The Relationship of Selected Variables to Dispositions, by Police Officers, of Persons Thought to be Mentally Ill

by

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DEDICATION

to the mentally ill,
who wait for these questions to be answered,

to Merla J. Olsen, RN, MS,
who taught me what it means to be a nurse,

to my parents,
William and Doris Reynolds,

to my Family,
of friends and relatives who have unceasingly
and sensitively given their support.

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CHAPTER I

INTRODUCTION

There is a growing body of literature citing the intent of the deinstitutionalization movement (Bloom, 1973; Test & Stein, 1976) and its apparent limitations (Aviram & Segal, 1973; Slavinsky, Tierney & Krauss, 1976; Whitmer, 1980; Zitrin, Hardesty, Burdock and Drossman, 1976). One consequence of those shortcomings seems to be increasing numbers of mentally ill seen both in the nation's jails (Aviram & Segal, 1973; Bonovitz & Guy, 1979; Petrich, 1976c; Whitmer, 1980) and living on our streets (Aviram & Segal, 1973; Bittner, 1967). There is very little information, however, concerning the frequency with which police officers are confronted with the problem of implementing dispositions for mentally ill people. One study by Bonovitz and Bonovitz (1981) cites a 227.6% increase in contacts by police with mentally ill people over a recent four-year period. The variables involved in deciding how to intervene with these people need to become visible in order to examine consequences of existing policy and plan appropriate services.

Housing mentally ill people in jail is not a new phenomenon. However, the assignment of psychiatric diagnoses and development of treatment for people in the jail setting is fairly new (Gibbs, 1978; Petrich, 1976a, 1976b, 1976c, 1978). Diagnoses apparently run the gamut with schizophrenia, personality disorder, mania, and depression heading the lists in most studies (Petrich, 1976a, 1976b, 1976c, 1978). Treatment facilities in jails have not often been described, probably because they are just beginning to be implemented in some spots across the country (Petrich, 1976a, 1976b, 1978).

Research is scant regarding the consequences of incarceration in a jail compared to hospitalization or some other form of crisis intervention. However, jailing has been shown to be associated with suicide rates higher than those prevailing for the general population (Gibbs, 1978).

Why mentally ill are jailed instead of hospitalized is a question not well understood at present. Whitmer (1980) contends that the law requires police and mental health professionals to work at cross purposes so that a population of people with mental illness becomes "forfeited." By this he means that whereas deinstitutionalization is intended to get clients out of institutions, professionals in mental health have only recently begun use of a variety of treatment forms which will keep these people out of institutions. The policeman sees himself as an agent of public peace and safety, and may find himself trying to institutionalize a subject whose behavior appears to threaten that peace and safety (Bittner, 1967). He is often thwarted, however, in his efforts. Commitment laws across the nation, in concert with deinstitutionalization, have become increasingly concerned with protecting the civil liberties of the mentally ill. It is ever more difficult to have someone committed for mental illness (Bonovitz & Guy, 1979). In Oregon, "dangerousness" must be established, as well as mental illness. The physician with whom an officer may collaborate then, has "dangerousness" as an additional criterion for involuntary hospitalization. While both may agree the person appears to be in need of treatment, the questions which remain are: Is he/she dangerous enough to be committed, or, would he/she comply with a voluntary treatment regimen? When both answers are in the negative, the police offi-

cer must then discover an alternative to commitment for his subject. For the officer, there may be no alternative disposition available and for the subject, no treatment.

Whitmer's description of a typical person with chronic mental illness is illustrative of the kinds of behavior police and mental health authorities often encounter.

> The social withdrawal of the forfeited patient, his fearfulness, impulsiveness, anger, confusion, and readiness to act are characteristic, indicative of his need for help, and frequently the only way he can ask for help. If we are to attempt to stabilize this population outside the hospital and outside the criminal justice system, then these characteristics cannot be taken as an unwillingness to continue treatment....He is also the person who never initiates outpatient contacts. He discontinues his medication, believing it to be the source of all his problems, citing as evidence his experience of uncomfortable side effects. He spends whatever he received from an income maintenance program in the first few days of the month, giving it to friends or spending it to self-medicate himself against anxiety with street drugs or alcohol. He will not live in any kind of residential care because the programs take too much of his income, threaten him with pernicious control over his longdisputed autonomy, and deprive him of the protection of social withdrawal allowed him in an isolated hotel room. He cannot work and he looks for diversion on the street. But his anxiety is great, his attention span limited, his frustration tolerance low,

> and his mistrust of people immense. Action is his self-prescription for cure (1980, pp. 67-68).

Whitmer suggests that such a person's refusal of treatment is a part of his illness. He further suggests that the real dichotomy may be not between civil liberties and the need for treatment, but between "...patients' needs versus available knowledge and resources" (p. 74).

It is likely that policemen are confronting many persons "forfeited" as a consequence of this gap. Although reluctant in his role, the policeman has become the "outreach worker" and the most likely to make the critical disposition decision in the public arena (Matthews, 1970; Patrick, 1978; Whitmer, 1980). Two authors have speculated as to what influences his attitudes and decisions. Patrick (1978) described her sample of policemen according to departmental rank, length of time on the force, age, education, frequency of contact with mentally ill and personal acquaintance with mentally ill individuals. Gove (1978) discussed some variables he thought might be involved in this kind of decision: behavior of the subject as well as of the complainant, the nature of the acts as perceived by the officer, the ease of obtaining treatment as well as its quality, facilities available at the local jail, established procedure as well as characteristics of the policeman himself. But to date, no one has systematically investigated the variables which determine types and frequencies of dispositions (Braunstein, 1980; Gove, 1978).

The purpose of the present investigation is to expand our knowledge of this phenomenon, by describing the disposition process as it occurs in a metropolitan area and by exploring the relationships of selected variables to disposition outcomes.

Review of the Literature

This review of literature covers the variables, as they are currently understood, which seem related to police involvement with mentally ill persons. First, the influence of the deinstitutionalization movement, its intent and its consequences are discussed. Also reviewed, though scant, is the literature which notes the apparent increase in the numbers of mentally ill found in jail. Third, the reasons why they may be jailed versus hospitalized are summarized. Fourth, diagnoses and treatment, which have been documented in some jails, will be discussed, including mention of the possible consequences of incarceration on mental health. Last, the literature pertaining to police attitudes and the frequency with which police officers must make dispositions for mentally ill people will be reviewed.

Deinstitutionalization

"As the term suggests, community mental health refers to all activities undertaken in the community in the name of mental health" (Bloom, 1973, p. 1). Bloom expands his definition by listing the characteristics which distinguish community mental health from institutional care. They are an emphasis on practice *in* the community, a "catchment area" population versus single patients, prevention services, indirect services such as consultation and education, crisis intervention, needs assessments and coordination of services, use of nonprofessional manpower and "natural helpers," community responsibility for its own mental health and its mentally ill residents and consideration of community characteristics which may be a source of stress to its inhabitants. Crisis intervention, needs assessment, coordination of services, and use of "natural helpers" are particularly salient to this

investigation. It is in these, as well as other service areas, that the limitations of the deinstitutionalization movement can be seen.

"Most societies are organized so that certain roles legitimately include crisis intervention activities. In Western countries, the police, physicians, and the clergy come to mind..." (Bloom, 1973, p. 21). It is in these crisis intervention activities that police are called upon to decide the immediate placement of mentally ill individuals. As will be discussed further, there is controversy among police officers and administrators as to whether or not psychiatric crisis intervention is part of the officers' role (Bittner, 1967; Colbach & Fosterling, 1976).

The facet of deinstitutionalization which was intended to enable communities to accept previous inhabitants of institutions into their populations was a careful assessment of patients' needs and coordination of necessary services. This is perhaps where the most serious failing occurred. The clinics which did and do exist to provide outpatient treatment account for 65% of mental health episodes as opposed to 23% in 1955 (Bloom, 1973), but studies have shown that these contacts do not involve the seriously mentally ill. Rather, the clinics were structured in such a way as to be more available to those who are able to keep appointments, participate in therapy, and make use of existing support systems (Bachrach, 1980; Slavinsky, Tierney, & Krauss, 1976; Whitmer, 1981). Not only were chronically mentally ill individuals discharged before community mental health professionals were fully prepared to help them, but also before any studies had been done to track movement of clients and their service needs. Particularly relevant for the present investigation, there were no predeinstitutionali-

zation studies describing jail populations (Bloom, 1973).

Apparently due to lack of this kind of planning, a "revolving door" syndrome is often seen. Hospital censuses have gone down dramatically, but there has been an alarming rise in admission rates as mentally ill people have returned to the hospital more frequently (Bassuk & Schoonover, 1981; Bassuk & Gerson, 1978; Bloom, 1973; Slavinsky, Tierney, & Krauss, 1976). In spite of the decrease in long term hospital utilization, funding was not transferred to communities so that there was a lack of follow up or effective treatment available in the community (Whitmer, 1980).

Resources available to chronically mentally ill were much reduced in all realms. Before deinstitutionalization, 65% of patients discharged from hospitals were sent home to families. Now only 23% have families to support them (Talbott, 1980). In 1974, it was calculated that group home space was available in the United States for only approximately 1% of the schizophrenic population (Talbott, 1980).

Arrest Rates of the Chronically Mentally Ill

There is some controversy but scant research regarding the frequency with which chronically mentally ill persons are arrested. Generally, research since 1965 has shown that, in certain categories of offense, former patients were arrested more often than the general population (Grunberg, Klinger, & Grument, 1977; Steadman, Cocozza, & Melick, 1978). But at least one group of authors postulates that perhaps the number has not increased as much as has the attention given to counting them (Steadman, Vanderwyst, & Ribner, 1978).

The dangerousness potential of mentally ill subjects has been described in terms of their arrest rates. Rappeport and Lassen (1964)

found that patients had higher arrest rates than the general population for robbery, but an equal rate for aggravated assault. Zitrin, Hardesty, Burdock & Drossman (1976) studied a group of 867 mental patients' records two years prior and two years post hospitalization. For their group, during the two years post hospitalization the number of arrests for bodily assault increased 1 1/2 times over the number for the two years prior to hospitalization. One-half of the violent crimes were committed by schizophrenics in the sample. Sosowsky (1978) studied arrest rates and charge categories for 301 mental patients and found the frequency of arrests for each of the major crimes was higher among the subjects of the study than in San Mateo County generally or in the urban areas of the United States as a whole, especially in the age category of 20 to 29 years. Seventy-five percent of the patients who were arrested were diagnosed as schizophrenic. Violent offenses occurred among the mentally ill expatients 3 1/2 times more often, potentially violent crimes occurred 1 1/2 times more often and non-violent offenses 3 times more often than in the local and the U.S. urban general population. Steadman, Vanderwyst & Ribner (1978) compared two groups of known criminal offenders with two groups of mentally ill, once in 1968 and once in 1975. They found that arrest rates for mentally ill subjects were higher than for the general population but lower than that for offenders. In addition, they found that members of both groups, once arrested, were much more likely to be arrested again.

