Police Interactions with People Perceived to have a Mental Health Problem: A Critical Review of Frames, Terminology, and Definitions

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Published on: Nov 20, 2018

DOI: 10.21428/cb6ab371.17e3af5a

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Abstract:

In the last two decades, interest in the topic of how police interact with individuals perceived to have a mental health problem has increased substantially. This interest has produced a growing body of research on the topic and with it an expansion in the variety of terms and frames used in discussing the issue. The variation in terminology and topic framing is important to consider for a number of theoretical and methodological reasons, including our ability as researchers to shape the wider response to the issue and concerns about the extent to which the varied terms are valid and comparable. To explore this topic, we undertook a scoping review of 92 articles on the topic published between 2000 and 2017. The findings show that the current framing tends to emphasize issues related to the mental health system and police training to the detriment of other forces related to the issue such as housing, poverty, and stigma. The analysis also shows that person with mental illness is the most common terminology used in the literature, but its use raises some concerns about validity and precision.

Keywords: Person with Mental Illness; Person in Crisis; Mental Health; Crisis Intervention Training; Police Interactions; Terminology

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This is a pre-copyedited, author-produced version of an article accepted for publication in *Victims & Offenders*, following peer review. The version of record, Frederick, T., O'Connor, C., & Koziarski, J. (2018). Police Interactions with People Perceived to have a Mental Health Problem: A Critical Review of Frames, Terminology, and Definitions.

Victims & Offenders, is available online at:

<https://doi.org/10.1080/15564886.2018.1512024>. When citing, please cite the version of record.

Introduction

In the last two decades, interest in the topic of how police interact with individuals perceived to have a mental health problem has increased substantially. This interest has been driven by a number of factors including increases in the number of mental health- related calls being fielded by officers (Durbin, Lin, & Zaslavsky, 2010), high-profile incidents in which individuals in crisis have been injured or killed by police (Iacobucci, 2014), and a growing interest in models such as co-response teams and

Crisis Intervention Teams (CITs) across police services (Dupont, Cochran, & Pillsbury, 2007; Shapiro et al., 2015). CIT and co-response refer to different types of partnerships between police services and the mental health system. CIT focuses on providing additional training to officers on how to identify and respond to people in mental health crisis, and co-response pairs officers with mental health workers who can assist with crisis related calls (Dupont et al., 2007; Shapiro et al., 2015)

In the context of this growing interest in the issue and an expanding body of research on the topic, there has been a related expansion in the variety of terms and frames being used in the research literature. For example, in referring to the citizens who are encountering the police, terms appearing in the literature include: *individuals in crisis*, *people with behavioral health challenges*, *persons with mental illness*, *the mentally ill*, *distressed persons*, *consumers*, *apprehended mental health patients*, *emotionally disturbed persons*, *people with mental health problems*, and *people with mental disturbances*. There is also substantial variation across studies regarding how the issue is framed and justified as a topic of importance. In their introductory remarks, authors might reference diverse processes such as deinstitutionalization, gentrification, or criminalization to explain the increase in mental health-related calls. They might also justify a focus on the topic on grounds related to safety, resource efficiencies, or social justice.

This variation in terminology and topic framing is important to consider for a number of theoretical and methodological reasons. From a methodological perspective, the variety of available terms raises questions about the extent to which the groupings used in the literature can be reasonably treated as constituents of the same population. For example, are people in crisis the same as people with mental illness? They are clearly related, but not all people experiencing crisis have a diagnosable mental illness, and not all people with diagnosable mental illness coming in contact with the police are in a state of crisis. For example, Livingston et al. (2014), in their research with mental health service consumers, found that only 35% of lifetime contacts with police among the sample were crisis related. Relatedly, Oliva, Morgan, and Compton (2010) reminded us that the causes of crisis events involving police are diverse (e.g., interpersonal conflict, substance use, acute stressful life event) and not always about mental illness. Further, we know that the calls flagged as mental health related are initiated for a number of reasons including the person as a victim, offender, witness, as someone in need of assistance, or as a source of suspicious or disorderly behavior (Brink, Livingston, & Desmarais, 2011). To this point, Wood, Watson, and Fulambarker (2017), in their observational study of police calls in Chicago, found that

the majority of calls do not involve violence or meet the threshold for apprehension and thus fall into what they describe as the gray zone of police work (also see Bittner, 1967; Morabito, 2007; Teplin, 1986). This definitional issue becomes even more complicated when we start to think about the challenges of standardization within these various terminologies. For example, within the policing literature what precisely defines a person with mental illness (PMI) or a person in crisis and are they being defined and measured the same way across articles?

