Title: Interactions between the police & persons with mental illnesses

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# Abstract:

This paper examines the interactions between the police and citizens with mental illnesses. There has been a rise in the numbers of interactions between both parties, particularly in the form of emotional disturbance calls. This paper will concentrate on such interactions, as well as the use of force by police against persons with mental illnesses. The changing role of the police means that they act as service providers to those with mental illnesses. This role means that police have three options to conclude an emotional disturbance call or mental breakdown of a person with a mental illness. These options are to arrest, to send the individual into civil commitment or to resolve the situation informally. The ADA also plays a role in such interactions including reasonable accommodations. The paper also addresses the role of guns, and in doing so considers Ireland given the lack of guns on the part of police and their less forceful treatment of those with mental illnesses. Finally solutions such as the use of CIT training will be provided.

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# Introduction

The central aim of this research paper is to investigate the interaction between police and those with mental illnesses. This relationship is currently understudied[[1]](#footnote-1) and there is a lack of understanding around the role police should play in the lives of citizens with mental illness. More specifically, the paper will focus on the use of force by police against those with mental illness. The paper is not solely concerned with how police can mistreat people with mental illness (for example through the use of excessive force), but also with how they can help (for example by putting individuals in touch with mental health services). The primary goal of this paper is to focus on how relations between this population and the police can be improved.

It is well documented that disproportionate numbers of individuals with mental illnesses (particularly severe mental illnesses such as bi-polar disorder and schizophrenia) are disproportionately incarcerated in jails and prisons.[[2]](#footnote-2) One study found that at least 50% of US prisoners have a mental illness.[[3]](#footnote-3) However, in terms of the frequency of interactions between the police and those with mental illness, there is an absence of data in this area.[[4]](#footnote-4) It is currently difficult to ascertain the numbers of individuals that come in contact with the police that have a mental illness, as well as the numbers of persons with mental illness that are arrested or sent to civil confinement. However, when we consider the vast overrepresentation of prisoners who have a mental illness in the criminal justice system as a whole, and considering that only a very small percentage of those who interact with the police actually get arrested, charged, brought to trial, convicted, and sentenced to prison, it is clear that the number is very high.[[5]](#footnote-5)

Not only is this paper concerned with such quantitative elements of when and how often police interact with those who have mental illnesses, but it is also concerned with the qualitative nature of those interactions. These interactions are qualitatively different than those police interactions with those who do not have mental illnesses.

A distinctive type of interaction between police and the mentally ill is what is termed emotional disturbance calls. Emotional disturbance calls are where members of the public or family members call the police to report bizarre, and in a smaller number of cases, criminal behavior.[[6]](#footnote-6) Police are called to the scene and are tasked solely, or in some jurisdictions with the help of a mental health professional, to resolve the disturbance as peacefully as possible. This paper will focus on these types of interactions and examine the possible outcomes, namely arrest, civil commitment or an informal solution. More generally, the paper will examine both the criminal law as it pertains to individuals with mental illnesses, but also civil mental health law. Furthermore, it will also, in part, undertake a comparative analysis with Ireland, given the differences in how police interact less aggressively with less force due to the absence of guns on the part of the Irish police.

In section A (1), this paper will examine the role of the police generally and particularly as they interact with those who have mental illnesses. In section A (2), the author discusses the extent of the problem at hand, namely how the police currently treat those with mental illness. We then turn in Section B to examine the extent of these interactions. Section C deals with the three potential outcomes that are possible to come out of interactions with police for those who have mental illness (namely arrest, civil commitment or an informal solution). Section D explores the use of force by police against those who have mental illnesses. Section E examines the role reasonable accommodations, under the Americans with Disabilities Act, can play. Section F confronts the controversial topic of guns and mental illness. Section G undertakes a comparative analysis with Ireland. Finally, Section H outlines possible solutions to the problems discussed in the paper.

## Definition of mental illness

To begin, it is important to understand what we mean by severe and persistent mental illness (SPMI). SPMI covers more serious mental illness diagnoses such as schizophrenia, bipolar disorders, and severe forms of depression.[[7]](#footnote-7) Generally, when the author refers to mental illness, we are referring to severe and persistent mental illnesses. Mental illness is a strong identity, and often externally is the predominant identity or label that we associate with such individuals.[[8]](#footnote-8) The author would call for a re-conceptualization of what type of people we think of when we mention that an individual has a mental illness.[[9]](#footnote-9) We need to think of those with mental illness beyond merely as potential criminal offenders or defendants, as indeed they may be victims, witnesses, missing persons, or ordinary members of the public.[[10]](#footnote-10) Mental illness has a profound effect on people's daily lives, and as we can see, this translates into a qualitatively different experience when dealing with police.[[11]](#footnote-11)

# Section A: Background

This research paper is cognizant of the history of how those with mental illness are treated within our society. This section of society is marked by a history of institutionalization, then deinstitutionalization and now trans-institutionalization.[[12]](#footnote-12) Unfortunately, the flow of funding did not follow the movement of people with mental illness out of institutions and into the community.[[13]](#footnote-13) Furthermore, it is worth noting that we have entered an era characterized by the “criminalization of mental illness”,[[14]](#footnote-14) largely spearheaded by the police.[[15]](#footnote-15) Mental illness has been criminalized to the extent that there are now more individuals with mental illness in U.S. prisons than U.S. mental hospitals.[[16]](#footnote-16) Since the the 1963 Community Mental Health Act,[[17]](#footnote-17) and resulting deinstitutionalization, we have seen a shift towards incarcerating the mentally ill in criminal justice institutions, rather than treating them in mental health facilities.[[18]](#footnote-18) Although there are a number of studies in the literature,[[19]](#footnote-19) the most reliable source of such statistics, is an outdated Bureau of Justice Statistics study where data was collected in 2002 and 2004. This study found that over 50% of state prisoners, almost 50% of federal prisoners, and almost 65% percent of jail inmates had mental health issues.[[20]](#footnote-20) There are now three to ten times more individuals with serious mental illnesses in U.S. prisons than U.S. mental hospitals.[[21]](#footnote-21) It is unclear to what extent such individuals had a mental illness upon entering prison or developed in prison. The decision to place individuals into the criminal justice system, rather than diverting individuals with mental illness into civil confinement rests largely with the police. Again, this underlines the importance of police discretion when individuals interact with the criminal justice system for the first time.[[22]](#footnote-22) In this regard, police are the gatekeepers to the criminal justice system.[[23]](#footnote-23)

# Section B: Role of the Police

First, it should be noted that the police are a subsystem of the general criminal law system, in addition to the judiciary and corrections subsystems.[[24]](#footnote-24) Moreover, the police are the most visible element of the criminal justice system, and the subsystem that people come into contact with most often.[[25]](#footnote-25)

While traditionally the powers of police were grounded in the common law, there has been a movement towards them being found in statute in more recent times.[[26]](#footnote-26) Within this mainly statutory framework, the dominant role of police appears to be one of public safety and law enforcement.[[27]](#footnote-27) It should be noted that “(t)he state exercises coercive force under the police power to protect the public order, security, and justice.”[[28]](#footnote-28) Importantly for this paper, additionally the state, through the police, act as *parens patrie* to help those in need.[[29]](#footnote-29) Here the police are involved in the civil committal of individuals with mental illness where they are a threat to themselves or others, or where they cannot take care of themselves.[[30]](#footnote-30) In pursuit of this parental role, some emerging policies in certain US states involve the police, following an altercation or emotional disturbance call, revisiting the individual in order to check on their welfare and medications.[[31]](#footnote-31) Unfortunately, despite the good intentions of such tactics, this may contribute to a net widening of those with mental illness finding themselves under the control of the criminal justice system as a whole and may also pose privacy concerns.[[32]](#footnote-32)