Reasons for Jailing Versus Hospitalization

There are few, if any, studies which have systematically examined the question of why some mentally ill people are incarcerated rather

than hospitalized. However, several authors have reported theories and observations on that topic. Braunstein (1980) found that those events which occurred in a public place were more likely to result in jailing the mentally ill person versus hospitalizing him/her. Conversely, private events, especially those involving family or friends, resulted more often in hospitalization.

As previously mentioned, considerable attention has been given to the lack of appropriate treatment in the community in order to avoid institutionalization of some kind. Egon Bittner contends "that the decision to invoke the law" regarding a mentally ill subject, "is not based on an appraisal of objective features of cases. Rather, the decision is a residual resource, the use of which is determined largely by the absence of other alternatives" (Bittner, 1967, p. 278). Bonovitz & Guy (1979) contend that increasingly restrictive civil commitment laws create this "absence of other alternatives" resulting in more frequent criminal incarceration.

As Whitmer (1980) has claimed, mental health professionals apparently tend to interpret the behavior of the chronically mentally ill as a refusal of treatment and thereby refuse them admission (Bassuk & Schoonover, 1981). Perhaps this is the result of what other authors have described as a limited tolerance for chronic patients in society generally (Aviram & Segal, 1973; Rachlin, Pam, & Milton, 1975), as well as among those who must deal with them more directly (Lamb, Sorkin, & Zusman, 1981; Talbott, 1980). At the same time, laws are being written to protect these people from lengthy hospitalization and to make institutional care more difficult to obtain (Whitmer, 1980). The result of this can be to make no treatment available. Jail then becomes the only

way to get a mentally ill person off the street (Abramson, 1972).

Talbott (1980), Test & Stein (1976), and Whitmer (1980) go further to say that mental health professionals have not yet developed the knowledge and resources necessary to enable the mentally ill to live successfully in the community. They attribute this situation to a lack of funding (or funding too complicated to be used in the community) and to a dearth of professionals who are prepared in the rehabilitation-resocialization model. Aviram & Segal (1973) discussed this problem in terms of public attitudes toward the mentally ill and resulting methods (formal and informal) of excluding them from communities. Advocates of mentally ill people have not yet discovered ways to enhance public acceptance of these people.

Diagnoses and Treatment in Jail

There have been more studies conducted in England than in the United States on the prevalence of mental illness among prisoners. Faulk (1976), in reviewing these British studies, stated that all reported a prevalence greater than 50%. In the United States, data are somewhat more sparse, although the importance of the problem of the imprisonment of the mentally ill has been recognized.

Thus a survey by the American Medical Association in 1973 estimated that only 13% of the nation's jails had psychiatric services available, "yet law enforcement personnel and jail staff consider psychiatric illness to be the single major health problem among inmates" (Petrich, 1976c, p. 1439). It might also be mentioned that in the setting studied by the present investigator, in 1980, there were 838 persons admitted to the County Booking Facility who were identified by nursing staff as mentally ill (Page, Note 1). The following studies

demonstrate a wide range of findings regarding prevalence and diagnoses of mental illness among prisoners.

Petrich has written a series of descriptive studies revealing typical diagnoses and the types of treatment used. One of these studies took place in King County Jail in Washington State. In a 5-month survey, 200 referrals to a half-time psychiatrist were noted. One-third of these were examined within 24 hours of booking. The overall morbidity rate was 4.6%, one-half being referred for "fighting, suicide attempts, and other grossly disorganized or disruptive behavior" (Petrich, 1976c, p. 1440). Those referred tended to be about ten years older than the general jail population and tended to be of a minority race. Eighty percent were felons. Most had prior arrests and been jailed, but few had served prison sentences. Most of the women and one-third of the men had attempted suicide previously and most had had previous psychiatric hospitalization (Petrich, 1976c). Although depression, sometimes with agitation and suicidal ideation, was common, over one-half of the referrals were diagnosed with personality disorder. Twenty-four of these were also alcoholic and/or drug dependent. One-quarter of the referrals were alcoholic and one-third drug dependent. Petrich could not, however, identify a pattern in the diagnoses which resulted in referral.

A study of mentally ill prisoners by Petrich (1976b) in another location produced slightly different results. About one-third of the total inmate population, or 539 prisoners (434 males and 105 females) were referred for psychiatric evaluation. The referrals were made by medical staff (38%), custodial staff (25%), social service personnel (21%), attorneys, family, or other inmates (16%). Of those referred,

approximately even numbers were misdemeanants and felons. Evaluation was accomplished within 24 hours of booking. The prisoners were diagnosed as follows: 49% psychotic (schizophrenic or manic), 27% antisocial, 20% alcoholic, 23% drug dependent, and 10% depressed. Two-thirds required and received community resource contacts upon discharge, 14% received conventional psychotherapy (3 or more sessions), and 11% was voluntarily hospitalized. Treatment was described as emphasizing crisis intervention, rapid mobilization of services, time-limited interventions, problem-oriented interviews, environmental manipulations, coordination with community resources, and pharmacotherapy. No data were provided regarding treatment successes or recidivism.

At still another jail, Petrich (1976a) implemented an acute care clinic. He identified 524 mentally disturbed prisoners over the period of one year. Of the 524, 422 were male and 102 female; 296 misdemeanants and 228 felons. The reasons for referral broke down into the following percentages: fighting (26%), bizarre behavior (24%), history of prior treatment (18%), suicidal thoughts or gestures (7%), anxiety (6%), request for medication (6%), withdrawal symptoms (5%), and crying (2%). Diagnoses were distributed as follows: schizophrenia (40%), antisocial personality (25%), drug dependence (24%), alcoholism (20%), mania (1%), depression (1%), and miscellaneous (3%). Sixty-six percent of these people required referral to out-of-jail resources as part of their treatment plan.

One year later, Petrich (1978) was able to identify two profiles. The most common referral was for a misdemeanant with psychotic illness who required long-term antipsychotic medication and close contact with community resources. The other typical referral was for an individual

with a character disorder and a situational reaction giving rise to suicidal ideation. Only 33 clients were identified as jail recidivists; 25 with 2 referrals, 6 with 3 referrals, and 2 with more than 3 referrals. Eighty-six percent of the total had previous psychiatric examination and/or treatment. Misdemeanants had been previously hospitalized more often than felons. Fifty percent of the misdemeanants were schizophrenic and 60% of the total referrals were for manifestly disordered and violent behavior.

James, Gregory, Jones & Rundell (1980) studied the psychiatric treatment needs of a prison population in Oklahoma for the purpose of developing a system of services. They objectively assessed a stratified sample (N=246) of prisoners and concluded that the incidence of mental illness was much higher than that of which the custody staff was aware, as reflected in the number of their referrals. A randomly selected subsample (N=174) was evaluated and assigned diagnoses. Thirty-five percent suffered from personality disorders, 25% were substance abusers, and 5% were schizophrenic. They claimed that 3 needed inpatient care, 8 needed day care, 50 needed outpatient care, 54 needed crisis intervention, and 59 were considered not in need of any type of psychiatric care.

The most recent study, by Lamb & Grant (1982), describes 102 male inmates from the Los Angeles County jail, randomly selected from those referred for psychiatric help. Ninety percent had had previous psychiatric hospitalization, 92% had previous arrest records (75% for felonies; 17% for misdemeanors), 80% exhibited overt psychopathology, 75% met commitment criteria, and 39% had been arrested for crimes of violence. "Thus it is clear that this population has had extensive exper-

ience with both the criminal justice and mental health systems, is characterized by severe acute and chronic mental illness and generally functions at a low level" (Lamb & Grant, p. 19).

In an analytical article, Gibbs (1978) has addressed the question of whether jails are such that they induce psychological trouble or that large numbers of mentally disordered people are taken to jail. He suggested the possibility that there is an interaction between predisposing factors in the individual and elements of the jail environment. The most widely reported mental health problem in jails is that of self-injury and/or suicide, and there is some speculation that it may be one of the effects of incarceration. Gibbs quoted Toch, "...with even the most conservative figures we can show that the problem of self-mutilation is endemic and that nothing commensurate occurs in other settings. If a problem even remotely similar were to arise in the outside world, it would provoke outrage and emergency intervention" (Gibbs, 1978, p. 22). Gove has stated, however, that "we do not know what the most problematic features of incarceration are in terms of precipitating mental illness" (Gove, 1978, p. 11).

Frequency of Police Dispositions and Influencing Factors

In 1978, Gove described what he believed an officer's options to be in dealing with mentally ill citizens, as well as the interacting variables which may influence his/her actions.

> When the police are called because a person has created trouble and/or is perceived as a threat to others, they essentially have three possible courses of action. The police can attempt to calm the individual(s) down by talking to them, isolating them, acting as mediators, etc. The

> police, on the basis of what they see and hear may decide an individual is mentally ill and play an official role in the initiation of commitment procedures to a mental hospital. Alternatively the police may arrest the individual who has created a disturbance on a variety of charges, a procedure which will generally lead to the individual's being placed in jail. A review of the literature indicates that there are almost no data on the factors affecting a particular choice of action or the frequency with which particular choices are made. The choice of action probably involves a complex set of factors including the behavior and demeanor of the individual, the behavior and demeanor of the complainants, the nature of the acts perceived by the police as well as those alleged to the police, the ease of initiation to mental hospitalization as well as the perceived quality of the hospital, the condition and facilities available at the local jail, established routine within the police department for dealing with such individuals, as well as the particular characteristics of the policemen involved (Gove, 1978, p. 7).

Lamb & Grant (1982) found it difficult to determine precisely why mentally ill inmates had been arrested. They did determine that police policy mandated that all persons committing felonies or with outstanding warrants went to jail. For misdemeanors, the reasons ranged, as Gove suggested, among the following: citizen insistence that the subject go to jail, subject not clearly mentally ill at the time of arrest, problems with obtaining hospitalization and combinations of these factors.

Bittner (1967), Matthews (1970), and Patrick (1978) all agreed in stating that police have clear authority to intervene with mentally ill individuals. They suggested that the disposition decision is one of discretion versus mandate. They also suggested several hypotheses as to why this often does not result in hospitalization. Bittner discussed five factors of influence. One is that police officers tend to be in close attitudinal agreement with the public at large in that they understand the seriousness of mental illness but "avail themselves of various forms of denial when it comes to doing anything about it" (Bittner, 1967, p. 280). Also, policemen confront such an abundance of disordered behavior daily that they use some system of "economy" in deciding when to intervene. Third, policemen believe, for the most part, that dealing with the mentally ill is not a task commensurate with their image as law enforcers. In addition, they believe that attempting to hospitalize someone takes too much time and offers too much opportunity to bring the officer's judgment into doubt. Lastly, officers are well aware that hospitalization is often prolonged and they are reluctant to be the catalyst for such incarceration especially if the subject is particularly unwilling to be hospitalized. Matthews (1970) claimed that the discretion an officer uses in deciding certain behavior warrants hospitalization is the same as deciding the subject is not guilty by reason of insanity. The officer is reluctant to invoke that privilege if others on the scene insist the subject is criminal. Matthews also concurred that if the commitment procedure is too cumbersome, officers will fall back on the criminal code.

