3NpZC9FVm1mTCp1aw%3D%3D

Swartz, M. S., Wilder, C. M., Swanson, J. W., Van Dorn, R. A., Robbins, P. C., Steadman, H. J., Moser, L. L., Gilbert, A. R., & Monahan, J. (2010). Assessing outcomes for consumers in New York's assisted outpatient treatment program. *Psychiatric Services, 61*(10): 976.

Szasz, T. (2003). *Liberation by oppression: A comparative study of slavery and psychiatry* Piscataway, NJ: Transaction Publisher.

Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the epidemiologic catchment area program. *American Journal of Public Health, 80*(6), 663.

Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness: Comparison with the national crime victimization survey. *Archives of General Psychiatry, 62*(8), 911.

Tonry, M. (1999). Why are US incarceration rates so high? *Crime and Delinquency, 45*, 419–437.

Torrey, E. F. (2010) *The insanity offense: The: How America's failure to treat the seriously mentally ill endangers its citizens*. New York: W.W. Norton.

Torrey, E. F., Geller, J., & Staff, T. A. C. (2008). *The shortage of public hospital beds for mentally ill persons*. Arlington, VA: Treatment Advocacy Center. Retrieved February 12, 2011, from http://www.mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf

Treffert, D. A. (1981). Legal "rites": Criminalizing the mentally ill. *Hillside Journal of Clinical Psychiatry, 3*(2), 123–137.

Violence, P. (2010). Prisons and terrorism radicalization and de-radicalization in 15 countries. London: International Centre for the Study of Radicalization and Political Violence, Kings College.

Whitaker, R. (2003). Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill. New York: Basic Books.

White House. (2002). National strategy for homeland security. Washington, DC: author.

THIS PAGE INTENTIONALLY LEFT BLANK

INITIAL DISTRIBUTION LIST

1. Defense Technical Information Center
   Ft. Belvoir, Virginia

2. Dudley Knox Library
   Naval Postgraduate School
   Monterey, California

3. Senator William J. Larkin Jr.
   New York State Senate
   Albany, New York

4. Senator Catharine Young
   New York State Senate
   Albany, New York

5. Assembly Member Aileen M. Gunther
   New York State Assembly
   Albany, New York

6. New York State Association of Chiefs of Police
   Schenectady, New York

7. International Association of Chiefs of Police
   Alexandria, Virginia