The police have responded to the popular “declining tolerance for public disorder” and have been tasked with what has been termed “‘quality-of-life’ crime enforcement”, such as public nuisance and being drunk in public.[[33]](#footnote-33) Barr explains that those most affected by the enforcement of such laws are the mentally ill.[[34]](#footnote-34) This is because those with mental illness are at greater risk of homelessness[[35]](#footnote-35) and poverty,[[36]](#footnote-36) and are the type of population that such crimes are generally enforced against.[[37]](#footnote-37)

It has been pointed out in an Irish context that there is an emerging “role conflict between traditional (law enforcement) and contemporary (social welfare) expectations of policing”,[[38]](#footnote-38) the same appears to be happening in the US.[[39]](#footnote-39)

Being cognizant of the movement toward community policing,[[40]](#footnote-40) and of the fact that the type of police force in society is generally one that is desired by the members of society,[[41]](#footnote-41) these two elements have meant the police role has manifested itself as more of a service provider to society and to the mentally ill.[[42]](#footnote-42) As stated above, some police visit the homes of individuals with mental illnesses to check on their welfare and ensure medication regimens are being adhered to.[[43]](#footnote-43) This is another demonstration of the movement away from traditional crime control to order maintenance.[[44]](#footnote-44) We can also see the shift in the police role towards a service model[[45]](#footnote-45) when we see joint endeavors by police with mental health professionals when dealing with the mentally ill.[[46]](#footnote-46) The police may resist the change and complexity[[47]](#footnote-47) in their function, and this may be a reason why some police officers may not respond to calls involving those with mental illnesses, as they feel these calls are outside their realm of responsibility and more so within the prerogative of mental health professionals.[[48]](#footnote-48) It is submitted that police should not ignore such calls and should fulfill their duties towards those with mental illnesses.

Wood et al. call for an expansion in the understanding of the role of police towards a continuum model.[[49]](#footnote-49) This encapsulates their capacity to be transporters, early interveners, co-interveners, etc.[[50]](#footnote-50) It is important to understand, as stated above, that police are both first responders to emotional disturbance calls, and in terms of solving the issues, are gatekeepers to the civil and criminal systems.[[51]](#footnote-51)

# Section C: Extent of Interactions

Morabito and Socia correctly note that there is a lack of data collection in this field.[[52]](#footnote-52) However, it has been found that 43.8 million adults experience mental illness annually in the United States,[[53]](#footnote-53) 60% of whom have not received treatment in the past year.[[54]](#footnote-54) Furthermore, in terms of bi-polar disorder, schizophrenia, and other forms of severe depression, 5% of US citizens have a serious mental illness.[[55]](#footnote-55)

In terms of the frequency of contact with the police, it is estimated that between 7% and 10% of all police calls involve those with mental illnesses.[[56]](#footnote-56) This is a surprisingly low figure given the high rates of mental illness in prison. Barr outlines that such frequencies of interactions are increasing.[[57]](#footnote-57) In a 1998 study, it was found that 92% of police officers were involved in a situation with an individual with mental illness in the past month.[[58]](#footnote-58) In Ireland, it is reported that the police engage with those with mental illness on a daily basis.[[59]](#footnote-59) Morabito and Socia point out that such contact is persistent and common.[[60]](#footnote-60) “Contact with the police is common among this population”[[61]](#footnote-61), and is increasing.[[62]](#footnote-62) In fact, it is estimated that 7% of police calls concern individuals with mental illnesses.[[63]](#footnote-63) In 2014, the US police received more than 130,000 calls from emotionally disturbed persons.[[64]](#footnote-64)

The increased contact with police may be due to a number of reasons: deinstitutionalization and the closure of mental health institutions (largely brought about by the 1963 Community Mental Health Act);[[65]](#footnote-65) police specifically targeting this population[[66]](#footnote-66) (for example for more surveillance and stops) [[67]](#footnote-67); risks of violence;[[68]](#footnote-68) drug use;[[69]](#footnote-69) or socio-demographic factors.[[70]](#footnote-70) In terms of socioeconomic factors, the population of mentally ill are associated with higher levels of many lifestyle characteristics (such as homelessness) that are also linked to increased contact with police.[[71]](#footnote-71) With deinstitutionalization, it was unfortunately common for individuals to fall “outside the country’s social safety net”.[[72]](#footnote-72) As a result, this population experienced (and continues to experience) problems of homelessness,[[73]](#footnote-73) poverty,[[74]](#footnote-74) addiction,[[75]](#footnote-75) unemployment[[76]](#footnote-76) and associated discrimination[[77]](#footnote-77) - the very criminogenic social determinants and factors that have such strong correlations with police contact and prison entry.[[78]](#footnote-78) These drivers of interaction with the criminal justice system have since been experienced disproportionately by those with mental illness.[[79]](#footnote-79) Lurigio argues that the harsh policies implemented by the police and other criminal justice actors are primarily to blame for the criminalization of poverty and disproportionate levels of incarceration for this sub-population of the mentally ill, particularly America’s draconian drug laws.[[80]](#footnote-80) The war on drugs has had a disproportionately harsh impact on those with mental illnesses.[[81]](#footnote-81) This is due to concurrent characteristics that put persons at risk of using drugs and engaging in criminality, and due to illicit drug and alcohol abuse amongst the mentally ill.[[82]](#footnote-82)

# Section D: Nature of the Interactions

As stated, one of the most common type of interactions between police and those with mental illnesses are emotional disturbance calls. These are calls made by family members or members of the public informing the police that a mental breakdown of an individual is currently taking place.[[83]](#footnote-83) The callers may also be concerned with the danger posed to the individual or others, or alternatively be reporting a public nuisance such as vagrancy, loitering, or trespass.[[84]](#footnote-84)

When police reach the scene, they may or may not be on notice that the individual has a mental illness.[[85]](#footnote-85) This is the major barrier to effective relations between this population and police. The emotional disturbance caller may not make the police aware of the mental illness. They may simply be calling due to irrational or strange behavior. As stated above these emotional disturbance calls are qualitatively different to ordinary police calls.[[86]](#footnote-86)

So how can the police ascertain if the individual has a mental illness? One method would be to ask the individual directly,[[87]](#footnote-87) although this often may not be possible under circumstances where the individual poses a threat to themselves or another. Another more likely avenue would be to get in touch with the individual’s family if a mental illness is suspected.[[88]](#footnote-88) In fact, if a mental illness is suspected, perhaps the police should operate on the assumption that a mental illness is involved.[[89]](#footnote-89) Given that many police departments have a policy of ticking a box in the incident report after a situation involving a person with mental illness,[[90]](#footnote-90) the police may also refer to their own databases and records for previous encounters with the individual at hand, and check whether a mental illness was noted at that stage. Finally, through police training, the officer could look out for signs of mental illness such as irrational behavior, sudden changes in behavior, confused thinking, irritability, signs of depression and anxiety, strange delusional thoughts, evidence of hallucinations, and expressions of suicidal tendencies.[[91]](#footnote-91)