Police officers' attitudes are also recognized as influential in their decisions regarding mentally ill people. Patrick (1978) con-

ducted an elaborate study of policemen's attitudes regarding mental illness and the mentally ill. She considered the influence on attitude of age, length of time on police force, education completed, and personal experience with mentally ill individuals. She found that officers with longer service on the police force expressed a more humanistic attitude toward the mentally ill, and that younger officers, especially those with a high school education or less, were more authoritarian in their views of how to handle mentally ill subjects. Officers who had known personally someone who was mentally ill were also more tolerant in their attitudes toward such people. However, attitudes did not differ according to whether or not the officer's life had been endangered by a mentally ill individual.

This review of literature can be summarized with the following statements:

(1) There is agreement in the literature that more chronically mentally ill individuals are living outside mental health institutions.

(2) There is controversy in the literature regarding whether or not there is a real increase in the numbers of mentally ill found in jail. However, authors generally agree that care of the mentally ill in jails is inadequate.

(3) The reasons for arresting versus hospitalizing mentally ill subjects are various and not well documented.

(4) Schizophrenia and character disorder are frequent diagnoses made in jail populations.

(5) There are no data as to the frequency with which police officers deal with mentally ill subjects.

(6) There is wide speculation as to what influences an officer's decision. Variables mentioned most frequently in the literature are the timing, convenience and quality of hospital care available, conflict with the officer's role as a law enforcer, established policy, and the officer's age, education, and experience.

Statement of the Problem

The purpose of this study is to describe the relationship of selected variables to the dispositions police make of persons they believe to be mentally ill. The variables selected represent four major areas which are thought to influence these dispositions, directly as well as indirectly; some characteristics of the officer himself, characteristics of the apparently mentally ill person, some conditions of the contact, and some process variables which, in the officer's judgment, determine the availability of options.

CHAPTER II

METHOD

Setting and Sample

The unit of analysis of this study was the disposition of a "mentally ill" person made by a police officer. The disposition was the resolution of a contact between an officer and a citizen the officer judged to be mentally ill. The contact may have been initiated by anyone; the officer, his dispatcher, or any citizen, including the mentally ill person. A problem may or may not have been identified as a result of the contact and the disposition may or may not have included transportation of the mentally ill person. Persons were identified as mentally ill either formally or informally; for example, by a family member, a citizen, or the officer himself. However, it was the officer who had to make it finally known to the investigator whether the subject was mentally ill in his/her estimation. It was of note to the investigator, a psychiatric-mental health nurse practitioner, that their judgments of mental illness were in complete agreement with her own. Dispositions which involved charging the subject with either a Class A felony or a Psychiatric Security Review Board (PSRB) Revocation would have been excluded, as they are pre-determined, and do not allow the officer to use his own discretion. However, there were no dispositions of these types encountered.

Seventeen officers were observed to obtain a total of 50 dispositions. The number per officer ranged from at least one to a maximum of six. It was not possible to obtain the same number per officer due to the constraints of officer availability.

The officers were a volunteer sample chosen from prowl car patrols assigned to the 4 pm to 12 midnight shift of Portland's Central Precinct. There were a total of 32 positions on this shift, 23 of which were filled. The 5 officers who did not participate were unable to do so because they had trainees riding with them. All who had space in their car (18) volunteered. One officer had no dispositions of the type being studied. The final sample, then, consisted of 17 officers.

The areas of the city represented by the 9 patrol districts involved were confined to the core downtown area, together with the northwest sections from the river to the city's outer edge. These are the areas identified in a recent grant proposal as the areas of concentration of mentally ill subjects in the west quadrant of Multnomah County (Dunne, Note 2). There were 3 districts from which most (30) dispositions came. They were in the northwest and "Old Town" sections as well as downtown near the river. (See precinct map in Appendix A.)

Bureau statistics collected during the first six months of 1981 do not identify a pattern of days of the week with the most psychiatric contacts. An effort was made to sample every day of the week with ride-alongs occurring only twice on Mondays, but from 5 to 7 times on each of the other days of the week.

The data were collected during the months of July and August, 1982. Although it is generally thought that more arrests occur during the summer, it is unclear what influence the time of year may have had. The investigator attempted to obtain as broad a sample of officers, mentally ill people, and dispositions as possible. However, the sample of dispositions remains a nonprobability sample, and hence may not be

truly representative. This limitation must be kept in mind when generalizing from the findings.

Police regulations are very clear about "when and how to deal with mentally ill persons." General Orders limit the officer's responsibility to those subjects dangerous to themselves or others. The Emergency Commitment Statutes then clearly state the officers' procedure (ORS 426.200-426.223). However, "if the examining physician determines the person is NOT mentally ill, (or not dangerous to himself or others), the officer will make an arrest if other charges prevail, or, with the subject's permission, return him to the original place of custody" (General Orders Section 850.20, Note 3). It is at this point in the commitment process that the disposition may be influenced by a number of variables. The majority of dispositions, however, were not commitment attempts and usually the officer most often had ample latitude in his/her decisions.

Data

The investigator accompanied one officer at a time, eight hours each shift, for a total of 37 "ride-alongs." Eleven of those rides resulted in no dispositions of the kind being studied. However, an evening did not occur during that time that at least one other officer did not receive a "1234" call, audible to the investigator over the radio.

Permission to do the study was received from the Police Bureau Administration and two officers were assigned to assist implementation of the study. These "ride-alongs" occurred under the auspices of an established program whereby interested citizens and students may accompany officers. Data were collected by observational technique. A

brief interview was conducted with each officer and all reports regarding mentally ill subjects were reviewed at the conclusion of each disposition. (See Questionnaire: Appendix B.) Otherwise, data were recorded on a checklist and by process recording as it was observed to occur. (See Worksheet: Appendix C.)

Dependent Variable: Type of Disposition

There are three major categories of dispositions: jail, health facility, remain in community. For each, subcategories will be distinguished - three for jail, three for health facility, and two for community.

Jail dispositions. There are three routes to a jail disposition. All these will be noted separately as they involve different consequences for the mentally ill person. In two of these cases, the subject has to be charged with a crime. It may be a misdemeanor or a felony crime. Misdemeanors are lesser crimes, usually violation of a municipal ordinance, conviction of which may result in a fine, community service, or incarceration for up to one year. Conviction of a felony is more serious. It may result in imprisonment in a penitentiary from one year to life.

The subject may go directly to jail from the scene of the contact (jail-direct), or the officer may attempt to obtain some type of health evaluation and/or treatment prior to incarceration (jail-after hospital). Hospitalization is a potential of the evaluation because the County has a contract with a local hospital ensuring hospital care, under secure conditions, for prisoners. Therefore, if the subject is taken to jail after an evaluation at this hospital, it means the physician deemed the subject well enough, both medically and psychiatrical-

ly, to go to jail. Were the subject to be evaluated at other than the contract hospital and then taken to jail, it would probably represent an unsuccessful commitment attempt.

The third route to jail is a noncriminal disposition, called a civil hold, reserved for inebriated subjects (jail-civil hold). ORS 426.410 provides that inebriated subjects can be lodged involuntarily from 4 to 72 hours either in jail or in a local detoxification center. Although these subjects receive some supervision while in jail, they receive no treatment or social service intervention beyond those few hours.

Health facility dispositions. There are also three possible routes to a health facility disposition. They also have potentially different outcomes and will be noted separately. Two of these routes result in at least a short-term hospitalization while the other results in a short stay (4 hours to 3 days) in a local detoxification center.

A police officer may initiate commitment proceedings by using a Peace Officer Hold, described in ORS 426.215 (POH). It requires that the officer have reasonable cause to believe that the individual is mentally ill and dangerous to himself or other people. The officer must transport the subject to a hospital where a physician must concur with him that the subject is in need of immediate care and custody. If so, the subject will be admitted involuntarily to the hospital for at least five days. If the physician disagrees, the officer must either develop another disposition or release the subject.

As noted earlier, for any health reason, an officer may decide an individual should be evaluated at a hospital. This may result in a voluntary admission to the hospital, (may or may not be in criminal

custody), should the physician deem the subject not well enough to be in jail (hospital).

An intoxicated mentally ill person can be lodged at a local detoxification center (Detox). He will receive general supervision, medical care when needed, and an opportunity to remain there voluntarily for five days of more comprehensive care. Often, however, when an intoxicated individual is diagnosed by Detox staff to be mentally ill, the officer will be asked to come back and develop a different disposition.

Community dispositions. There are two general community dispositions. Neither one involves the criminal justice system, and each may, although not necessarily, result in voluntary treatment and/or community supervision of some sort.

In some situations, the officer may decide the best resolution of a contact is to ask a local mobile crisis team to intervene for him (crisis team). The team may provide anything from simple transportation to crisis intervention and referral. This disposition may result in the voluntary hospitalization of the subject.

In some cases, it is also possible for the officer to invoke a simple community disposition (informal). This may include such things as an agreement with the subject to "move on" or "go home," enlisting another citizen's assistance in aiding or monitoring the subject, transporting the subject to his own or someone else's home, or agreeing to check on the subject's status periodically. Specific notes were kept to identify resources called into play in these cases, but it became clear that for the most part the officer used his/her own counseling skills and gave instructions as to how the subject should behave for the immediate future. This sometimes included offering

reassurance and the willingness to "check on you later."

Independent Variables

Four groups of independent variables were examined for their possible direct as well as indirect influences on dispositions. They are, first, characteristics of the officers, second, characteristics of the mentally ill citizens, third, the characteristics of the context, and fourth, characteristics of the process.

Characteristics of the police officer. The first set of variables describe the police officer himself. Descriptive characteristics included age, race, sex, number of years as a policeman, and level of education in numbers of years of high school, college, or post-graduate work. Two facts of past personal experience were obtained as well: whether or not his/her life had ever been endangered by a mentally ill person and whether or not anyone he/she had ever known or was related to had been mentally ill.

Characteristics of the "mentally ill" person. The second group of variables are those descriptive of the mentally ill person. They included age, sex, and race, and previous contact with the justice system, that is, whether or not s/he had been previously arrested in this city and whether or not there were current "wants or warrants" for this person. When the individual was arrested, the classification of the charge was recorded.

Two other variables are judged to be of major importance in determining dispositions. The first is the behavior of the person which apparently resulted in contact with the police officer. This behavior was described as witnessed by the investigator, as recounted verbally by a participant in the contact, and/or as summarized in the officer's official report.

The second variable recorded for each mentally ill person was that of dangerousness. The measure for assessing the extent of dangerousness was one developed by Braunstein (1980) for a similar group of mentally ill detainees in neighboring Lane County. For purposes of this study, those aspects of the subject's behavior considered "dangerous" were self-mutilation, suicide attempts, danger to others. Verbal threat was distinguished from an actual attempt. For self-mutilation, suicide, and dangerousness to others, verbal threats were scored "1" and "2.". A verbal threat without a plan was given a score of "1" and a similar threat which included a plan was given a score of "2." Actual attempts were represented by a score of "3" if non-life-threatening, and by a score of "4" if lifethreatening. Total dangerousness score might vary from 0 to 12.

The second measure of dangerousness was based on the present investigator's intuitive judgment of the need for close supervision for a life-threatening condition. Scores are "0" (no problem), "1" (minimal), "2" (moderate), "3" (frequent), and "4" (continuous). (See Appendix D.)