Beyond the methodological implications, the terms and frames we use also have the ability to shape the construction of the problem itself, as well as the proposed solutions. Becker's (1963) classic words on this topic are insightful:

Even though a practice may be harmful in an objective sense to the group in which it occurs, the harm needs to be discovered and pointed out. People must be made to feel that something ought to be done about it. Someone must call the public's attention to these matters, supply the push necessary to get things done, and direct such energies as are aroused in the proper direction to get a rule created. Deviance is the product of enterprise in the largest sense; without the enterprise required to get rules made, the deviance which consists of breaking the rule could not exist. (p. 162)

In this instance, we are talking more about problems and policies than specifically about deviance and rules, but the point still holds. The labelling of something as a problem, and the subsequent enterprise to define and develop a response to that problem, is a contested and inherently social process that incorporates and reflects issues of power (also see Foucault, 1972/2006; Hacking, 2006). In the enterprise of defining and responding to current issues with mental health-related police calls, researchers play an important role and wield a significant amount of power. The terminology and frames that we use as researchers not only have the ability to construct the issue in particular ways within the academic literature, but also to shape the response to the issue through an influence on policy makers, police services, the media, and the public.

History also underscores for us the extra care that needs to be taken on issues related to research and the creation of discourse around mental health. A history of activism and scholarship shows how mental illness and psychiatric disability have a long history of being labeled and framed in a way that stigmatizes, homogenizes, and depersonalizes those involved (Corrigan, 2014; Goffman, 1961; Out Loud, 2010). These labeling processes often frame the negative outcomes and experiences associated with

mental illness and psychiatric disability as an individual problem, related to the nature of the illness, rather than as the result of more systemic or rights based issues such as poverty, stigma, and access to adequate community-based healthcare (Benbow, Rudnick, Forchuk, & Edwards, 2014; Mingus, 2010; Morrow & Weisser, 2012; Stroman, 2003). There is also fear associated with mental illness and a strong belief that people with mental illness are inherently irrational and dangerous (Morabito & Socia, 2015). As a result, there has been a longstanding grassroots effort to reclaim and redefine what it means to have mental illness. Although guided by differing political philosophies, terminology such as consumer/survivor, recovery, Mad, and individuals with psychiatric disabilities have all come out of this push against totalizing views of mental illness that frame it as a central and negative definer of a person's life and as something best addressed through hospitalization (Davidson, 2010; LeFrançois, Menzies, & Reaume, 2013; Stroman, 2003). These efforts help to underline what is at stake in the language we use and the need to be as careful and thoughtful with our language and our terminology as possible.

We can also reflect more generally on historical changes in the language around mental health as attitudes and ideas have changed over the last 200 years. Through this time, terms such as *madness* and *neurosis* have been replaced with more precise diagnostic language such as *anxiety* and *depression* (Corrigan, 2014; Romm, 2015). The term *mental health* is also a relatively recent creation, with its use really developing during the 1950s to draw attention to a continuum of wellness that can apply to anyone and that can change over time (Jahoda, 1958). This compares to a binary term such as *mental illness* that divides people into more fixed categories as either healthy or sick. Similarly, there has been a growing push toward more person-first language such as PMI rather than simply describing someone as mentally ill (Corrigan, 2014; SAMHSA, 2016). Relatedly, the term *chronic mental illness* has been replaced with distinct terms such as *serious mental illness* and *severe and persistent mental illness*. This distinction acknowledges that someone can have a serious disorder such as schizophrenia that does not result in severe or persistent disability (SAMHSA, 2016). However, complexity remains around the term *serious mental illness*. For example, in the United States, SAMHSA uses the term to refer to diagnosable mental disorders that have at any time in a person's life resulted in serious functional impairment. However, legal definitions of the term can vary by state and do not necessarily require functional impairment. Serious mental illness usually refers to disorders such as schizophrenia, major depression, and bipolar disorder, but under the SAMHSA definition, a person could technically experience serious functional

impairment as a result of any mental health disorder listed in the DSM-IV (SAMHSA, 2016). Another illustration of this complexity comes from Gray, Hastings, Love, and O'Reilly's (2016) analysis of different Canadian provincial mental health acts. Within the same country, we see regional variation in the conditions in which someone can be apprehended and involuntary confined in an institution, including differences in how mental health disorders are defined across the various pieces of legislation.