When aware of a mental illness, the police should ideally contact and invite to the scene a mental health professional. They should also draw on their training (if indeed they received any!) at this stage. Such training focuses on de-escalation and how to effectively communicate and engage with the individual who has a mental illness. Often those with mental illness will not respond appropriately to normal and often aggressive police tactics which tend to escalate the situation.[[92]](#footnote-92) It is also worth noting here that those with mental illness are more susceptible to coercive police tactics, with a higher likelihood to acquiesce and give false statements.[[93]](#footnote-93) (It is no wonder then that those with mental illnesses are at a heightened risk of experiencing wrongful convictions.[[94]](#footnote-94))

As stated previously contemporary police tactics centers on frequent and aggressive interactions with youths such as *Terry* stops. A *Terry* stop is essentially a stop and frisk encounter between an individual and police, where the police have reasonable suspicion that a crime has been committed.[[95]](#footnote-95) A study by Colombia professors, including the influential Jeffrey Fagan, demonstrated not only the subsequent negative mental health complications following such a policy, but more generally called for a less aggressive police approach towards those with pre-existing mental health concerns.[[96]](#footnote-96) Similarly, the Justice Department's report on Baltimore police was highly critical of their dealing with those who have mental illness, particularly on their use of force against the mentally ill and their failure to distinguish emotional disturbance calls from calls reporting that a crime has been committed.[[97]](#footnote-97)

It is important to note that irrational behavior exhibited by a person with mental illness may be misinterpreted as aggressive,[[98]](#footnote-98) criminal,[[99]](#footnote-99) or resisting arrest,[[100]](#footnote-100) when often the taking of such actions is “not truly volitional”[[101]](#footnote-101) and the individual may not simply understand the police instructions.[[102]](#footnote-102) It is important to remember that such behavior may be unintended but difficult to control. Fagan et al. point out that those “displaying mental health symptoms might have attracted greater reasonable suspicion, or responded to police questioning in ways that escalated their situations”.[[103]](#footnote-103)

Police often fail to recognize symptoms of mental illness and misinterpret this behavior as dangerous, which is to the detriment of relations between the mentally ill and the police.[[104]](#footnote-104) Police often perceive those with mentally ill as a major threat to themselves and police safety.[[105]](#footnote-105) It has been also found that both parties, the mentally ill individual and the police officers, are often fearful of the other party, which also contributes to an escalation of the situation.[[106]](#footnote-106)

It is vital that police do not buy into the commonly held myths around the inherent link between mental illness and violence as popularized by the media.[[107]](#footnote-107) Certain preconceptions can mean that police come ready for a violent altercation and act accordingly.[[108]](#footnote-108) Police perceptions appear to continue to hold onto the myth of dangerousness of persons with mental illness.[[109]](#footnote-109) It is well established that a myth of dangerousness surrounding those with mental illness is widespread.[[110]](#footnote-110) For instance, a national survey study found that 46% of the public believe that those with mental illness were “far more dangerous than the general population”.[[111]](#footnote-111) This misperception leads to stigma and reduced access to mental health services.[[112]](#footnote-112) This myth is further perpetuated by the media.[[113]](#footnote-113) Most violent crime is in fact not committed by those with mental illness[[114]](#footnote-114) and is relatively rare.[[115]](#footnote-115) (However, it should be noted on the other hand that “the rate of violence among seriously mentally ill persons who are hallucinating or delusional is higher than the general population.”)[[116]](#footnote-116) It has been found that less than 5% of overall violence in the US are committed by those with mental illnesses.[[117]](#footnote-117) When we combine these misconceptions with the general ad-hoc responses to emotional disturbance calls, there is a heightened risk for the situation to deteriorate.[[118]](#footnote-118)

We now turn to whether there is any truth to the dangerousness myth that surrounds those who are mentally ill. Statistically, it is four times more likely that a police officer would kill a person with mental illness than the other way around.[[119]](#footnote-119) According to the most recent data available from the FBI, in 2015 there was 41 officers killed during duty - only 2 of these (a total of 4%) involved an individual with mental illness.[[120]](#footnote-120) Furthermore, in terms of assaults of officers, of the 50,212 assaults, only 1,710 (3%) were situations involving those with mental illnesses.[[121]](#footnote-121) It is worth noting that injury rates to police are the same as those committed by individuals without mental illness.[[122]](#footnote-122) Police incidents involving those with mental illnesses are covered widely by the media,[[123]](#footnote-123) and perpetuate the myth of dangerousness.[[124]](#footnote-124) Furthermore, and more generally, most of those with mental illness are not a danger to anyone, except maybe themselves.[[125]](#footnote-125)

When police respond to situations involving persons with mental illness, in most cases no crime has been committed.[[126]](#footnote-126) Where crimes are committed by those with illness, they tend to be minor non-violent offenses such as public order offenses, property and drug crimes.[[127]](#footnote-127) (We can see here the problem of the common co-current alcohol and drug dependency issues[[128]](#footnote-128) and homelessness[[129]](#footnote-129) for those who have mental illnesses.) Often persons with mental illness are more likely to be victims than perpetrators of crime.[[130]](#footnote-130)

While initially focusing on de-escalating the situation, the police should also be cognizant of what to do once the situation is under control. Police have large amounts of discretion in this regard,[[131]](#footnote-131) with a large variety of outcomes.[[132]](#footnote-132) In fact, traditionally speaking, the interaction of police and those with mental illness had low visibility and observation by society.[[133]](#footnote-133) However, bearing in mind the Black Lives Matter movement and their reliance on social media and recording of police behavior,[[134]](#footnote-134) in an increasingly digital society with YouTube, iPhones, iPads etc, as well as police body cameras, police discretion can be analyzed more closely.[[135]](#footnote-135) In the near future we should see more concrete examples of how the police treat and mistreat those with mental illnesses.[[136]](#footnote-136) See recently the video recordings of the death of individuals with mental illnesses, namely Freddie Gray in Baltimore,[[137]](#footnote-137) Randy Rodick in Denver,[[138]](#footnote-138) Freddy Centeno in Fresno,[[139]](#footnote-139) Muhammad Muhaymin in Phoenix,[[140]](#footnote-140) Jason Harrison in Dallas,[[141]](#footnote-141) and Sean Moore in San Francisco[[142]](#footnote-142).

The options facing police when interacting with those who have mental illnesses essentially boils down to three options: to arrest the individual thus forcing them into the criminal justice system; to coercively or otherwise transfer the individual into the civil mental health system; or finally to do nothing essentially not invoking the criminal or civil procedures, leaving the scene having given the individual appropriate resources for further help.[[143]](#footnote-143)

## 1. Arrest

According to Teplin, arrest and use of force by police is how this population is handled and subjugated by the state.[[144]](#footnote-144) Indeed, it has been found by some commentators that those with mental illness experience high rates of arrest.[[145]](#footnote-145) Despite this, arrest has been found to be the least likely outcome for interactions with police when compared with being sent to civil commitment and informal solutions.[[146]](#footnote-146) As stated above, it has been found that those with mental illness are “unfairly targeted” by police.[[147]](#footnote-147) But what are the arrest rates for such individuals?