Context variables. The third major group of independent variables describe context of the contact. They are the nature of the location, the identity of the complainant, and the time it takes to resolve a contact.

The behavior or event which resulted in contact with the police officer occurred either in public or in private. For the purposes of this study, a private location was characterized as one which originated in a location believed by its inhabitants to be private. That is, the event occurred in a place considered, by prevalent social mores, to

be a place one would not enter without an invitation, if one did not dwell there oneself; for example, a house, an apartment, a hotel room, a boarding house. A public location, by contrast, was defined as one which is open to anyone who chooses to be there, with or without a specific purpose; for example, the street, a tavern, a hotel lobby, an office building, a bus, or a theater.

The complainant was characterized by his/her role at the time of making the complaint and by whether or not the subject was known to the complainant. That is, the complainant might encounter the subject as a private citizen, a business owner or manager, health professional, police officer, security officer, bartender, etc. He/she might or might not have had previous experience with the subject. That is, he/she might know the subject only by sight or name, be related in some way, or be a complete stranger.

One factor, as the literature suggests, that is important to a police officer is the time it takes to resolve a contact. For the purpose of this study, each contact was timed by the investigator from the time the subject was encountered until the disposition was completed.

Process variables. The fourth group of variables are representative for the most part of the interaction of the representatives of the health and justice systems; the police officer and the agency personnel. An attempt was made to discover how the health and justice systems interacted to help or hinder resolutions of a disposition. The reason given, should a subject be refused admission to any facility, was recorded, as well as a process recording of the events which culminated in a disposition. Interactions between police and agency personnel as well as "thinking out loud" were recorded.

Design and Procedure

A descriptive study was done using participant observation and a brief interview questionnaire as data collection methods. A worksheet check-off list (see Appendix C) was used to record observations. The questionnaire covers only the information elicited from the officer about him/herself (see Appendix B).

The data were collected by direct observation of dispositions as they occurred. They were identified for inclusion in the study when the officer described a subject in any way as mentally ill. A familiar euphemism used by police bureau staff to identify such subjects is "1234." Persons acting under influence of alcohol or drugs were not excluded if they were identified as "mental," "crazy," "1234," or in any other way suggestive of mental illness.

Upon arrival at the scene of a study-identified contact, the time, subject, and context variables, and whether or not the subject was known to the officer were recorded. This information was available by simply watching and listening. Disposition and process variables were recorded as the disposition progressed, and the time once again recorded at its finish. Police officer characteristics were recorded once at the end of the ride-along experiences with that officer.

Instructions to officers were given to 4 p.m. to 12 a.m. shift officers as a group at several roll call meetings during the week prior to data collection. They were also read to each officer as many times as was necessary at the outset of each shift. (See Appendix E.)

The confidentiality of the officers was recognized by Bureau Administration officials as requisite. Although the identity of any officer in any district on a specific shift was generally known, it was

agreed that no attempt will ever be made to have the investigator verify any officer's identity, nor would any data be used to evaluate the performances of officers (see Appendix F). A single letter, used in order of occurrence, served to identify each officer. A reference list for this code was kept locked in a file cabinet at the investigator's home until data collection was complete, and then destroyed. At no time was the officer's name or badge number recorded on any worksheet. (See Appendix G.)

The confidentiality of mentally ill persons was similarly protected. A single number used in order of occurrence, identified each contact. Although the officer must identify the subject by name in order to complete a disposition, at no time was his/her name recorded by the investigator. Neither was the date or specific location of contact recorded, as this information could be used to reference police reports which are open to the public. The description of the subject's behavior by the investigator occurred independently of the officer's observations and was not seen or used by the officer in any way. There was no intervention with mentally ill subjects nor any information gathered regarding them not available by simple observation. The investigator adhered to the requisites of participant observation in that she gave no information nor made inquiries which might influence disposition of the subject. Any questions remaining regarding nominal characteristics of the mentally ill person were clarified by reading the officer's official report, which was completed at the conclusion of each disposition.

CHAPTER III

RESULTS AND DISCUSSION

The purpose of this study was to describe police dispositions of persons they believed to be mentally ill, and to reveal the relationship of selected variables to those dispositions. In this chapter, the first section describes the nature of the dispositions made, and includes cases to illustrate the conditions and processes involved in each type of disposition. Succeeding sections concern background characteristics of the police officers, background characteristics and behavior of the mentally ill subjects, and characteristics of the context in which the dispositions were made. In each instance, these characteristics are described, and their relationships to type of disposition are explored.

Dispositions

Table I lists types of disposition by frequency of occurrence. Most of the mentally ill were _not_ taken to jail, nor to a hospital, but left in the community. This finding is more in accord with those of Aviram & Segal (1973) who describe the "ghettoization" of mentally ill than with the findings of Bonovitz & Guy (1979), Petrich (1976c), and Whitmer (1980) who report the incarceration of the mentally ill. Aviram & Segal (1973) describe the collection of mentally ill in the "back alleys" of urban settings vs. the "back wards" of institutions. They indicate that police officers are often in the uncomfortable position of deciding between "the street" or jail when commitment will not be possible (1973). The present investigation supports these observations as well as those of Bittner (1967) who states that police often use an "economy" of response in favor of leaving people "on the street" (p. 280).

Table I

Type of Disposition Made by Police for Mentally Ill Persons

Types of Disposition	Frequency		Percent of Total
Jail - Total	9		18%
Direct		8	16
After Hospital		0	0
Civil Hold		1	2
Health Facility - Total	12		24%
POH		3	6
Hospital		4	8
Detox		5	10
Community - Total	29		58%
Crisis Team		0	0
Informal		29	58

It may be that a change has occurred in the intervening years since Bonovitz & Guy (1979), Petrich (1976c), and Whitmer (1980) first reported a trend to the incarceration of the mentally ill in jails. For example, in Portland, jail overcrowding has resulted in frequent immediate release of those charged with lesser crimes. Realization that these subjects will most likely be removed from the community for only a few hours at most prevents officers from using jail as an alternative. To quote two officers, "It's a waste of my time to take them to jail. They beat me back to the street."; and regarding the general lack of alternatives, "My mind is made up before I get there, usually."

Specific Types of Dispositions

Gove suggested that the behavior of the subjects and complainants as perceived by the officer, the ease of obtaining treatment, quality of available treatment, nature of facilities at the local jail, and established procedure might influence an officer's disposition decision. He further outlined the officer's choices to include 1) to calm, isolate and/or mediate (community); 2) to commit (health-POH) or 3) to arrest (jail-direct)(1978). This portion of the results will recount examples of each kind of disposition used in this study with particular attention to any patterns and their possible influences. The dispositions are grouped in their three major categories: jail, health facility, and community.

Jail direct. Excluding two direct jail dispositions, one due to an outstanding warrant and one involving a suicide attempt (see Appendix H), the remaining 6 shared a common denominator. In each a complainant insisted on pressing charges on a subject whose behavior was in violation of the law. According to the results of this study, a

signed complaint was apparently synonymous with going to jail. Officers were unwilling to "forego" certain levels of charges in order to obtain treatment. Bittner has likened this latter point to deeming the individual "not guilty by reason of insanity," which officers are trained to leave to the judicial system. To quote an officer not involved with Case #1, "I know she belongs in the hospital and I'd rather take her there, but these charges are just too serious, possession of a controlled substance and carrying a concealed weapon (felonies). I think I better just take her to jail." The following description is typical of these dispositions.

CASE #1

The officer was called by the dispatcher for a shoplifter being detained by store security at a downtown department store. The subject was a 53-year-old black female sitting in the security office, wearing the allegedly stolen clothing. Store security had observed her to emerge from the dressing room wearing the clothing she had carried into it and then to proceed out the door to the street where she was apprehended. It had been necessary physically to restrain her and march her to the office. Upon our arrival she was sitting quietly, making munching mouth movements, staring at the wall. There was no odor of alcohol noted on her breath. As the officer questioned her she responded with sentences unrelated to his questions. She made statements such as "My son's spirit will take care of you! No I won't sit in that chair, it manipulates my vagina!" She began pacing around the room and shouting. The officer radioed for assistance from two officers, one male and one female. The store security officers had the complaint form filled out and signed when we arrived. The subject was transported in the "paddy

wagon" to jail, followed by the officer. Jail personnel did not question her suitability for incarceration and removed the clothes from her body to be returned to the store. Neither the police nor security officers had previous experience with this subject. She had no existing warrants, though she had been arrested before. She was charged with a misdemeanor and not judged by the investigator to be dangerous.

Jail-after hospital. There were no subjects taken first to the hospital and then to jail.

Jail-civil hold. There was only one disposition of this type which is reported below. Although the officer did not know the subject, he apparently knew that the subject's behavior would be unacceptable at Detox.

CASE #2

The only civil hold taken to jail was a 46-year-old Caucasian male, known to the complainant (a bartender). While the officer was handling a separate incident, the subject and victim came tumbling out of a tavern. The subject was threatening the victim with a broken bottle; both were obviously intoxicated. No one knew how the fight had started but the subject had been asked to leave the premises several times. He continued this behavior until the officer knocked the bottle out of his hand with a nightstick and stopped his advances with the nightstick to his chest. Neither the bartender nor the victim wanted to sign a complaint. The officer said "I know they won't take him at Detox. He'll start a fight." He was taken to jail on a civil hold. While in the car, the subject continued muttering to himself and staring at the seat. Upon arrival he sat staring at the sidewalk apparently unable to negotiate getting out of the car. The officer lifted him

by his arms and showed him how to move his feet. Jail personnel accepted him without question. He received a dangerousness score of 4 (out of 12) from the investigator.

Health-POH. There were 3 instances of this type of disposition, each illuminating different aspects of the apparent difficulty in using this option. All 3 took substantially more time than the other dispositions, 2 requiring 3 hours and the other 89 minutes. They all involved dangerous subjects. One case is reported here and the remaining two in the appendices (Appendix H).

CASE #3

This call was for a 23-year-old Caucasian female, not known to anyone in the situation, and without a history of arrests. She was noticed by a passerby to be sitting on a bus stop yelling and crying unintelligibly. The dispatcher radioed the district officer to see a "possible 1234" at that location. We found her lying on the bus bench screaming, frothing at the mouth, and crying. No odor of alcohol was noted. Her words could not be understood but she became physically abusive (kicking, swinging arms, spitting, attempted to bite officer) when anyone approached. With both police and ambulance back-up, the subject was restrained and transported to the local emergency room. The investigator rated her level of dangerousness to be a 3, while her need for supervision was rated at four.

The next major portion of time for this disposition was dedicated to obtaining hospital admission. The psychiatric unit associated with the emergency room was full. The ER physician questioned that the woman was mentally ill, thinking she was "drunk." After some further interviewing he agreed she was "delusional." The officer requested

that admission then be arranged at the state hospital but the ER nurse stated that the subject would not be accepted there. The officer then telephoned his sergeant for assistance. The sergeant called the state hospital and reported back to the officer. He apparently discovered that the state hospital was under the impression that the subject was drunk. The institution physician then called the ER physician and agreed to accept the subject. During this time, legal papers were found in the subject's property indicating she had been diagnosed as paranoid schizophrenic and that her two children had been removed from her custody.

