Testimony of

Chief Gary Margolis

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Good morning and thank you for allowing me to appear before you today. My name is Gary Margolis and I am the Chief of Police for the University of Vermont. As Senator Leahy knows, Vermont is struggling like other states across this nation to determine how we in the criminal justice system can improve our response to people with mental illness.

The importance of addressing the issue of people with mental illness in contact with the criminal justice system cannot be overstated. This issue is difficult and complex; I applaud you for taking it on. I am at once struck by the enormity of the problem and by the creativity and drive in the police community to significantly address the problem if given the proper support, resources and leadership.

Today I am here representing the Police Executive Research Forum (PERF), which is a membership organization of progressive police chief professionals dedicated to advancing policing services to all members of our communities. PERF general members collectively serve more than half the nation's population and see the indignities, the tremendous resources expended without positive result, and human costs our current system generally imposes on the response to people with mental illnesses who come into contact with police.

I am also here representing the Criminal Justice / Mental Health Consensus Project. The Council of State Governments, a nonprofit organization serving all elected and appointed state government officials, has coordinated this two-year initiative. Together with municipal police chiefs, sheriffs, officers, mental health professionals and criminal justice representatives that included prosecutors, defense attorneys, judges, jail and prison administrators and so many others, we worked to develop concrete recommendations for dealing with some of the greatest obstacles to providing appropriate responses to people with mental illnesses who are at risk of criminal justice involvement. We worked with victim advocates, consumers and other stakeholders in an unprecedented project with tremendous result: hundreds of recommendations that explain how to improve the criminal justice system's response to people with mental illness. I want to provide you with a brief context in which to consider law enforcement's recommendations in the Consensus Project. It really comes down to how we want to use our police resources. The grim reality is that police will need to focus more attention on terrorism and even assume a potentially greater role in activities traditionally conducted by the FBI--all without the infusion of much greater numbers of police personnel and other resources. More routine police duties must be honed to be efficient and effective. The question is how to do this in an area that has always generated significant repeat calls for police service and for which police alone cannot address the underlying causes of those requests for assistance.

In my testimony, I will describe existing traditional responses to people with mental illness in Vermont and communities across the country that have failed to address a problem of crisis

proportions. In the second part of my testimony, I will review the elements of programs and policies that both the law enforcement and mental health community agree would improve these responses. I will also provide some examples of how communities across the country have successfully implemented these programs and policies. Finally, I would like to suggest steps that you and your committee can take to help the law enforcement community address this problem.

CALLS FOR POLICE SERVICE IN WHICH MENTAL ILLNESS IS A FACTOR

Given the limits of this testimony, I will discuss the types of situations police encounter that take up most of our time and generate the greatest concern. Most of these encounters involve people who, essentially, are displaying the symptoms of untreated mental illness. I want to be clear from the start that I'm not suggesting that people with mental illness who commit serious crimes should not be arrested. Any person who commits a serious crime should be arrested, prosecuted and appropriately sentenced. But as the examples I am about to provide you illustrate, when it comes to our response to people with mental illness who commit less serious crimes, we can serve them and our communities better with collaborative police-mental health approaches.

Please "Do Something"

Many police encounters involve a person who is acting in a disorderly or disturbing manner--whether or not a crime has been committed. This may include a man muttering to himself in front of a store, or urinating on a street corner yelling obscenities at people passing by. Or a person standing in the middle of Main Street attempting to direct traffic. Or a person apparently homeless, passed out in the park. Many times concerned citizens place these calls requesting police assistance, though in some cases, business owners or others simply want the police to take the person from the area.

In other cases, a mother, son, or other family member calls us: a loved one with a history of mental illness needs immediate help and they do not know where to turn. Sometimes, the family may be frightened for their safety or for that of their loved one in crisis, or they simply can't take the stress any longer and want help and relief.
In these scenarios, some people want to see the person with mental illnesses receive needed treatment, while others are simply disturbed by the behaviors and want immediate interventions that will get the individual away from them. And because often we're the only resource available 24 hours a day, 7 days a week, they call us. In fact, in many rural areas, like in Vermont, Utah, or Alabama, we may be the only resource available within a 45-minute drive.

Officers who arrive on the scene aren't mental health professionals, and we don't expect them to be diagnosticians. Oftentimes, they can't know whether the person has a physical problem (e.g., seizures), is intoxicated or drugged, mentally ill, or some combination of these. So, in most communities without appropriate programs, the police have three options. The first option is to do nothing, or simply to encourage the person to move along. While this is certainly not encouraged, we need to accept the reality that in some communities, particularly those in which there are severely inadequate treatment services for which an individual qualifies, it continues to be a reality.