Older studies, such as that undertaken by Teplin, showed not only disproportionate interactions but also disproportionate arrest rates for those with mental illness.[[148]](#footnote-148) Elsewhere, Fischer worryingly declared that 42-50% of those with a mental illness will be arrested in their lives, compared to 7-8% of the general population.[[149]](#footnote-149) In particular, for those with mental illness, these arrests are mainly for minor offenses.[[150]](#footnote-150) Bernstein and Seltzer have found that arrest rates are twice as high when compared with those without mental illness.[[151]](#footnote-151) Before that, Teplin reported that arrest rates for those with mental illness were nearly 70% greater.[[152]](#footnote-152) In fact, Watson and Angell found that less experienced officers are more likely to arrest than their more experienced colleagues.[[153]](#footnote-153) Consequently, any training should focus on the more experienced members of the force to act as leaders setting the standard for the younger members of the police unit or department. This approach is even more plausible when we consider that more experienced police achieve more from training in this space and retain knowledge for longer periods of time.[[154]](#footnote-154)

However, more recent studies, such as that by Engel and Novak, found the opposite to the earlier studies.[[155]](#footnote-155) They found arrest rates for those with mental illness were lower than those without mental illnesses.[[156]](#footnote-156) The author of this paper would question the validity of generalizing these findings, particularly when we consider the following if we have disproportionate numbers in prisons, and given that police act as gatekeepers to the criminal justice system, this author queries how there is not disproportionate levels of interactions and arrest rates between police and those with mental illness.[[157]](#footnote-157)

What are the causes of arrests for those with mental illness? These arrests in some instances may take the form of mercy bookings, where police are concerned for the welfare of the individual and arrest them so as to ensure they are provided with food and shelter at the police station or jail.[[158]](#footnote-158) Furthermore, Fishcer has noted that higher arrest rates are also due to increased likelihood of resisting (74%),[[159]](#footnote-159) “drug and alcohol abuse, homelessness... nuisance bookings, barriers to effective police responses; and faulty public perceptions of mental illness.”[[160]](#footnote-160) Despite these findings, it should be noted that diversion away from the criminal justice system is key at the point of arrest,[[161]](#footnote-161) and instead police should focus on the next two options. The following two options have the potential to solve the underlying issue and perhaps the cause of crime, namely the person's mental illness.[[162]](#footnote-162)

## 2. Civil Commitment

Civil commitment involves police transporting an individual with a mental illness and checking them into a mental health hospital or other institution.[[163]](#footnote-163) After being transported to a civil detention center, the individual with a mental illness is then brought before a judge “to decide whether that person is mentally ill and dangerous.”[[164]](#footnote-164) As Wood et al. point out, police “must have probable cause to believe civil commitment criteria are present—i.e., dangerousness or incompetence due to mental illness”.[[165]](#footnote-165) According to the courts in *Foucha v Louisiana*, the individual must both have a recognizable mental illness, but also be a danger to themselves or others.[[166]](#footnote-166) While compared to arrest, civil commitment appears to be a less invasive option, however, it too represents “substantial intrusions into ordinarily protected liberties.”[[167]](#footnote-167) One problem with civil commitment when compared to a prison sentence, is that the duration of commitment is indefinite, it depends on recovery and so could theoretically last the whole life of an individual, whereas a prison sentence is for a definitive amount of time.[[168]](#footnote-168)

Opting for civil commitment not only “result(s) in clinically appropriate treatment more efficiently than a criminal trial”,[[169]](#footnote-169) but also satisfies the public desire for incapacitation as the individual is committed to a mental health institution and so, from a deterrence perspective, the risk to others is reduced.[[170]](#footnote-170)

If a crime has been committed, and the police still opt for civil commitment, it is an expression that the person is not fully responsible or culpable for their actions, similar to what a successful insanity plea would do.[[171]](#footnote-171)

We should also address the idea of what body decides to use diversionary programs.[[172]](#footnote-172) Often it depends on who is dealing with the matter on the ground in real time.[[173]](#footnote-173) For instance, if it is solely the police dealing with the incident on their own, and if they have the requisite training, then they will make the decision whether to divert the individual or not.[[174]](#footnote-174) However, if they are solving the issue with the help of mental health professionals, then they can be involved or take the decision to divert .[[175]](#footnote-175)

## 3. Informal Solutions or ‘Doing nothing’[[176]](#footnote-176)

As seen, police have large amounts of discretion when it comes to the end of an emotional disturbance scenario. Their final option is to end the matter informally, neither arresting nor using civil commitment. This may involve providing contacts of available services to the person with mental illness. This is not only the most time efficient option of the three initially, but also the one that eliminates the possibility of criminalization.[[177]](#footnote-177) The choice to resolve the situation informally may require follow-up calls by the police.[[178]](#footnote-178)

According to some studies and commentators, such as Morabito and Socia, the police act more leniently towards those with mental illness.[[179]](#footnote-179) Similarly, Price found that police are actually more empathetic to those who have mental illnesses.[[180]](#footnote-180) However, how is this the case when there are disproportionate numbers of people with mental illness in prison?

One reason for this apparent leniency may be the amount of options open to police when interacting with those who have mental illnesses. Ordinarily, when confronting an individual without a mental illness, the police have two options - either to arrest or not to arrest. However, in terms of interactions with those with mental illnesses, they have these two options, in addition to the option of committing the person to civil confinement and finally the option of ‘doing nothing’ and informally resolving the situation.[[181]](#footnote-181)

According to Hoover, police are generally not antagonistic towards those with mental illness, but actually want to help.[[182]](#footnote-182) He argues that the problem lies in a lack of resources and the fact that such altercations and alternative solutions to the altercations (such as civil commitment) are often more time consuming than traditional police activity, such as arrest.[[183]](#footnote-183)

Before police reach the decision whether to arrest, transport the individual into the civil commitment procedure or solve the situation informally, force may or may not be used to reach these outcomes.

# Section E: Force

We have just discussed the three options that represent, essentially, peaceful conclusions to these encounters, to the extent that arrest and (involuntary) committal are peaceful! However, such peaceful outcomes are not always the result. At times police use fatal and non-fatal force during the course of such interactions. It appears from recent media coverage that fatal outcomes are increasing in frequency.[[184]](#footnote-184) The coverage of the deaths of the likes of Alfred Olang,[[185]](#footnote-185) James Hall,[[186]](#footnote-186) Kelly Thomas, and Ezell Ford in one state alone (California) have brought this topic into the homes of many Americans.[[187]](#footnote-187) However, generally the use of force by police is rare.[[188]](#footnote-188) While the use of deadly force can be warranted in a very limited set of circumstances,[[189]](#footnote-189) the widespread reporting of such scenarios suggests that fatal force is being used excessively, and also suggests that reporting and visibility of such uses of force are increasing.