The approximately one hour remaining was spent in transporting the subject to the state institution. It remained unclear how the state hospital had originally refused to accept the client. The officer was obviously exasperated: "See, these are 'mental health professionals' ...see how well they communicate! It never fails to take all this hassle."

Health-hospital. There were four voluntary hospital admissions, ranging in time from 40 minutes to 1 hour and 35 minutes. The factor which seemed to have the most impact on time for this disposition was whether or not there was family involvement: those without families took 1 hour, 35 minutes and 1 hour, 22 minutes; those with family involvement took 40 minutes and 1 hour, 15 minutes. The case reported here was chosen because it demonstrates the level of crisis-intervention skill typical of many of these officers and the significant time expenditure involved in handling such a case.

CASE #4

The subject was a 37-year-old Thai female who had become mute and motionless while sitting at her desk at work. Her supervisor and co-workers called the police when at 7 p.m. they had been unable either to get her home or to a hospital. These people related the day's events and the subject's history as they understood it.

She had a long standing mental illness for which she had been recently ostracized from her family. She had been hospitalized previously at both the state institution and a local private hospital, and had been receiving outpatient care. Today she had been agitated and disorganized but still communicative. She told her boss that she had changed the beneficiary of her life insurance. Having been persuaded to take a cab to see her outpatient care giver, she had run away from there suddenly, without regard for oncoming traffic, and left her purse there. Somehow she had returned to her desk at work, having ceased talking or moving for the past 6 hours. The investigator rated her need for supervision as continuous but saw no evidence of overt dangerousness.

Other than a brief period of transportation to a local hospital, the officer spent nearly the entire 95 minutes talking with the subject and exploring alternatives. He seemed to think that unless he observed some dangerous behavior, he could not sign a commitment hold.

He spoke with all the people in the situation, kept the subject informed of all his thoughts and actions, and had telephone conversations with the outpatient therapist, the family, his sergeant, and the subject's physician at the private hospital. The sergeant told him he could do a commitment hold if necessary based on the subject's apparent

inability to care for herself. The physician agreed to admit the subject so that if she would go voluntarily, there would be no need for a hold. Perhaps because of the officer's skillful process of including the subject in his thinking, she stood and silently followed him when he asked her to accompany him. She was admitted within moments of her arrival.

Health-Detox. There were five subjects placed at the detoxification center. All had brought attention to themselves with behavior which could have resulted in arrest. However, there were no people in the situation who wished to sign a complaint in any of these cases and the subjects were obviously intoxicated. The Public Inebriate Act provides an alternative in the form of a detoxification center empowered to hold people involuntarily from 4 to 72 hours. In spite of the officer also identifying these people as "1234," they were accepted at the Detoxification Center without question. It is not known how many hours they remained there. A typical Detox disposition will be recounted here.

CASE #5

The dispatcher called the district officer for "a violent 1234 at the (local hotel)." The subject was a white male of unknown age, unknown to anyone on the scene and without an arrest history. Upon our arrival he was stumbling out the front door of the hotel carrying some heavy boots. He immediately began swinging the boots by their laces in the radius his arms would allow. He was tall and muscular but barely able to walk. He was speaking unintelligibly and apparently to no one. There was a strong odor of alcohol and the subject was alternately laughing and crying. He was given a dangerousness score of three. The

officer stopped his behavior by backing him against a wall with his nightstick and insisting he drop the boots. The paddy wagon was called to take him to Detox.

Community-crisis team. There were no dispositions of this nature occurring during the study ride-alongs.

Community-informal. The largest portion of dispositions were of this type. Two cases are reported as examples in order to illuminate what the investigator considered to be three important observations.

First, the majority of community-informal dispositions (26 of 29) did not involve any "natural helpers" of any kind. For the most part officers were acting alone, using solely their interpersonal skills in offering reassurance and instruction. As Whitmer (1980) has written, often the psychiatrically disturbed remain socially isolated outside of institutions and resist attempts at communal housing as a threat to their autonomy. Thus, there are no networks to rely upon.

Second, at least three community dispositions were for cases that did not reach the "critical point" that apparently exists to meet the dangerousness criterion, but were still at substantial risk when left in the community without support.

Last, five community dispositions were attempts at crisis prevention. Three of these involved subjects known to the officer. The officers were familiar enough with the subjects' histories to spot trouble brewing and avert it by acting as the subjects' support person. The police force itself apparently provides a social support network for these subjects.

The cases reported here are typical of informal community dispositions and illustrative of these observations.

CASE #6

The officer knew the subject's history from having observed him for two years. He was a 32-year-old Caucasian with an arrest history but no outstanding warrants. The officer was acutely aware of the young man's deterioration, as shown by the following quote.

> ....He was gone for a while so I assume he was in the hospital. I don't know how he got there but pretty soon I started seeing him again. He looked real good. He's a nice young guy, kind of quiet, but he was talking then and taking care of himself.
>
> Now look at him -- dirty, eating out of the garbage, bugs in his hair....I thought about trying to find his parents, but hell, they probably don't want him either.

When we encountered him, the young man was sitting on his haunches arranging items confiscated from the garbage in a design on the sidewalk. When he noticed us, he remained mute, stared blankly, made some slow deliberate gestures with his hands, apparently symbolic in nature, and remained fixed. After some moments of silence, he stood and walked away without ever speaking. Addressing the subject by his first name, the officer's intervention consisted of gently informing the young man that the restaurant complained about his picking in the garbage and he would have to "move on."

CASE #7

Although the officer made no comment about this disposition, he was apparently influenced by the subject's cooperativeness in leaving the bus depot (eliminating arrest) and by his willingness to be hospitalized (not involuntary so no commitment hold necessary). Not seeing

his role as one of providing transportation, the only alternative he saw was to expect the subject to obtain treatment on his own.

This call was for a 38-year-old man brought to our attention for "loitering" in the bus depot. He told us that his "nerves were shot." "The voices" were telling him to kill himself and that if he were not already out of his Loxitane, he would take an overdose. He had been living temporarily with a "very religious" family who "had lots of kids" but found he "couldn't go back there." The voices were compelling and he was "desperate to find a way" to get away from them. He whispered he would go to a hospital if "someone would take me." Apparently to do so himself would be in open defiance of the voices. The officer kindly instructed him that he should be in a hospital and gave him directions as to where and when to catch a bus going to the local emergency room. He also warned him that he would be arrested for trespassing if he re-entered the bus depot. We left him standing on the street, leaning on a parking meter, staring straight ahead. In the words of a different officer, "It's within the domain of police work to make documentation of probable cause. It's up to someone else to develop treatment plans and provide transportation. I avoid all 1234's if at all possible. They leave a bad taste in my mouth."

Characteristics of Officers

The officers were a very homogeneous group with respect to sex, race, and education. All but one were male, and all but two were White. As may be noted in Table II, all had attended college, with years of formal education ranging from 13 to 17. Somewhat more variability may be noted among the officers with respect to age, and years of experience as police officers. Although all young adults, their

Table II

Background Characteristics of Police Officers Making Dispositions of Mentally Ill Subjects (N=17)

Background Characteristic	Mean	Standard Deviation	Range
Age	32.5	4.1	26-39
Years as Officer	6.2	2.5	1-13
Years of Education	14.8	1.2	13-17

ages ranged from 26 to 39 years, and their years of experience from 1 to 13 years. The officers differed also in two other experiential aspects. Twelve of the officers reported that their lives had been threatened sometime in the past by mentally ill persons; five reported they had never been so threatened. Eight reported they had friends or relatives who had suffered from mental illness; nine reported they did not. For a display of these characteristics for each officer and their respective types of dispositions, see Table VII (Appendix I).

An analysis was attempted to determine whether or not officer characteristics affected the dispositions they made. For this analysis, one disposition was randomly selected from those each officer had made. Dispositions were then dichotomized into those representing an action taken by the officer (i.e., the subject was transferred to jail or to a health facility), and those representing no action (i.e., the subject was left in the community). Due to lack of variability among the officers, the possible effects of officer's sex, race, or education on type of disposition could not be examined. The relationships between the remaining variables, and type of disposition were analyzed. The results are presented in Table III.

It is evident that the officer's age had no effect on type of disposition. Neither did the officer's experiences of a previous threat to life, or of mental illness in a friend or relative. Only length of service appeared to be related to type of disposition. Those officers who had served in the force for a shorter period of time tended to take action more frequently than officers with more seniority. Apparently, over time the officers learn _not_ to take action, but to leave persons who are mentally ill in the community. This is supported by this quo-

Table III

Relation of Background Characteristics of Police Officers to Nature of Disposition Made (N=17)

Characteristic	Nature of Disposition[a]		Significance of Difference
	Action Taken	No Action	
Age (mean)	31.4	33.6	N.S.
Years as officer (mean)	5.0	7.6	t=2.27*
Life Threatened			
Yes	8	4	N.S.[b]
No	1	4	
Relative/Friend Mentally Ill			
Yes	6	2	N.S.[b]
No	4	5	

*$p < .05$ N.S. = not significant

[a]In these analyses, a disposition to jail or health facility was considered as taking action, and leaving the individual in the community was considered no action.

[b]Fisher's exact test was employed.

tation from an officer. "If they (family or complainant) don't want them arrested then I leave them right where I find 'em." As mentioned earlier, Bittner (1967) has postulated that officers see so much aberrant behavior that they develop an "economy" of when to intervene.

Additionally, it was noted by the investigator that officers seem to believe that families should be dealing with the problems of the mentally ill. As one officer said, "I can't fill in for missing parents; that's who should be taking some responsibility." This attitude prevails in the face of Talbott's statistics (1980) that tell us only 23% of hospital discharged mentally ill have families to help support them in any way.

Characteristics of the "Mentally Ill" Persons

Table IV presents data on the background characteristics and behavior of the persons judged to be mentally ill. The majority were male, and all but 7 were Caucasian. They ranged in age from 22 to 81 years, with a mean age of 39.9. For most, (62%) alcohol was not a factor in the problematic behavior resulting in the contact of subject with police officer. Most were judged not to be dangerous. The dangerousness score was obtained by summing the scores assigned to the individual for 3 types of behavior: self-mutilatory, suicidal, and dangerousness to others. The overall score could vary in principle from 0 to 12 (see Appendix C). No subject scored higher than 4 on that scale; and 29 persons received scores of 0. As for the component behaviors, only 2 persons manifested any self-mutilatory behavior, 6 some suicidal ideation or behavior, and 15 some behavior dangerous to others.