With these considerations in mind, we engage in an analysis of the frames, terminology, and definitions used in the scholarly literature surrounding interactions between the police and people perceived as having a mental health problem. Frames refer to the historical and systemic forces cited by the authors in explaining the interaction between the police and people believed to have mental illness. This includes the grounds on which a focus on the topic is justified. The terminology refers to the particular language used in the article for referring to mental health-related calls or the mental health status of the citizen involved in the call (e.g., PMI). Last, we also consider how the preferred terminology is being used through an examination of how the term is being explicitly or implicitly defined, including through the operationalization of key variables. Focusing on these three areas, the aim of the analysis is to examine the relative use of different terms and frames over a 17-year period and to consider the implications of that usage for how we understand and construct the issue.

Methods

The methodology for our analysis involved conducting a scoping review of the literature on police responses to mental health calls. A scoping review broadly and systematically examines the literature on a particular topic. This allows for many different types of studies to be included in the scoping review and synthesizes the state of research knowledge in a particular area (Arksey & O'Malley, 2005; Daudt, van Mossel, & Scott, 2010; Levac, Colquhoun, & O'Brien, 2010). While more frequently used in the health sciences than the social sciences (Pham et al., 2014), the systematic nature of scoping reviews is more reliable than traditional literature reviews because the methods utilized to search for literature are well documented and can be replicated (Levac et al., 2010; Valaitis et al., 2012). The overall goal of a scoping review is to be comprehensive and develop as complete a collection as possible of pertinent literature on a topic (Arksey & O'Malley, 2005).

Arksey and O'Malley's (2005) five-stage framework for conducting scoping reviews¹ guided our approach. These stages include formulating a research question, searching

for relevant literature to help answer the research question, determining which research articles to include and exclude, developing an analysis plan, and summarizing the results. Applying this framework to our own research study, we first formulated a research question. The broad research question guiding our approach was “How are police responses to mental health-related incidents discussed in the academic literature?” More specifically, we were interested in examining the frames, terminology, and definitions used by researchers.

Second, to be comprehensive, we first searched the literature broadly utilizing the terms *policing* and *mental health*. This returned thousands of results, many of which were unrelated to our research question. Therefore, our search was refined to focus more specifically on police responses to mental health-related incidents. As Arksey and O'Malley (2005) noted, “[t]he process is not linear but iterative” (p. 22). Our refined search terms included police and each of the following terms: *mental health*; *persons with mental illness*; *people with mental illness*; *person with mental illness*; *behavioral health*; *mental disorder*; *mental health crisis*; *people in crisis*; *persons in crisis*; *Crisis Intervention Team*; *co-response*; *mobile crisis*; *mental health response*. The online library databases ProQuest and Scholars Portal were utilized to conduct this search.

Third, abstracts of articles yielded from the search were read for relevance and were included in our analysis if they were in some way related to police responses to mental health related incidents. The type of article and quality of the study did not impact inclusion. To further focus our search, we limited our inclusion criteria to articles related to the contexts of Canada and the United States given their similar policies around policing and mental health. Finally, we included only literature published between January 2000 and May 2017 to limit our analysis to the more contemporary research on the topic. In total, the present study included 92 articles for analysis. Most of the articles came from either policing or mental health-related journals and the list included a mix of original research and review articles. Common topics included discussions and evaluations of co-response and CIT programs, training evaluations, interviews with police officers about their experience with mental health calls, interviews with consumers about their contact with police, quantitative analysis of arrest records and mental health apprehensions, and observational studies of police interactions.