Despite the large media coverage of the use of deadly force against those with mental illness,[[190]](#footnote-190) there appears to be no governmental systematic monitoring of police shootings[[191]](#footnote-191) or use of force.[[192]](#footnote-192) However, a Treatment Advocacy Center report estimates that people with mental illnesses are 16 times more likely than others to be killed by police.[[193]](#footnote-193) According to a Washington Post study, over 1,500 people were shot by police in 2015, with almost 400 constituting an emotional disturbance call with the victims having a mental illness.[[194]](#footnote-194) According to Steadman and Morrissette, emotional crises by those with mental illness constituted-approximately one quarter of all fatal police shootings in 2015.[[195]](#footnote-195) In an older study, Zdanowicz reported that in one year 30 mentally ill people were killed during interactions with the police.[[196]](#footnote-196)

However, despite these studies other commentators, such as Skeem and Bibeau, argue that force is used less frequently than first thought against those with mental illness.[[197]](#footnote-197) Johnson[[198]](#footnote-198) and Morabito and Socia have come to similar conclusions.[[199]](#footnote-199)

Force can be used by police when necessitated by the totality of the circumstances,[[200]](#footnote-200) for instance where the individual with a gun shoots or threatens to shoot a police officer or member of the public.

Use of force is at the core of the police function in society according to Greene.[[201]](#footnote-201) Max Weber stated that the state has a “monopoly on the legitimate use of physical force”,[[202]](#footnote-202) through the police. In fact, Trotsky once said that “(e)very state is founded on force.”[[203]](#footnote-203) However, when force is used, some argue it is used disproportionately on minority groups[[204]](#footnote-204) such as those with disabilities. This approach more generally has a tendency to escalate the situation.[[205]](#footnote-205)

According to Morabito and Socia, those with mental illness are more likely to show resistance and be under the influence of drugs and alcohol, and these are the factors that may contribute to high rates of force used by police.[[206]](#footnote-206)When a citizen is acting irrationally, there is a higher likelihood of force being used against them by police.[[207]](#footnote-207) This is most likely due to this behavior being misinterpreted as being threatening.[[208]](#footnote-208) Taking control of situations is a top priority for police on the ground. However, “control requires the officer to be able to predict accurately the actions of the citizen”.[[209]](#footnote-209) This is why interactions with the mentally ill are so unpredictable, as their mental illness often results in irrational behavior.[[210]](#footnote-210) When those with mental illness disobey police orders, it is not for the ordinary reasons that is at issue for those without mental illnesses, but a matter of being “ill, confused and unable to comport their behaviors to the officers’ and society’s expectation”.[[211]](#footnote-211)

Engel states that despite the new studies, it is still relatively unknown whether force is used more or less frequently against those with mental illness.[[212]](#footnote-212) In fact, both Engel and Alpert state that the “use of force (against those with mental illness) is a relatively rare event”.[[213]](#footnote-213) When we pit these conclusions against the previous studies that found higher rates of arrest and force against those with mental illness, it appears that even though the arrest rates may not be *disproportionately* high, they are significantly high nonetheless, as evidenced by their coverage in the media and academia.[[214]](#footnote-214)

## Excessive force

Minimal amounts of force are expected of the police, and enforced by law.[[215]](#footnote-215) When police abuse this authority and use excessive force, people with mental illnesses, and anyone affected, can bring causes of action under the Fourth Amendment, the Fourteenth Amendment, and 42 U.S.C. §1983.[[216]](#footnote-216) In terms of excessive force, once police officers act with no ‘malicious intent’ and stay within the scope of their employment, no legal liability will ensue. Unrestricted use of force is not allowed.[[217]](#footnote-217) Police use of force must be the least invasive or violent option available.[[218]](#footnote-218) The police officer’s conduct must be objectively reasonable under the totality of the circumstances, and must not go beyond what is necessary.[[219]](#footnote-219) According to the Graham factors from *Graham v Connor*,[[220]](#footnote-220) certain issues are relevant to this totality of the circumstances test, namely the severity of the alleged crime, a threat to the officers or to others, and whether the individual was resisting arrest or attempting to escape.[[221]](#footnote-221) Other more recent factors outlined in *Palmquist v. Selvik*[[222]](#footnote-222) include an officer’s knowledge of a suspect’s emotionally disturbed status. This knowledge should inform the officer to act in an appropriately tailored manner in terms of interactions and in terms of force used.[[223]](#footnote-223) More generally, *Tennessee v. Garner*[[224]](#footnote-224) outlined the circumstances of when an officer can use deadly force. These factors include whether an officer is threatened by a deadly weapon, when there is probable cause of a threat of serious physical harm or death to the officer or another, or probable cause to believe that the suspect has committed a crime involving threatened or actual serious injury or death to another. Without such circumstances, using lethal force against someone is unreasonable and excessive.[[225]](#footnote-225) Furthermore, importantly for this paper, for liability to occur in the circumstances of an emotional disturbance call, it must be proved that the officer knew (actual notice), or should have known (constructive notice), that the person being dealt with had a mental illness and was in an emotionally distressed situation.[[226]](#footnote-226)

### “Suicide by cop”

“Suicide by cop” is another situation facing police in regards to those with mental illness discussed by Lord. Lord explains that those with mental illness who have suicidal wishes, deliberately break the law and engage the police in a shoot-off situation, ultimately to bring about their own death.[[227]](#footnote-227) Again, force is used here, however it is not likely to be excessive as the individual essentially invites the police to shoot them, by brandishing a weapon and threatening to kill another person. Police have few options if the person has a gun and has shot someone or threatened to do so.[[228]](#footnote-228)

# Section F: Reasonable Accommodations

Another important aspect of the police’s relationship with those with mental illness is the concept of reasonable accommodations. What role does the Americans with Disabilities Act (“the ADA”) play in these interactions? The ADA prohibits discrimination across various fields including public services.[[229]](#footnote-229) The ADA was introduced not only to eliminate physical barriers and to create employment opportunities, but for the wider cultural change of “breaking down stereotypes, dispelling myths and quieting fears”.[[230]](#footnote-230) Unfortunately, “changing mentalities is much more difficult than providing access or accommodation for the disabled. Mentalities... infiltrate all levels of society and culture”.[[231]](#footnote-231) We can see this same difficulty of changing police culture when it comes to mental illness.[[232]](#footnote-232)

The 1998 Supreme Court case *Pennsylvania Department of Corrections v. Yeskey*[[233]](#footnote-233) found that those with mental illness, while being subject to law enforcement, were not receiving a benefit from the government. According to Auner, since this decision, courts have been more receptive to applying the ADA to law enforcement activities.[[234]](#footnote-234) For example, in *Gohier v. Enright*,the Court applied the reasoning of *Lewis* and *Jackson* to ascertain whether the use of force by police in this instance was based on the person’s disability, not based on their committal of a crime.[[235]](#footnote-235) The Court in *Gohier* distinguished *Lewis v Truitt*[[236]](#footnote-236)and *Jackson v Town of Sanford*[[237]](#footnote-237) on the facts, as in those cases the issue was wrongful arrest, where the police officer perceived actions taken by the defendant were symptoms of their disability, rather than unlawful conduct. As a result, if a certain fact pattern comes before the courts, it is plausible they will follow the *Lewis* and *Jackson* cases if, on the facts, an arrest is made on the basis of the person’s symptoms of mental illness rather than unlawful conduct. As such, the ADA governs issues of arrest in such circumstances.