Nearly half had been arrested at some time previously, within the State of Oregon. Steadman, CoCozza and Melick (1978) claimed that men-

Table IV

Background Characteristics and Behavior of Mentally Ill Persons

In Relation to Type of Disposition (N=50)

Subject's Characteristics and Behavior	All Dispositions N	(%)	Dispositions Health Facility (N=12)	Jail (N=9)	Community (N=29)
Sex					
Male	34	(68)	6	6	22
Female	16	(32)	6	3	7
Age[a]					
Mean	39.9		39.3	37.7	40.7
SD	14.8		17.1	9.1	15.3
Previous Arrests[b]					
Yes	22	(44)	8	3	13
No	24	(48)	3	7	12
Alcohol Involvement					
Yes	19	(38)	6	5	8
No	31	(62)	6	4	21
Charged at Scene					
Yes	12	(24)	0	8	4
No	38	(76)	12	1	25
Dangerousness[c] (mean score)	1.1		1.7	1.6	0.7
Yes	21	(42)	7	5	9
No	29	(58)	5	4	20
Need for Supervision[d]					
Yes	16	(32)	7	2	7
No	34	(68)	5	7	22

[a]No information for 3 subjects.

[b]No information for 4 subjects.

[c]Subjects were classed as not dangerous if they received an overall score of 0, and dangerous if they received scores from 1 to 12.

[d]Subjects were classed as needing supervision of their health if they received a score of 1 to 4 and not in need of supervision if they received a 0.

tally ill persons experience more contacts with law enforcement agents than does the "general population." The finding of this study accords with that view. However, it is also true that the subjects did not appear to be "hardened" criminals, in that only one had an outstanding warrant. Moreover, of the 12 charges at the scene of the encounter, 10 were for misdemeanors such as shoplifting, minor assault, drinking on the street, property damage, and disorderly conduct. In 4 instances, the offense was considered sufficiently minor to merit citations in place of incarceration.

Were any of the background characteristics of the subjects or their behavior related to the type of disposition made? Table IV reveals that sex, age, the fact of previous arrest, and alcohol involvement were not related systematically to disposition. However, dangerousness to self or others was a factor. Those acting in a dangerous way were more likely to be taken to jail or to a health agency than other mentally ill persons. The mean dangerousness score of the persons left in the community was 0.7, whereas the mean dangerousness score of the 21 persons taken to jail or a hospital was 1.6 ($t=2.30$, $p<.05$). As can be seen in Cases #3 and #7, dangerousness to self or others apparently has to be overtly demonstrated and imminent. Those charged at the scene with a felony or misdemeanor were also somewhat less likely to be left in the community ($t=4.1$, $p<.05$).

The fact that only subjects who were clearly endangering their own lives or the lives of others were removed from the street to treatment settings reflects local police policy. According to Gove (1978), Bittner (1967), and Colbach & Fosterling (1976), such a policy derives from the basic ambivalence of police officers toward their role as

crisis intervention specialists. This ambivalence holds despite the fact that 80% of police work appears to deal with noncriminal matters, and that "most police calls are only a variation on a theme of social dysfunction within the community" (Colbach & Fosterling, 1976, p. 81). Bittner (1967) has similarly observed that police see so much aberrant behavior that they thereby develop an "economy" of when to intervene.

Characteristics of the Context

Forty-one of the events resulting in dispositions took place in public settings, such as on the sidewalk, or in a business establishment. In the majority of instances, the officer was not acquainted with the subject. The complainants however, knew the mentally ill person about as often as not. The complainants were business owners or managers in 14 instances, private citizens in 10 others, and the police officers themselves in 10 (see Table V).

The time taken to make the disposition varied widely, with a range of from 1 to 180 minutes. Thirty-three dispositions took 34 minutes or less, 17 took 35 or more minutes. Two of the latter took 180 minutes or 3 hours.

Were these characteristics of the context related to the type of disposition? Table VI shows that in all instances in which the police officer knew the mentally ill person, that person was left in the community. Case #6 illustrates that tendency. The complainants' previous acquaintance with the subject appeared not to be related to disposition outcome. However, the complainants' requests for action were usually honored. All of the jail dispositions and one of the involuntary hospitalizations were requested by complainants. Although those who went to the detoxification center behaved in a manner which might have re-

Table V

Disposition by Role of Complainant

Status of Complainant	Jail	Health Facility	Community	Total
Officer	0	2	8	10
Businessman (Including bartender)	4	4	6	14
Citizen	3	3	4	10
Other*	2	3	11	16
	9	12	29	50

*Bus drivers (3), security guards (6), health officers (3), self (4)

Table VI

Characteristics of the Context to Type of Police Disposition Made of Mentally Ill Persons (N=50)

Characteristic of Context	All Dispositions		Types of Dispositions					
			Health Facility		Jail		Community	
	N	(%)	N	(%)	N	(%)	N	(%)
Setting								
Public	41	(82)	5	(12)	9	(22)	27	(66)
Private	9	(18)	7	(78)	0	(0)	2	(22)
Subject Known to Officer								
Yes	6	(12)	0	(0)	0	(0)	6	(100)
No	44	(88)	12	(27)	9	(20)	23	(52)
Subject Known to Complainant[a]								
Yes	26	(52)	8	(31)	3	(12)	15	(58)
No	22	(44)	4	(18)	6	(27)	12	(55)
Time Taken by Disposition								
Mean (min.)	35.0		75.2		45.3		15.2	
SD	39.2		59.4		18.0		13.4	

[a]No information for 2 subjects

sulted in arrest, there were no complainants requesting arrest. This finding concurs with that of Braunstein (1980) who reported that police often made dispositions in accord with complainants' requests.

Events occurring in private settings were somewhat more likely to result in some type of action disposition (either jail or health facility) than events occurring in public places (Chi-square = 4.1, $p<.05$). Finally, the types of disposition did vary in time taken to complete, with health facility dispositions taking by far the longest period of time ($F = 17.0$, $p<.001$). This time, of course cannot be said to have influenced the dispositions in that it is not determined until after the event. However, it is highly likely that the times spent by the officers in the present instances approximate the times the officers had spent in similar cases previously. In short, the officers may have expected health facility dispositions to consume considerably more time than community dispositions, and this may have been a factor influencing their choice of disposition. The question was not directly posed to the officers, regarding whether indeed such an expectation influenced their actions, but the time it took to complete various dispositions appears to be a distinguishing factor.

Finally, the two findings that, first, hospital dispositions took substantially more time than other dispositions, and, second, that officers with the longest experience were more likely to leave subjects in the community, may be related. Possibly experienced officers tended to avoid use of the mental health system because of the length of time required. This leaves a tremendous gap between the only two systems available for serving the mentally ill. Whitmer (1980) has suggested this gap results in "forfeiture" of these citizens, and demonstrates

the lack of knowledge and resources necessary for the successful deinstitutionalization of the chronically mentally ill. It was noted that officers sometimes acted in a supportive fashion toward some subjects and initiated preventive interventions. Perhaps their frequent use of informal community dispositions reflects their perception of an absence of other alternatives. Bittner (1967) has suggested that this perception plays a role in police decisions.

CHAPTER IV

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Summary

It is increasingly apparent that many mentally ill people are residing in the nation's jails and on urban streets since the advent of the deinstitutionalization movement. There are very few data which document the extent of their contact with law enforcement officers or the processes involved in their dispositions. The purpose of this study was to describe the influence of certain variables, designated as important in the literature, on police dispositions of persons they consider mentally ill.

The investigation was conducted in collaboration with a local urban police bureau. Seventeen evening shift officers volunteered to be observed, and completed 50 dispositions of people they regarded as mentally ill. Data were collected regarding the characteristics of the police officers, characteristics of the mentally ill subjects, and characteristics of the context of their contact. Descriptions of the processing of the dispositions were also recorded. There were eight possible types of dispositions which were classified into three major categories: jail, health facility, and community.

Most of the dispositions made (29) fell into the informal community category. They involved almost no informal resources in the community, with the police most often acting as mediators/advocates and performing their duties in isolation. Subjects so disposed of were, on at least three occasions, in need of immediate care in the investigator's judgment. Their behavior, however, did not reach a "critical

point" clearly indicative of imminent death or destruction. Six of these dispositions were performed by officers who knew those subjects to some extent. Three of those six dispositions were obvious attempts by officers to prevent a crisis. In no instance was a local mobile crisis team utilized.

There were only 9 jail dispositions. Eight persons were taken directly to jail on charges (6 misdemeanants and 2 felons) and 1 person was put on a civil hold for being intoxicated and fighting. Of the 8 persons taken directly to jail, none was first taken to a hospital for evaluation. In all 8 cases, the complainants signed charges and insisted on arrest.

Health facility dispositions included 3 involuntary commitment hospitalizations, 4 voluntary hospitalizations, and 5 detoxification center detentions. Two of the involuntary hospitalizations involved imminent death of either the subject or someone else. A third subject was causing substantial property damage and threatening some danger to those in his environment. However, his complainants did not want him to be arrested. (It is not known whether or not these subjects were committed at hearing.) The four voluntary hospitalizations also involved persons in (or causing) imminent danger of death, but able to respond to either their families' or the officer's urging to receive treatment. In no case did the individual's behavior warrant arrest. All five subjects taken to a detoxification center were intoxicated and behaving in a way which could have resulted in arrest. However, access to the detoxification center provided what was apparently a preferred alternative to the street when complainants did not press charges.

The officers were a strikingly homogeneous group, being largely Caucasian males in their mid-thirties. Although they varied to some extent on both their years of experience (range 1-13 years) and their personal experience with mentally ill people, only their years of experience was significantly related to the type of disposition chosen. More experienced officers tended to leave mentally ill people in the community, usually exactly where they were encountered. They apparently had learned over time not to involve either the justice or mental health systems. On six occasions, the officer was noted to have had previous experience with the subject, and in every instance the subjects were left in the community. Perhaps knowing something about what to expect from a subject reduces the officers' likelihood of removing him or her from the community.

The subjects characterized as mentally ill ranged in age from 22 to 81 years, 35.5 being the median. All but 7 were Caucasian, with 34 being male and 16 female. Nineteen subjects were noted by the investigator to be under the influence of alcohol but this had no apparent relationship to disposition. Subjects were mainly nondangerous and noncriminal.

Each subject received two dangerousness scores. One was on a scale of 0-12 which rated 3 behaviors: self-mutilation, suicide, danger to others. They were additionally rated (0-4) by the investigator as to their need for health supervision. Those that were dangerous were significantly more likely to be taken either to jail or a health facility rather than being left in the community.

The encounters occurred most often in a public setting. However, those that originated in a private location appeared to conclude more

often with a health disposition. Complainants were about as likely to have had previous experience with the subjects as not. Most of the complainants were the citizen bystanders (10), business owners/managers, including bartenders (14), or officers themselves (10). On 6 of the 10 occasions, the officers knew the subjects and in all 6 cases the informal community disposition was used. The time involved for completion of each type of disposition varied widely. If these times resemble those previously experienced in making dispositions, then the expected time may have had an influence. Hospital dispositions took significantly more time than any other type, whether involuntary or not. It was noted that the two voluntary hospitalizations which took the least time were expedited by the efforts of family members. It is evident in three hospitalizations that the troubled interface between law enforcement and hospital personnel accounted for the length of time required to complete dispositions. Two other hospitalizations reflected the enormous time investment required to safely cope with and contain mentally ill behavior.

Conclusions

There were four major conclusions to be drawn from these results, with implications for further study, service planning, and nursing practice. First, police officers find it difficult and time consuming to use the mental health system. As a result, with more experience they become less likely to obtain treatment for people, even when they clearly see the need for it. It is also quite obvious that officers might be cultivated as a treatment resource, since with a little assistance from families or complainants, they obtained treatment oriented dispositions.