Fourth, we conducted a content analysis of the included articles using NVivo qualitative software. Each of the articles were read and coded for themes relevant to

answering our research question. More specifically, we coded for the different types of terminology used to refer to the individuals the police were responding to for the mental health incident (e.g., people with mental illness, people in crisis, mentally disordered person). As terms were discovered, we used the search function to search for the term and its related variations throughout all of the articles and to code those instances. For example, person with mental illness was searched using the command: *“people with mental illness”* OR *“persons with mental illness”* OR *“person with mental illness”* OR *“PMI”* OR *“PwMI”* OR *“persons with a mental illness”* OR *“person affected by mental illness”* OR *“people affected by mental illnesses”* OR *“individual with mental illnesses”* OR *“persons with a mental illness”* OR *“people with mental illnesses”* OR *“persons with mental illnesses”*. This is not a perfect method, as there is likely to be variations we miss, but it does include the most common appearing terms and therefore is a reliable strategy for estimating the relative prevalence of a term. We also manually coded each article for its preferred term, which we define as the term used most prominently within the article (e.g., used in the title, used most frequently throughout the article). Similarly, each article was coded for the different ways that the issue was framed, as well as the preferred framing, assessed as the frame given the most emphasis within the article. The focus here was on the way the authors explained the roots and systemic drivers behind the current situation involving the police response to mental health-related incidents (e.g., deinstitutionalization, criminalization, homelessness). The importance of the issue, as presented in the articles, was also coded by identifying the rationales and justifications provided by each article for why the issue is important to study. Finally, we examined how the terminology used in each article (e.g., mental illness, mental disorder) was defined or operationalized. The methodology and topic area were also coded for each article.

In terms of coding procedure, the authors first engaged in an open coding procedure of 30 articles. Initial codes were developed independently utilizing NVivo software (QSR International, version 11 Melbourne, Australia) and then discussed amongst the authors to ensure consistency in coding procedures. Next, we each coded the same article, which we then subsequently reviewed as a group for inconsistencies. We discussed the identified incongruences and agreed on a coding strategy. Next, we developed an NVivo file with agreed-on codes. We divided the articles among ourselves and again coded independently. Any new codes that emerged were discussed and added to the file as necessary. Once coding was complete, each of our NVivo files was merged into one file for analysis. Tyler Frederick reviewed this file for consistency and we met again as a group to clarify and revise any inconsistencies that had emerged.

The final stage of Arksey and O'Malley's (2005) framework entails reporting the results of our analysis. Our aim in the next section is to present an overview of the findings from our analysis of reviewed articles. However, in addition to identifying how this issue was discussed in the articles, we are equally as interested in identifying what was not discussed.

Results

Framing and Justification

In total, we identified 17 different frames used to explain the current situation regarding mental health-related calls that have been documented in recent decades (see Table 1). A key finding from the analysis is that criminalization was the most prominent single frame employed in the literature. It was used by 48% of the 92 articles reviewed and was identified as the preferred frame in 19.5% of the articles. Articles employing this framing focused on the overrepresentation of individuals with mental illness in prisons and jails. For example, Krishan et al. (2014) wrote:

The over-representation of persons with serious mental illnesses in the criminal justice system in recent decades is a prominent concern in mental health, advocacy, and criminal justice communities. Incarceration of persons with mental illnesses complicates their long-term psychosocial functioning and contributes to overcrowding and resource burdens in detention settings. (p. 359)

Criminalization is not always specifically defined within each article and it can connote slightly different things across articles. For some articles, it is discussed largely as an issue of overrepresentation and the criminal justice system taking on the unfulfilled role of the mental health system (Davidson, 2016):

Many communities lack dispositional alternatives to arrest for persons with a mental illness engaging in maladaptive, criminal behavior. While this behavior may be a manifestation of the individual's mental illness, law enforcement officers must frequently resort to arrest when responding to these calls for service. As a result, the burden of caring for and managing this population has been largely transferred to correctional facilities. (pp. 47-48)

Other articles, in comparison, placed more emphasis on problematic policing practices and emphasize that people are often being arrested for minor crimes or disruptive behavior that can be linked to their illness (Compton & Chien, 2008). This more critical

take on criminalization is the more common approach within the literature and is consistent with Engel and Silver's (2001) discussion of the term.

[TABLE 1 ABOUT HERE]

The next most common single frames were deinstitutionalization and a framing emphasizing police as a common frontline response to people in crisis.