As both a victim of a crime and as a suspect at the time of arrest, individuals with mental illnesses are entitled to reasonable accommodations at the police station. According to the *Sheehan* case, the ADA only becomes operative after arrest.[[238]](#footnote-238) Difficulties arise within ‘on the street scenarios’ where there is a risk of danger to the individual or others. Title II of the ADA can apply to the scene of an arrest or interaction with a member of the public. However, often the police and state rely on the exigent circumstance exception, that there was an immediate requirement to protect the officer or another from harm.[[239]](#footnote-239) There is no entitlement to equal participation under the ADA if an individual poses a threat to others.

Individuals with mental illness are also afforded general procedural rights afforded to all suspects. However, when we consider that those with mental illnesses have problems with understanding their rights and are more susceptible to false confessions, we can see why more protective procedural rights may be required.[[240]](#footnote-240) Procedural rights offered by the ADA reasonable accommodations are only required when police have, or should have, knowledge of the disability. See for example *Sperry v. Maes*. Here the police officers had some knowledge of a mental illness, but not to a sufficient extent as to trigger the ADA, with the court stating that “the officers had no duty to further investigate the extent of plaintiff's disability.” [[241]](#footnote-241) We see here how crucial knowledge of a mental illness is in terms of triggering any ADA requirements.[[242]](#footnote-242)

If reasonable accommodations are required, what kinds of accommodations should be made available? The provision of such accommodations may have an impact on the admissibility of evidence. This is particularly important when we consider that detainees with mental illnesses are more likely to acquiesce to police pressure during interrogations.[[243]](#footnote-243) This traditional style of questioning may need to be amended in order to satisfy reasonable accommodation requirements.[[244]](#footnote-244) Another element that may be required is the reasonable accommodation of rest breaks during interrogations.

# Section G: Guns

Another factor in the discussion on police and the mentally ill is gun use and ownership - both on the part of the police and of those with mental illness. At this point in the paper, we will pivot to incorporate a comparative approach, and examine how police in Ireland do not use guns but succeed in managing those with mental illnesses more appropriately than their U.S. counterparts (if we consider success being the least amount of harm being done to the individual).

According to section 922(g) of the Gun Control Act of 1968, reasons to restrict gun ownership include the fact that an individual has been “adjudicated as a mental defective” or have been “committed to a mental institution.”[[245]](#footnote-245) This covers not only those who pose a danger to society (for instance who have been deemed incompetent to stand a criminal trial or who successfully argued an insanity defense), who correctly should have limited access to firearms, but also to people who cannot arrange their own affairs. [[246]](#footnote-246)

The risks associated with general gun ownership have been widely debated in the US.[[247]](#footnote-247) Approximately 40% of US homes own a gun.[[248]](#footnote-248) In addition to the Gun Control Act 1968, the US, through legislation in 2008 the NICS Improvement Amendments Act of 2007, prohibited gun ownership by those with mental illness. One concern the author of this paper would have with such policies is that stricter gun laws may contribute to the further stigmatization of those with mental illnesses and sustain the myth of dangerousness associated with all who have mental illness.[[249]](#footnote-249)

Firearm prohibition should not be used against an individual just because they have appeared before the courts on their capacity to manage certain elements of their livelihoods. The restriction of access to guns should be limited to circumstances where that individual has proved to be a danger to themselves or others in the past (incompetency to stand trial, or the use of the insanity offense).[[250]](#footnote-250) As the American Psychological Association points out, “it must be recognized that persons with serious mental illness commit only a small proportion of firearm-related homicides”.[[251]](#footnote-251) In fact, persons with severe mental illness are more at risk of harming themselves than others, with suicide, not homicide, accounting for over 60% of all gun fatalities in the United States.[[252]](#footnote-252) According to a study undertaken by the organization Everytown For Gun Safety, in only 11% of mass shootings were concerns raised about the killer’s mental health prior to the crime.[[253]](#footnote-253)

Mass shootings, such as those at Newtown, CT, Aurora, CO, and Tucson, AZ, have been reacted to in two ways. One is the discussion that is led by the political left on gun control that is a topic of taboo for the right. But there is an alternative narrative on the role mental illness, not guns, play in these mass shootings, as led by the conservative right, who seek to avoid discussing guns generally.[[254]](#footnote-254) For example, this position is best represented by the conservative Anne Coulter’s reaction to the mass shooting in Newton, CT that “guns don't kill people, the mentally ill do”.[[255]](#footnote-255) This again perpetuates the myth of dangerousness regarding people with mental illness.

# Section H: Ireland

Given that many of these scenarios in the US involve the use of guns on the part of the police, and sometimes on the part of the person with a mental illness, we now move to a comparative analysis with the jurisdiction of Ireland. The rationale behind choosing Ireland as the subject of comparison is twofold. Not only does Ireland have strict gun control laws, but also their police are also largely unarmed (with only specialized units having firearms).[[256]](#footnote-256) Having said that, Ireland too has struggled with the use of lethal force on those with mental illness, with a small few infamous cases. In particular, there is one case that resulted in a political inquiry into the handling of the situation by police, called the Barr Tribunal which illustrates the issues (similar to the US experience) Irish law enforcement face when dealing with the mentally ill.

As the Report of Joint Working Group on Mental Health Services and the Police states, there is a “dearth” of analysis on this topic in Ireland, even more so than the US.[[257]](#footnote-257) This report found that there is an increase of contact between those with mental illness and the police, largely due to de-institutionalization and increased treatment of the mentally ill in the community.[[258]](#footnote-258) They come in contact with police due to other issues, such as domestic or public disturbances, minor offenses or homelessness.[[259]](#footnote-259) Again, similar to the US,[[260]](#footnote-260) the Irish police (An Garda Siochana or the Gardaí) act as frontline actors when it comes to those with mental illness.[[261]](#footnote-261) Similar to the US, in Ireland there have been calls to divert those with mental illness away from the criminal justice system, particularly if a minor crime is involved.[[262]](#footnote-262) Generally, police have more discretion when dealing with minor offenses or where no crime has been committed.[[263]](#footnote-263)

The Irish police have authority to bring those with mental health illnesses into involuntary committal under Section 12 of the Mental Health Act 2001.[[264]](#footnote-264) Under Section 12, people with mental illnesses who pose a danger to themselves or others, can be brought into police custody, be examined by a police doctor and be placed under the care of local community mental health care. Although the Irish police interact and serve people with mental illness and often commit them to mental health services informally, without triggering the lengthy Section 12 procedures, they have no statutory basis for doing so.[[265]](#footnote-265)

The Barr Tribunal investigated the Irish police response to a man with a history of mental illness, who was ultimately shot dead by police after an altercation. John Carthy was a registered owner of a shotgun.[[266]](#footnote-266) However, this was revoked by the Irish police, as a result of threats Mr. Carthy made to members of the public.[[267]](#footnote-267) The firearm was returned to Mr. Carthy after his psychiatrist stated he was fit to hold the gun.[[268]](#footnote-268) It was this gun that was used during the siege situation with the police. The Tribunal found various errors made by the police, including a failure to reach out to mental health professionals during the siege incident.[[269]](#footnote-269) Furthermore, the Irish police were not only criticized domestically by the Tribunal, but also internationally by Amnesty International.[[270]](#footnote-270) The former director of Amnesty International Ireland has stated that John Carthy’s case is not a once off, but a consistent concern.[[271]](#footnote-271)

Aside from this incident, there does not appear to be many other publicized cases in Ireland by either the media or in case law on the interactions between police and the mentally ill that would be akin to the common practice in the US of standoffs between those with mental illnesses and the police. There is, however, a more unique problem of treating the mentally ill inappropriately while in police custody in Ireland. There appears to be a contrast here between the US experience and the Irish experience of deaths or injuries occurring to individuals with mental illness committed by the police. In the US, due to police yielding guns in almost all cases, any harm that results is likely to occur during the “standoff/siege” period, where traditionally their only tactic is the use of blunt instruments, such as guns and tazers.[[272]](#footnote-272) Whereas in Ireland, given that police are unarmed, there is very little likelihood of police killing an individual with mental illness (the John Carthy case is one of few exceptions). Instead, any harm or death that occurs as a result of interacting with the Irish police, is likely to occur after arrest.