The second option, which we do promote, is to link the person with appropriate mental health services and supports. Unfortunately, in many communities, such services do not exist or are unknown to the officer, particularly where no innovative collaborative programs have been implemented. In many cases, the only option available to the officer is to take the person to an emergency room, where the officer may wait hours before the individual is evaluated. Without insurance or circumstances serious enough to warrant commitment, the person is often quickly released into the community, where the officer will invariably encounter the person again behaving in a way that originally prompted someone to call the police.

The third option available to the responding officer is to arrest the individual. After all, some minor crime typically has been committed: disturbing the peace, trespassing, loitering, lewd behavior, vandalism, or another quality-of-life offense. This option becomes especially attractive to officers who have tried unsuccessfully to link individuals with mental health services. It is not uncommon for police to exercise this option. Police are frustrated by the lack of community-based mental health resources, especially for those with co-occurring disorders like alcohol or drug abuse. With nowhere else to turn, law enforcement officers often arrest these minor offenders who end up in a criminal justice system that is ill-equipped to meet their needs, and will often exacerbate them. There, they decompensate further. They re-enter the community often far worse than when they entered. Then the cycle begins again.

Immediate Threat to Self, Police or Public

Another type of call for police service involving a person with mental illness is the relatively rare call involving a person who has a weapon and who is behaving in an irrational and threatening manner. I am reluctant to talk about these stories because, as compelling as they may be, they perpetuate this myth that people with mental illnesses are more violent than the general population. Although the public tends to associate violence with mental illness, experts have conducted extensive studies, and they have found that in the absence of substance abuse, that the correlation between mental illness and violence is no greater than in the general population (Steadman et al. 1998).

Still, these are the situations that become front-page news stories in every state and are the calls that every officer dreads. Vermont is no exception. On December 2, 2001, a Sunday morning, Robert Woodward interrupted services at All Souls Church in West Brattleboro. He held a folding knife with a 3.5-inch blade to his right eye while threatening to kill himself if people left the service. Brattleboro police units were dispatched to the church. Mr. Woodward refused to comply with repeated police requests to drop the knife, and when he advanced towards the police with the knife in his hand, he was shot seven times. He died a few hours later. In a statement to a rescue squad member, Mr. Woodward said, "Please tell the officer I assaulted that I did not want to hurt him. I would not have harmed him. I just wanted him to shoot me." The State Attorney General conducted an extensive investigation of the incident and concluded that the shooting death of Robert Woodward "although tragic, was legally justified."

Cops know that we must intervene in ways that minimize the chances for such tragedies to occur. An encounter in which de-escalation techniques are unsuccessful, or never appropriately applied, can increase the likelihood that lethal force is used and people are hurt. There are far too many stories, in every jurisdiction I have talked to about this, in which the person with mental illness is

injured or killed or that person lashes out at an officer or bystander. And too often, police had been there before, had a previous contact with the individual or known of the problem, but the underlying mental health issues were never fully addressed. I want to provide some suggestions as to how to prevent the loss of life or serious injury. Before I do that, however, I want to explain the impact of tragedies like the one that occurred in the Brattleboro church. At the same time, I want to underscore that the encounters that our officers have on a much more regular basis with people with mental illness have their own tragic outcomes.

COSTS

The costs of not meeting the needs of people with mental illness cannot be computed simply in the dollars spent for police services, overtime and other investments, but in many other human and fiscal costs as well.

Lives Destroyed

Traditional criminal justice interventions for people with mental illness who commit minor crimes decimate lives. Arrests of people with mental illness who have committed relatively minor crimes set in motion a series of events that can result in incarceration, deterioration of the person's health, longer jail or prison terms, escalation in behaviors, the person losing employment (if any) or housing. Arrest or incarceration could add to the stigma associated with mental illness and preempt future employment and housing options that can then result in additional contacts with police. These lives are difficult, if not impossible, to rebuild--for them and their loved ones.

If mental health needs are inadequately addressed, symptoms may escalate and increase police contacts. With each contact comes a risk that the encounter will result in the individual with mental illness being arrested, or the individual or officer being injured. In communities with no innovative police-mental health program, there are also no long-term positive outcomes for meeting the individual's problems that prompted the call for service.

The situations in which a serious crime has been committed can devastate victims and their families. While responses to serious crimes prompt the clearest course for police action, they often have the greatest human costs. Often lives have been lost or changed forever.