Second, the isolation within which officers presently operate should be recognized. Officers, among themselves, constitute the only real network of support available to many chronically mentally ill. Once again, the officers' treatment orientation could be seen in their attempts at preventive intervention in spite of a perceived lack of resources.

Third, as may be noted in the cases presented, the interface between law enforcement and health personnel often operated in a destructive manner. There is a potential in this area for vast improvement toward creating a "safety net" for those who fall into this "crack" and increasing the efficiency of both systems.

Fourth, alcohol abuse was not as prevalent as might have been expected among the subjects encountered. Because of the area of the city ("skid row") in which these dispositions occurred, the public might readily assume many of these people to be intoxicated rather than mentally ill. Police officers have apparently become adept at differentiating alcoholism from mental illness.

Limitations

Certain limitations of the study must be acknowledged. First, it was not possible to determine the influence of certain officer related characteristics (age, race, sex, education) because the sample was too homogenous. A larger sample of officers may have provided more variability along those dimensions and permitted testing of those relationships.

Second, in this study, attitudes of the officers were not directly ascertained. Hence, some variables which might better explain their behavior may have been overlooked.

A third limitation of the study is that the observations, as for example, those regarding dangerousness and alcohol involvement, were made by the investigator alone. Therefore, the effect of bias is intensified rather than diffused among a group of observers.

Fourth, the tool used to score dangerousness has not been extensively tested for reliability and validity and once again, was used by a single rater. Last, the apparent lack of resources available to aid officers in developing dispositions may have been, at least in part, an artifact of conducting the study on the evening shift.

Recommendations

The results of this study suggest that an efficient, integrated system of care does not now exist for some deinstitutionalized mentally ill people. The mental health and law enforcement systems are the two most utilized resources, yet they are poorly coordinated. Further study is needed along two major dimensions; one, the treatment needs of the mentally ill, and two, the specific problems encountered when health and law enforcement personnel attempt to work together.

Community mental health and law enforcement personnel might participate in a study. Mentally ill subjects encountered in a variety of settings could be assessed for both short and long term treatment requirements. Personnel in these settings could also be tested regarding their attitudes and expectations both of mentally ill persons and of other personnel they encounter. These data might provide a basis upon which to approach planning and implementing services in which both systems could more easily participate.

At this point, a pilot project implemented on the basis of the above findings, could be initiated. It might resemble the model provided in this study by the detoxification center. A nursing, non-hospital based assessment and referral center might prove to be the "safety net" needed to integrate the two systems and overcome the shortfalls of deinstitutionalization.

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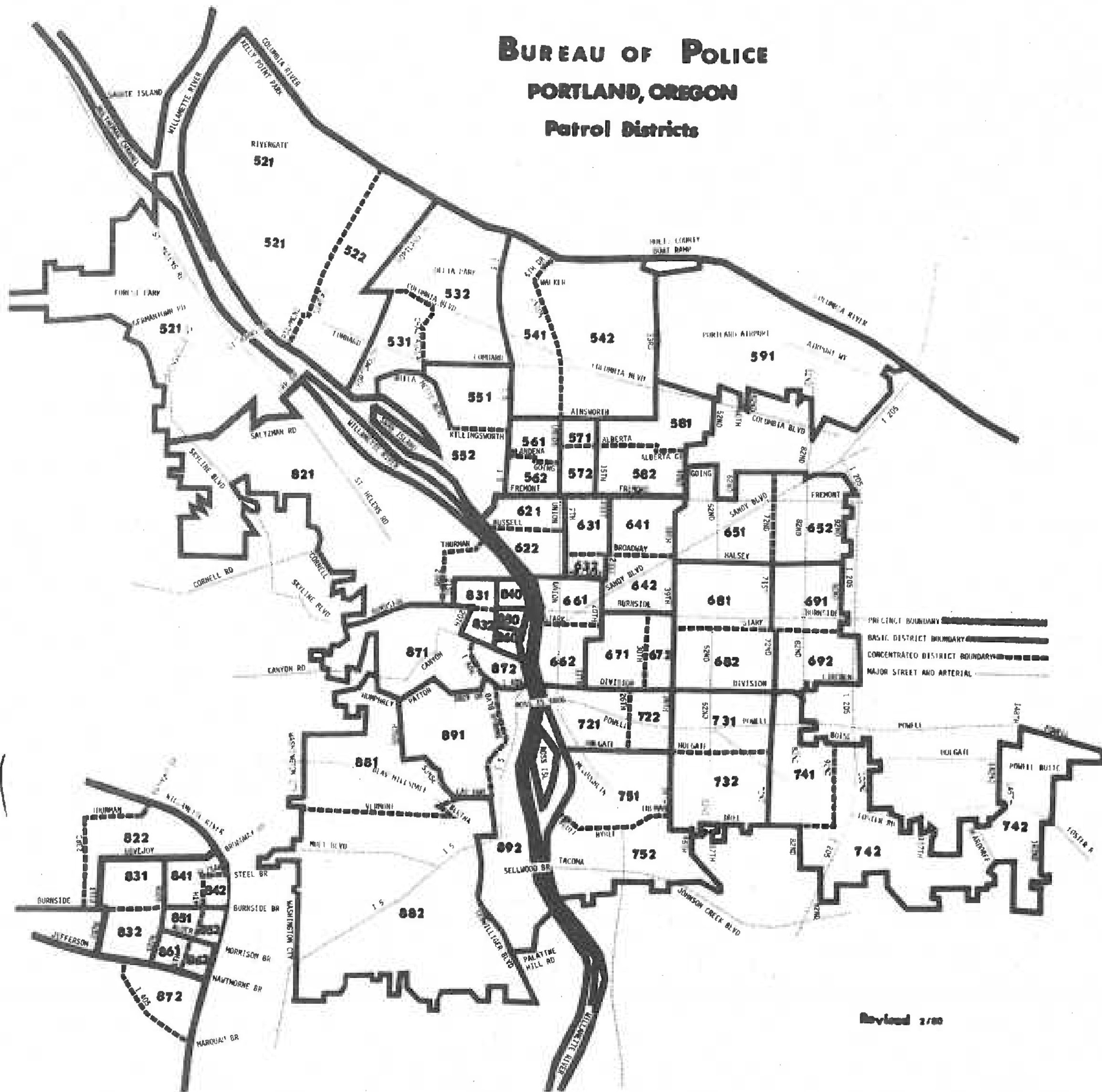
APPENDICES

Appendix A

Police Bureau Map


Bureau of Police
PORTLAND, OREGON
Patrol Districts
PRECINCT BOUNDARY
BASIC DISTRICT BOUNDARY
CONCENTRATED DISTRICT BOUNDARY
MAJOR STREET AND ARTERIAL
COLUMBIA RIVER
KELLY POINT PARK
RIVERGATE
521
522
531
532
541
542
551
552
561
562
571
572
581
582
591
PORTLAND AIRPORT
621
622
631
641
642
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661
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681
682
691
692
721
722
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732
741
742
751
752
821
822
831
832
841
842
851
861
871
872
881
882
891
892
ST HELENS RD
SKYLINE BLVD
CORNELL RD
CANYON RD
SALTZMAN RD
AINSWORTH
ALBERTA
KILLINGSWORTH
FREMONT
SANDY BLVD
HALSEY
BROADWAY
BURNSIDE
STARK
DIVISION
POWELL
HOLGATE
TACOMA
SELLWOOD BR
BURNSIDE BR
MORRISON BR
HAWTHORNE BR
STEEL BR
MARQUAM BR
JOHNSON CREEK BLVD
COLUMBIA BLVD
LOVEJOY
THURMAN
JEFFERSON
POWELL BUTTE
WILLAMETTE RIVER
Revised 2/80

Appendix B

Officer Interview Questionnaire

OFFICER QUESTIONNAIRE

Code letter _____

Sex _____

Race _____

Age _____

1. How many years have you been a police officer?____________________

____

2. How many years of education do you have?____________________

____

3. Has your life ever been threatened by a mentally ill person?

____

____

4. Have you known or been related to anyone with a mental illness?

____

____

____

____

____

Appendix C

Worksheet

WORKSHEET

Officer code letter _____

Subject code number _____

Time begin ________ end ________ Total ________

Subject: age______ race______ sex______ known to officer (Y/N)________

known to c/o (Y/N)______ current wants/warrants (Y/N)______

previously arrested (Y/N)_________ charge (O,F,M)__________

Context: location Pu or Pr________ complainant by role______________

Subject's behavior/description

Dangerousness Score__________

DISPOSITION PROCESS

Dispositions in order of occurrence 1-8

Largest no. = final dispo.

_____Jail direct

_____Jail after hospital

_____Jail - Civil Hold

_____Health - POH

_____Health - Hospital

_____Health - Detox

_____Community - Crisis Team

_____Community - Informal

Appendix D

Dangerousness Rating Tool

II. DANGEROUSNESS

To what degree is the subject:

	Problem Not Present	VERBAL THREAT		ATTEMPT	
		No Plan	Plan	Not Life Threat-ening	Life Threat-ening
1. Behaving in a manner dangerous to self:	0	1	2	3	4
a. Self-Mutilation	( )	( )	( )	( )	( )
b. Suicide	( )	( )	( )	( )	( )
2. Behaving in a manner dangerous to others:	( )	( )	( )	( )	( )

	No	Minimal	Moderate	Frequent	Continuous
	0	1	2	3	4
3. In need of close monitoring and supervision for life threatening condition.	( )	( )	( )	( )	( )

Appendix E

Instructions to Officers

Instructions for Officers

If you should agree to participate in this study, please read and sign the Informed Consent Form. Following is a list of the information and assistance I will need in order to complete the study.

1. I am interested in observing all dispositions of mentally ill people, not just those that are commitable.

2. Please tell me anytime you think a subject may be mentally ill, even if mental illness has nothing to do with your reason for contacting him/her. It is expected that some mentally ill subjects will also be intoxicated.

3. Do not conduct business any differently than you ordinarily would.

4. The information I will need from you about the mentally ill person is: age, whether or not they have current wants or warrants, whether or not they have been previously arrested, the class of their charge if they are arrested, whether or not they are known to you and/or to the complainant.

5. I will ask you five questions about yourself and your experience with mentally ill people, only once, at the end of the data collection period.

6. I need the same number of dispositions from each officer who participates, with a hoped-for total of 50, i.e., 10 officers, 5 dispositions each; 5 officers, 10 dispositions each, etc. Data collection should occur in those districts where these contacts are most likely to occur.

Thank you for your participation.

Rosalyne Reynolds, R.N.

Appendix F

Letter of Permission

CITY OF
PORTLAND, OREGON
BUREAU OF POLICE

Francis J. Ivancie, Mayor
Ronald R. Still, Chief of Police
222 S.W. Pine
Portland, Oregon 97204

January 29, 1982

Rosalyne B. Reynolds, R.N., PMHNP
3245 SW Scholls Ferry Rd.
Portland, OR 97221

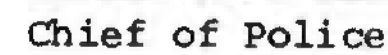
Dear Ms. Reynolds:

I have read your proposal for studying "The Relationship of Selected Variables to Dispositions, by Police Officers, of Persons Thought to be Mentally Ill." You have my permission to proceed as set forth in the proposal.