While there exists procedures to systemically review deaths while in the custody of Irish prisons, none exists for deaths while in police custody, despite calls for this policy change.[[273]](#footnote-273) In terms of investigating single occurrences of death in police custody, this is governed by the Garda Síochána Act 2005. This was introduced after findings of another tribunal, called the Morris Tribunal.[[274]](#footnote-274) Under the Garda Síochána Act 2005 section 102(1), the head of the Irish police, the Garda Commissioner, is under a legal obligation both under domestic law but also under Article 2 of the European Convention on Human Rights, to refer any possible death or serious harm occurrences that occurred in police custody to the Garda Síochána Ombudsman Commission (GSOC). GSOC can then choose to instigate an investigation. In 2015, the Garda Commissioner referred 52 (15 were fatalities) incidents to GSOC under section 102(1) of the Garda Síochána Act 2005. This compared with 41 in 2013, 72 in 2012, 90 in 2011 and 103 in 2010.[[275]](#footnote-275) According to Adeleke et al., the GSOC “has no immediate explanation for this trend.”[[276]](#footnote-276) When cases are referred, GSOC can opt for a criminal investigation in partnership with the Director of Public Prosecutions (the state prosecutor) or opt for a disciplinary hearing.

The most recently available data on the issue states that of all complaints made to GSOC about police behavior, 4% of complainants had psychological disabilities. In order to understand the significance of this statistic, it would be useful to have affirmative official statistics on the presence of mental illness in the Irish population generally. Unfortunately, there is little available statistics on the number of people with mental illness in Ireland. Two Irish studies shows that between 9% and 14% of Irish people have a mental illness.[[277]](#footnote-277) Furthermore, if Ireland follows European trends, then it is likely that around 6% of Irish people have a mental illness.[[278]](#footnote-278) When we consider these statistics (between 6 and 14%) in comparison to 4% of complainants of police behavior had a psychological illness, this is clearly a worrying trend that suggests people with mental illness are disproportionately mistreated by police in Ireland.

In terms of cases of deaths in police custody, the 2015 GSOC reports that two men with a mental illness died while in the custody of the police.[[279]](#footnote-279) In the first case, police were called to the scene of an alleged disturbance, and the individual was arrested under section 12 of the Mental Health Act 2001.[[280]](#footnote-280) The arrestee was placed in a police vehicle.[[281]](#footnote-281) He was then found to be unconscious and immediate medical attention was sought by the police.[[282]](#footnote-282) Unfortunately, the man died at the hospital due to cardiac arrest, due to Excited Delirium Syndrome, following the arrest.[[283]](#footnote-283) An investigation into the death took place, where it was found the arrest was justified and no police misconduct was found.[[284]](#footnote-284)

In another 2015 case, a man, who the police subsequently discovered had a history of mental illness, committed suicide in the presence of police after the police attempted to seize his car as the car-tax was not up to date.[[285]](#footnote-285) The investigation confirmed that the police officers did not have actual or constructive notice of the mental illness, and did all they could to save the man.[[286]](#footnote-286) No criminal or disciplinary action was taken in this case either.[[287]](#footnote-287)

In a third 2015 case, the police were called to the house of a disturbance where an individual was exhibiting distressed and aggressive behavior, that turned out to be symptoms of his mental illness.[[288]](#footnote-288) The police officers were on notice of the mental illness, as well as the fact that he had recently attempted suicide.[[289]](#footnote-289) After the man was acting aggressively towards police, he was arrested for a breach of the peace.[[290]](#footnote-290) He was placed in the back of a police van without handcuffs.[[291]](#footnote-291) When the police arrived at the police station they discovered the arrestee had slit his wrists with a knife.[[292]](#footnote-292) He was treated for his injuries and thankfully survived.[[293]](#footnote-293) Given the harm that occurred, and indeed what could have occurred (death due to suicide), the police officers were criticized for not placing handcuffs on the arrestee, particularly since they were on notice of his mental health issues.[[294]](#footnote-294) Again, no criminal or disciplinary actions were taken.[[295]](#footnote-295)

These three cases are illustrative of the prevalence of the problem in Ireland. Given that previous GSOC reports fail to list any incident involving the mentally ill,[[296]](#footnote-296) the extent of such interactions are either increasing or are becoming more aware to the authorities.

We now turn to the issue of guns in Ireland. Although Ireland traditionally has strict gun control laws and policies, Sarma explains that there is a growing movement towards a more liberal legislative model that allows access to guns for “sport-shooting purposes”.[[297]](#footnote-297) Over 15,000 guns are licensed in Ireland annually.[[298]](#footnote-298) A 2004 Irish case has forced the Irish police to issue certificates for handguns. The then High Court Judge Charleton explained in *McCarron v. Kearney* that the firearms laws is Ireland are so complex that he called for the codification of such laws.[[299]](#footnote-299) However, the firearms law relating to the mentally ill is quite clear. Section 8 of the Firearms Act 1925 lists persons of unsound mind as people not entitled to have a gun. According to the Irish police, “(i)t should be remembered that simply because a person has received treatment in the past for certain illnesses or conditions, such as depression or stress, it does not automatically follow that they are unfit to possess a firearm. It is simply one of the factors to be considered with all other evidence relating to the applicant’s character and history.”[[300]](#footnote-300) However, at the time of the Barr Tribunal applications for firearms did not have a section on mental health of the applicant.[[301]](#footnote-301) Since then, the Criminal Justice Act 2006 has allowed police to receive testimony of medical advisors regarding the applicant’s medical history.[[302]](#footnote-302)

There is reportedly an increase in the rates of both gun ownership in Ireland, but also of gun violence.[[303]](#footnote-303) Unfortunately there is no academic commentary on what role mental illness plays in these increasing rates of gun violence and firearm ownership in Ireland. The United Nations has reported that 12% of the Irish population have a gun in their household.[[304]](#footnote-304) It should be made clear that people of unsound mind, the definition of which still remains in question, are not allowed to own guns in Ireland. In order to own a gun in Ireland, applicants must certify that they have no mental illness that would interfere with their ability to use a gun safely.[[305]](#footnote-305) When making an application, applicants give permission for the decision maker (i.e. a police officer) to contact that person’s doctor or mental health provider such as a psychiatrist.