Poor Officer Morale

We as police officers want to do the right thing. But when it comes to people with mental illness, we often feel like we're contributing to a hopeless cycle, and this hurts morale among line staff and undermines our credibility with the community. Police respond time after time to the same locations and individuals. They spend considerable resources responding to calls and transporting individuals to services. These efforts often are fruitless. The individual is turned away because he or she doesn't meet access criteria or the individual is back on the streets no better off a few days later.

The relatively rare incident involving a person with mental illness that includes the use of lethal force harms a community and can devastate an officer. The report from the Vermont Attorney General regarding the shooting in Brattleboro pointed to the "pain and strife" that Mr.

Woodward's death "caused and continues to cause for his family and many members of the Brattleboro community... Some witnesses expressed guilt for what happened and blame themselves for not having been able to help." And let us not forget the police officers themselves. Even though the shooting is entirely justified, suicide-by-cop is a traumatic experience from which some officers never recover.

Inefficient and Ineffective Use of Resources

It is hard to talk about police resources when the human costs are so compelling, and it almost seems to denigrate their importance to discuss such practical issues as resources. We do not, in any way, want this discussion to be perceived as such. The reality is, however, that police response is and will be dictated by resources available within the agency, and the level of support or resources in the community that they can access.

My colleagues and I face tremendous challenges as we reposition local policing to respond to the latest threats to domestic security. But our efforts to combat terrorism cannot impede our progress on other fronts. We cannot abandon our efforts to prevent crime, ensure public safety and serve all our citizens with dignity and fairness. We do, however, need to be more effective and efficient in all our efforts.

Calls for police service in which mental illness is a factor make up between seven and 10 percent of all police contacts, and continue to pose significant operational problems for police (Borum, Deane, Steadman and Morrissey 1998). They also tend to take a considerable amount of the officer's time (DeCuir and Lamb 1996). The police resources currently spent in many communities across the nation are not resulting in lasting positive outcomes. Police refer individuals to agencies that cannot provide services or extended care, for a variety of reasons. They spend hours transporting individuals for treatment, assessment or commitment that may or may not be available or granted. They often spend considerable time on the scene trying to resolve issues that are best handled by mental health professionals. Too often they are simply waiting with the individual to be seen or transferred. Some of these issues have been addressed by innovative efforts to improve the police response to people with mental illnesses.

WHAT DO WE DO?

It is tempting--and would be easy--to spend the remainder of my allotted time detailing how we got to this point, the reasons why the system is broken, and the frustrations and terrible experiences police have had trying to minimize contacts by people with mental illness with the criminal justice system. But I think it is more important to focus on some basic truths: that every community has different resources, priorities and problems and that we need responses that can be tailored to the unique needs of local communities. We need to work collaboratively, across disciplines, to develop any meaningful long-term solutions related to improving the criminal justice response to people with mental illness.

These are a few of the many principles to which we adhered through the Consensus Project. Like those communities that have pioneered new programs to improve the response to people with mental illness who come into contact with the criminal justice system, we brought together all key stakeholders in the criminal justice and mental health communities.

With PERF's help, we identified four basic approaches that improve the police response to people with mental illness. These include using the following:

1) Crisis Intervention Teams(CITs) in which specially trained, uniformed officers respond to every call in which mental illness is a factor;

2) Individual mental health professionals, who either ride along with officers in special teams or respond when called by an officer after the scene has been secured;

3) Comprehensive Advance Responses, where the traditional police response is modified by mandating advanced, 40-hour training for all officers within the department; and

4) Mobile Crisis Teams (MCTs), which are county-based teams that act as secondary responders who are called out once the scene has been secured by law enforcement.

The recommendations for the law enforcement section are drawn from these models and specifically address detailed suggestions for improving training and collaboration, as well as the following:

1) Dispatch Protocols to determine whether mental illness is a factor in the call and relaying relevant information accurately and appropriately to officers;

2) On-Scene Assessment that involves recognizing signs or symptoms of mental illness; stabilizing the scene; determining whether a serious crime has been committed; consulting with personnel with mental health expertise; and determining whether the person might meet the criteria for emergency evaluation;

3) On-Scene Response that promotes referral to mental health services and supports, provides information to victims and families, and facilitates transportation and detention when necessary;

4) Incident Documentation that captures relevant data in calls for service data and reports; and

5) Police Response Evaluation based on consultation with service providers to evaluate referral mechanisms and to identify individuals who come into repeat contact with the police.