The provisions you have made to safeguard the confidentiality of the officers and the mentally ill persons are acceptable to the Police Bureau. No one in the Police Bureau will ask you to identify the officers, nor will any data collected be used to evaluate the performance of the officers.

Sergeant Roger Hediger will help you coordinate the projects at Central Precinct. If you need further assistance or if any problems develop, please contact Lt. Webber.

Very truly yours,



Chief of Police

RW/njg

cc: Lt. Roberta Webber
Sgt. Hediger

Appendix G

Informed Consent Form

INFORMED CONSENT FORM

I ______________________________ herewith agree to serve as a participant in the investigation entitled, "The Relationship of Selected Variables to Dispositions, by Police Officers, of Persons Thought to be Mentally Ill," by Rosalyne Reynolds, R.N., B.S., under the supervision of Julia Brown, Ph.D.

The investigation aims at establishing a baseline of information regarding police officers' handling of mentally ill subjects. The frequency of such contact and some possible influencing factors are the specific focus. My participation requires no extra work time. It will require me to answer a five-question interview, to allow Ms. Reynolds to accompany me during my shift, and to tell her when I think that a subject is mentally ill. Ms. Reynolds understands that she accompanys me at her own risk and that I may exclude her from observing my function at any time. I understand that my performance is not being evaluated and that the Portland Police Bureau has agreed not to use any result of this study for that purpose. I further understand that I will not directly benefit as a result of my participation, but that the resulting data may assist in developing better services for the mentally ill subjects I encounter.

I understand that the information obtained will be confidential and that my anonymity will be protected by the use of code letters to identify individual questionnaires. The confidentiality of the supposed mentally ill subject will also be protected.

Ms. Reynolds has offered to answer any questions I might have about my participation in this study. I understand that I am free to refuse to participate or to withdraw from participation at any time without effect on my employment or professional affiliations at the Portland Police Bureau.

I have read the above and agree to participate in this investigation.

______________________ ______________________________

Date Officer's Signature

____

Investigator's Signature

Appendix H

Additional Cases

Case #8

Health - POH

Event

A group home operator had called an ambulance hoping one of the residents could be transported to the hospital. The ambulance crew called for police backup due to their difficulty in restraining the man. He was small, wiry, and loud. He would sit momentarily smoking a cigarette and then suddenly jump to his feet, grab the nearest chair or table and begin waving it around, banging it on walls and floor until it broke. One table and a chair were already lying on the floor in pieces. The manager stated that the subject had not been taking his medication regularly (lithium, stelazine, cogentin) and had been drinking alcohol that day. He displayed loosening of associations, grandiose delusions, and pressure of speech as well as some involuntary perioral facial movements. No one had apparently been injured. The investigator did not rate him as dangerous (0 on scale of 0-12) but to be in need of continuous supervision (4).

Disposition

The officer radioed the local ER and was told a POH bed was available in the psychiatric unit of the hospital. The subject was handcuffed and transported by the officer without incident, although the subject's speech continued on uninterrupted. Upon arrival in the ER, the subject was placed in a holding room, still handcuffed, while the nurse provided the officer with appropriate forms to be completed. It was then 45 minutes before any personnel spoke to the officer again. Finally, the resident recognized the investigator and inquired as to the reason for our presence in the ER. Apparently, the staff had

changed shifts and not reported that there was a patient in the holding room. The resident proceeded with the admission without further delay.

Case #9

Health - POH

Event

This call was from a nurse at a local hospital who was keeping a patient talking on another line. She managed to maintain this dual function throughout this episode.

The patient was threatening to shoot herself or "any cop" who tried to stop her. While the nurse engaged the woman on the telephone, several officers evacuated surrounding apartments and tried to formulate a plan for entering the woman's apartment. Finally, with coaching from the officers, the nurse was able to gain the woman's agreement to meet her downtown for a drink. As she emerged from the apartment she was safely apprehended. There was indeed a .38 revolver in the apartment, lying next to the telephone. She was dressed completely in black with cape and boots. No odor of alcohol was noted but she was tearful and irritable. She received a dangerous score of 2 on each of 2 subscores (suicide and danger to others) for a total of 4. Her need of supervision was rated as a 3.

Disposition

Two officers transported her directly to the state hospital. They commented that so much time had been required to contain the situation that they wanted to use the fastest route possible to the hospital. Though the distance to travel was greater, the officers stated that their observation was that admissions actually go faster at the state hospital.

Case #10

Jail-direct

Event

A passing motorist stopped the officer to report a man standing on the other side of the bridge railing. The subject was found just as described, holding on with one hand, tearful, irritable and with a strong odor of alcohol. A back-up officer was called and then the subject was approached. In a somewhat irritable tone, the officer said, "That water won't kill you." The subject replied, "OK, I'll hit the bricks then!" The man began side stepping toward the end of the bridge. The second officer then engaged him in conversation regarding who he was, how he felt, etc. As one officer talked, the other moved closer until one was close enough to grab him. Prior to being reached, the subject was somewhat belligerent. Once the officers had hold of him, he became more tearful and apologetic and shared his history. He had hitchhiked to Portland from New York the week before and was out of money. He had gotten into a fight with "some Indians." He was camped under the bridge but had left his shoes and bedroll there because "they were waiting" for him. He was given a dangerousness score of 4.

Disposition

The subject was taken to jail, charged with disorderly conduct. The officers did not discuss the disposition itself but did express their impatience with the subject. They apparently felt he should have taken a more "responsible" approach to his problems.

Case #11

Community-informal

Event

We were called to "a fight in front of Burger King." Upon arrival, both subject and victim were sitting on the sidewalk, a bystander mildly restraining the subject and an ambulance crew tending to the victim. The victim was an elderly man who had sustained a deep laceration on his forehead. The subject was talking continually stating he had not been in a fight. "Look, there's no blood on my hands." There was blood on his shirt and pants however. He claimed to be part of the FBI and that he had just "saved Portland" by "eliminating this guy." There was no alcohol on his breath but he was poorly groomed with tattered clothing.

Disposition

The officer attempted to handcuff the subject but discovered that one hand was fractured with a badly deformed thumb. The officer said, "Oh, hell, I'm not going through all that at the hospital." He believed that if he took the subject to the custody hospital to repair his hand, travel time would be inconvenient. He also felt sure that the closer quadrant hospital would not agree that the subject was mentally ill and dangerous. He resolved the situation for himself by giving the subject a citation for assault IV and instructing him that a cab was on the way to transport him to a hospital; the cab to be paid for by the City. It is not known if the subject reached the hospital. The victim was taken to a hospital by the ambulance.

Case #12

Community-informal

Event

An apartment manager called complaining that a tenant was chanting and yelling in his apartment and would not answer the door or respond to her requests to be quiet. She was concerned because he was yelling something like, "I'm going to kill you!" Upon arrival, the officers had to knock several times to get an answer. A young man answered the door who was apparently alone. He was cooperative but stared blankly and took several moments to respond to anything said to him. He claimed to be "meditating" in order to "get out" his "negative feelings." He denied saying he would kill anyone but admitted that he would "if it would relieve" him of "any hassles." He admitted to having been prescribed mellaril but doesn't "like the way it changes" him. He also said he does not like "to play kiss up games" with doctors. "I've talked to a number of them in several states. It's always ths same story." He reported having trouble sleeping but that he was "eating OK." He said he did not feel like hurting himself. The apartment was empty except for a mattress on the floor and several books and papers scattered about. There was no food in the refrigerator. He was given a dangerousness score of 1.

Disposition

He was left in his apartment with instructions to keep his voice down. The officers also indicated that if it were necessary for them to return they would consider taking him to the hospital. Upon leaving, the officers conferred with the manager. They told her that the young man was apparently mentally ill but not commitable so that they would have to leave him there.

Appendix I

Table VII

Table VII

Characteristics of Officers with Frequencies of Dispositions

Officer Characteristics						Dispositions			
Officer Letter	Sex M=Male F=Female	Age In Years	Years of Experience	Life Ever Threatened Y=Yes/N=No	Knows/Related to Someone With Mental Illness Y=Yes/N=No	Number of Health Dispositions	Number of Jail Dispositions	Number of Community Dispositions	TOTAL
A	M	31	8	Y	Y	2	0	2	4
B	M	34	5	Y	Y	0	1	4	5
C	M	31	5	Y	N	0	0	1	1
D	M	30	5.5	Y	Y	2	1	0	3
E	M	31	8	N	Y	0	2	3	5
F	M	35	8	N	N	0	0	1	1
G	M	31	8.5	Y	Y	1	1	1	3
H	M	39	5	N	N	0	0	1	1
I	F	26	1	Y	Y	2	1	3	6
J	M	33	5	Y	N	1	1	2	4
K	M	31	6.5	Y	N	0	0	3	3
L	M	32	8	Y	N	1	0	3	4
M	M	39	5	Y	N	2	0	0	2
N	M	28	6	Y	Y	1	0	2	3
O	M	36	5.5	N	N	0	1	0	1
P	M	39	13	N	N	0	0	2	2
Q	M	26	5	Y	Y	0	1	1	2

AN ABSTRACT OF THE

CLINICAL INVESTIGATION OF

Rosalyne B. Reynolds

For the MASTER OF NURSING

Date of Receiving this Degree: June 10, 1983

Title: THE RELATIONSHIP OF SELECTED VARIABLES TO THE DISPOSITION, BY POLICE OFFICERS, OF SUBJECTS THOUGHT TO BE MENTALLY ILL

Approved:
Julia Brown, Ph.D., Professor, Advisor

A descriptive study was done to identify which of selected characteristics of mentally ill people, police officers, and the context in which they come into contact with each other are significantly related to one of three major categories of dispositions for the mentally ill person: jail, hospital, remain in community. The sample consisted of 50 dispositions from 17 volunteer officers. All the officers were from the evening shift of an urban police bureau. The investigator accompanied the officers on their patrols under the auspices of an established "ride-along" program. Data was collected by the participant observation technique with one short interview questionnaire for each officer.

The officers were a very homogenous group. The only officer variable having a significant relationship to dispositions was that of years of experience. Those with more experience tended to leave subjects in the community. The subjects were predominantly Caucasian

ABSTRACT OF CLINICAL INVESTIGATION

males, noncriminal, and nondangerous. Those that were dangerous were significantly more often taken to either a health facility or jail and those that were charged at the scene were most sure of going to jail. The two context variables which proved to be significant were the time it takes to complete a disposition and whether the officer knew the subject. Health related dispositions took substantially longer than either jail or community dispositions. All of the subjects who were known by the officers were left in the community. The outstanding observation of the process of dispositions was the isolation within which the police officers worked. There were no informal community networks or families to call upon.

There were two major limitations. A small sample of officers restricts what can be known about the influence of officer characteristics. All observations were made by a single investigator, intensifying the effect of bias.

Further study of the short and long term treatment needs of mentally ill subjects who come into contact with police is indicated. Also, the difficulty in the interface of the law enforcement and health systems needs further examination.