In terms of the police, only 20-25% of Irish police are trained to carry a firearm.[[306]](#footnote-306) As such, if ordinary members of the Irish police are involved in an emotional disturbance call, they do not have the option to use a gun as a fatal use of force. This essentially eliminates the possibility of a death of a civilian under such circumstances. While this is clearly an effective policy, it seems very unlikely that, given the Second Amendment gun culture and wide possession and usage of guns by civilians (with 40% of US households owning a gun),[[307]](#footnote-307) that the US police would give up their use of guns.[[308]](#footnote-308) (In fact, certain police departments are trained to routinely point their guns at individuals, such as Baltimore PD, even if a mental illness is present.)[[309]](#footnote-309) This is particularly disappointing when we consider that Ireland has lower crime rates than the US.[[310]](#footnote-310) However, pragmatically, the US police could undertake a policy not to bring firearms to emotional disturbance calls where the person with the mental illness is not armed themselves.

# Section I: Solutions

There are few solutions offered in the literature[[311]](#footnote-311) aimed at solving the issues raised in this paper other than training. [[312]](#footnote-312) Almost all of the literature focuses on police training as the sole solution.[[313]](#footnote-313) Torrey et al. are in the minority by proposing alternative or concurrent solutions such as getting more individuals with mental illness into treatment before they come in contact with the police at all.[[314]](#footnote-314) Others have called for the introduction of pre-adjudication diversion programs both in the US[[315]](#footnote-315) and Ireland.[[316]](#footnote-316) Another solution called for in this paper is for police to refrain from bringing firearms to emotional disturbance calls, learning from the Irish approach.

It is interesting to note that in the US and Ireland, both police forces want more training on how to deal with the mentally ill.[[317]](#footnote-317) Additionally, it has become a national governmental concern with recommendations regarding policing the mentally ill being made by the U.S. President’s Task Force on 21st Century Policing,[[318]](#footnote-318) as well as by other bodies such as the International Association of Chiefs of Police[[319]](#footnote-319) and the Police Executive Research Forum[[320]](#footnote-320). Hails and Borum have found that almost all police have received some training on mental illness,[[321]](#footnote-321) however the quality and duration of training varies widely.[[322]](#footnote-322) Similarly, a recent report by the Council of State Governments Justice Center and the International Association of Directors of Law Enforcement has found that 40 of 42 states studied had some training on mental illness.[[323]](#footnote-323) Such training is not only desirable, but is required by law under the ADA to satisfy reasonable accommodations for those with disabilities, as evidenced by the House Committee Report on the Act[[324]](#footnote-324) and the case *Gohier v. Enright*.[[325]](#footnote-325) Most recently, all Chicago police dispatchers have been trained in mental health awareness and de-escalation tactics.[[326]](#footnote-326) However, it is apparent from the ill-treatment of the mentally ill by police, that such training is insufficient or lacks the duration and quality desired.[[327]](#footnote-327) In fact, Greenberg found that on average only four hours of training was allocated to the subject of how to treat the mentally ill.[[328]](#footnote-328)

Unfortunately most training regimens are introduced in states after much publicized tragedies and so is reactive in this regard.[[329]](#footnote-329) Changes in public policy, particularly in the criminal justice sphere, often are predicated and driven by the development of crises such as the current situation of how the police treat those with mental illness, “rather than being dictated by evidence of what works best”.[[330]](#footnote-330) Furthermore, Reuland et al. believe that the introduction of Crisis Intervention Team (“CIT”) policies was based on the fear of dangerousness associated with the mentally ill, rather than a concern for their welfare or better treatment.[[331]](#footnote-331)

The author of this paper would argue that nationwide and consistent training should be introduced as a preventative measure. This paper would join the call of Lamb et al. that all officers should receive such training not just the specialized units that deal predominantly with the mentally ill.[[332]](#footnote-332) The current training provided is inadequate, with a failure to provide consistent follow-up training.[[333]](#footnote-333) Training would hopefully change cultural attitudes of the police, and prepare them for interactions with the mentally ill.[[334]](#footnote-334) Such training is not only advisable but may be necessary to avoid liability. For example, according to *Olsen v Layton Hills Mall*, a municipality can be sued for the failure to adequately train officers regarding mental illness.[[335]](#footnote-335)

In terms of the content of such training, it should include the following topics: how to recognize mental illness, how to de-escalate a crisis, warnings of suicide tendencies, when to use specialized teams, when to divert from the criminal system and when to invoke the civil commitment procedures, what reasonable accommodations may be required and to ensure that community resource materials are provided.[[336]](#footnote-336) One key element of training ought to be communication strategies to be deployed when dealing with a mental health crisis. If such communication skills are invoked during an altercation, there is a higher likelihood of a peaceful outcome.[[337]](#footnote-337)

Calls for training in Ireland is absent in the literature, but called for by the police themselves.[[338]](#footnote-338) Following the approach of some progressive US police departments, in Ireland there should also be specific members of the police force assigned for interacting with those with mental illness.[[339]](#footnote-339) The Barr Tribunal called for training of the part of the Irish police also, as well as improved relations with the mental health professionals.

It is argued in this paper that every officer should be trained with a general mental illness training, and then specialized mental health police officers should receive more tailored and specific training.

In terms of the effectiveness of such training, older studies suggest that training was successful in improving identification of mental illness. However, cultural changes were not as successful.[[340]](#footnote-340)

## CIT

In terms of more specific solutions, currently in vogue is the response of police along with mental health services to the scene of a mental health crisis, such as Crisis Intervention Team (CIT). The primary goal of such programs is diversion away from the criminal justice system.[[341]](#footnote-341) It is interesting to note that the CIT training came into being after the shooting by Memphis police of a mentally ill man suffering from schizophrenia.[[342]](#footnote-342) CIT is a pre-arrest diversion program designed to divert people with mental illnesses away from the criminal justice system.[[343]](#footnote-343) Discretion rests with police to make this diversionary decision to move the individual into the care of mental health emergency services.[[344]](#footnote-344) CIT has now reached over 1000 communities.[[345]](#footnote-345)

Currently, police are often reluctant to call on the help of outside mental health professionals.[[346]](#footnote-346) Where such relationships do exist, it is important to remember that the police’s role in these interactions is not to treat or diagnose mental illness, but to provide individuals with resources. Having said that, such units can provide emergency funds for medication and check that prescribed medication is being accorded with.

# Conclusion

It has been argued in this paper that people with mental illnesses pose significant and unique concerns to the police force. People with mental illnesses have frequent contact with police, and face high arrest rates. This paper has unearthed the large amount of discretion that is yielded by the police during their interactions with those who have mental illnesses. This discretion, when used most effectively, diverts persons with mental illnesses away from the criminal justice system, and instead provides them with access to suitable mental health care. Unfortunately not all of these interactions end peacefully. There is often use of force by the police to bring emotional disturbance calls to an abrupt ending. Use of deadly force has been widely publicized by the media and presents a large problem to police. This paper also touched on what the police could positively do in the form of reasonable accommodations. It then turned to the issue of guns and mental illness. Unfortunately after high profile shootings, these two separate concerns get conflated and fused. The paper examined Ireland to discover why it does not have the same problems surrounding the use of fatal force. This paper concluded with proposed solutions to the problem, including using approaches taken by the Irish police, as well as a focus on improving training on this issue. Currently, the majority of police forces are not in a position to successfully deal with this population. As a result, this paper joins the chorus of calls for more adequate training in this field. Should this need for better training fail to materialize in policy changes, then we are likely to see more examples of uses of fatal force by police against those with mental illness.

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