There are many innovative, promising efforts around the country that illustrate the successful implementation of aspects of these recommendations. For example, in Memphis, before the implementation of their Crisis Intervention Team (CIT) model, officers spent 4-6 hours at the medical center waiting for the person to be admitted for mental health care; the wait time now averages about 15 minutes (Vickers 2000). Shortly after the Memphis CIT was implemented, injuries that individuals with mental illnesses suffered during the course of their encounter with the police decreased by nearly 40 percent. While this certainly has reduced the human costs detailed above, it would be remiss to not mention the implications for reduced liability and resources spent defending police use of force, even if deemed proper.

In Houston, the estimated time for obtaining a mental health warrant dropped from three to four hours to 15 minutes. This reduced the amount of time that a person with mental illness remained in police custody and expedited treatment.

In the San Diego Police Department, the Psychiatric Emergency Response Team (PERT) (sworn officers are partnered with mental health professionals) in its first year realized significant reductions in time required for police interventions and far fewer jail dispositions. Many more incidents were resolved on scene.

In 1999, the Albuquerque Police Department, which also employs a CIT model, reported that officers arrested, transported to jail, or otherwise took into protective custody fewer than 10 percent of those people with mental illnesses they contacted. Injuries were also reduced to just more than 1 percent of calls after their CIT model was implemented. The decrease in use of SWAT was reported at 58 percent (Bower and Pettit 2001).

The effectiveness of new programs has been measured in savings in resources and overall impact: For example, a study of three police departments that had implemented innovative solutions (Memphis, Knoxville and Birmingham) demonstrated that 34.7 percent were resolved on scene; subjects were referred to long-term mental health specialists in 13 percent of the cases; and 45.7 percent were immediately transported to a treatment facility or were admitted to a hospital. Only 6.7 percent of the incidents from the total survey resulted in arrest (Borum et al. 1998).

Numerous other police departments, from Montgomery County, Md., to Minneapolis, Minn., to Seattle, Wash., are also in the midst of implementing similar approaches.

LOOKING TO CONGRESS

Throughout my testimony, I have attempted to underscore a key finding in our Consensus Project: Effective police responses to people with mental illness depend on extensive collaborations with the mental health community. Funding for the consensus project is an excellent example of valuable collaboration across systems at the federal level. The U.S. Department of Justice (Office of Justice Programs) and the U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Agency) each contributed extensively to the project. To their credit, they also promoted efforts by state and local governments to develop the solutions, rather than imposing a one-size-fits-all federal mandate to address this complex problem.

Indeed, federal agency support for the Consensus Project has been a wonderful first step to assist law enforcement in improving the response to people with mental illness. Another important step was the enactment of "America's Law Enforcement and Mental Health Project," the law that Sen. DeWine and other committee members originally sponsored. It recognizes the importance of training law enforcement officers regarding responses to people with mental illness. We hope that funds beyond the initial $4 million will be appropriated to that program, and that the grant program will make police departments eligible for some of this funding support.

These recent developments notwithstanding, considerable work remains. We need the help and leadership of this committee promoting the implementation of the examples in the report. Today's hearing marks an exciting step in that direction. These are the steps I respectfully request you consider taking next.

First, we need the federal government's help determining what works. The Consensus Project is complete with countless examples describing innovative efforts by communities to address the problem. For many of these models we need an evidence base. The federal government is in a unique position to fund and oversee these program evaluations.

Second, despite the extraordinary value of the innovative programs I described earlier, the budget crises in most states, counties, and cities are so severe that the flexibility to fund a new program doesn't exist--even if it will generate cost savings. Resources from the federal government--both in the form of technical assistance from national experts and direct funding support--are essential to help us overcome this hurdle.

Third, discretionary grants from the federal government can be extremely effective in facilitating coordination between criminal justice and mental health organizations. A grant assigning responsibilities to both DOJ and HHS could effect this type of collaboration. We in law enforcement would be happy to work with you to see this type of concept converted into legislation.

CONCLUSION

In these difficult times, it is easy to dismiss efforts such as those we raise today. I implore you to think otherwise. Never before has local law enforcement been more taxed to do more with less. We are at a critical crossroads in our community policing work and in our efforts to serve vulnerable populations. This is precisely the time that we must act to ensure that police resources are properly focused to ensure the greatest possible public safety and quality-of-life outcomes. Police services must have the greatest possible impact and long-term results. The accounts I have provided you today demonstrate that there are tremendous costs--in human lives, dignity, dollars and police resources--that we can no longer afford to sustain in how we respond to people with mental illnesses who come into contact with the criminal justice system.

There are also solutions to this problem, which the Consensus Project Report describes, and which we can implement with your help. The bottom line is: We can do better. We owe it to the people with mental illnesses who trust us to respond fairly; to their families and loved ones; to victims and to the communities who need to trust the police to respond effectively to their calls for service.

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