Deinstitutionalization was used by 32% of the articles and was the preferred frame among 12% of the articles reviewed. The articles we reviewed provided varying amounts of detail and description of the process. This could mean simply making reference to the process as a bit of historical background, for example, Tyuse (2012) wrote, "it is widely accepted that the high number of inmates with mental illness is attributable to the deinstitutionalization of psychiatric services that began in the 1960s" (p. 464). This compares to other articles that provided a more detailed description that touches on some of the broader issues linked to deinstitutionalization. For example, Tully and Smith (2015) wrote:

Over the past several decades, law enforcement officers have become increasingly more involved with the mentally ill population. The reasons for this increase are many, including but not limited to deinstitutionalisation. Deinstitutionalisation, a programme created under the Kennedy administration, had two goals: to decrease the number of persons housed in mental health facilities and eventually to close a large percentage of these mental health facilities with the end goal of saving federal funds (Harcourt, 2011). This mass closure of mental institutions and ultimate displacement of those with mental illness create significant problems for the criminal justice system. These dislocated individuals often found themselves homeless, being incarcerated for minor offences and being stigmatised by those who did not understand the concepts surrounding mental illness. (pp. 51-52)

From our coding, approximately 63% of articles using the deinstitutionalization framing were only brief mentions. Articles, providing a broader and more developed framing also sometimes included reference to tighter commitment laws and the underfunding of community mental health services as a way of placing the trend in a broader context (see Engel & Silver, 2001).

The crisis-focused framing was used by 26% of the articles and was the preferred framing among 12% of the articles. For example, Broussard et al. (2010) wrote, "as first responders in crisis situations involving persons with serious mental illnesses, law enforcement officers are often the principal source of referral to psychiatric

emergency services (PES) and play an important role in the initiation of mental health treatment.” (p. 579). This framing was common in articles focusing on discussing or evaluating CIT.

A significant proportion of the articles employed multiple frames and we were not able to isolate one clear preferred framing (23% of the articles). This categorization might apply, for example, to an article that touched on deinstitutionalization, crisis, and criminalization in their discussion. Conversely, 21% of the articles offered no obvious framing and the analysis was characterized by a straightforward reporting of empirical findings without much additional context or discussion.

It is interesting to note that only a small percentage of articles directly discussed stigma or discrimination (9%), or other broader systemic forces such as gentrification (2%), homelessness (16%), inadequate government supports (17%), or the role played by disorder focused policing strategies (11%). The reduced attention to these themes also has implications for the criminalization framing because, as noted, there was variation in the extent to which articles provided a broader context to why we see overrepresentation of people with mental illness in the criminal justice system.

Another dimension to the framing that we examined was the grounds on which the article justified the need for improved knowledge on the interactions between police and people with mental illness. The most common justification or rationale was the need for more diversion away from the criminal justice system, which was used by 59% of the articles. The next most common rationales were the need for increased collaboration between the police and mental health providers (39%), the need to improve interactions (37%), and the need to improve the safety of the citizens involved (32%). These rationales all make sense given the emphasis in the articles on frames concerning overrepresentation and police as a frontline response to individuals in crisis.

Terminology and Definitions

The analysis identified 23 different terms used to reference individuals with behavioral health problems or individuals suspected of having behavioral health problems. The most commonly used term by a large margin was PMI or a related term. It was used by 88 of the 92 articles we reviewed (96%) and was identified as the preferred term among 59% of the articles. Furthermore, the term was used over 2,300 times across the 92 articles. The term *mentally ill* was also common with 94% usage across the articles, with approximately 751 occurrences. The next most popular term was *people*

in crisis, which was used by 72% of articles, but was less popular as a preferred term (8%) and had much lower usage, at approximately 155 occurrences. *Consumer* (66%), *subject* (61%), and *people with serious mental illness* (58%) were also common terms used in the literature.

A key finding to note regarding the definition of terminology is that it was common for articles not to provide a direct definition of their preferred term and instead it was necessary to infer definitions from the article's methodology or broader discussion. In the remainder of the section, we focus on two of the most popular terms, PMI and *person in crisis*, to explore more precisely how the terms were being used, defined, and operationalized.

We will focus first on articles that were identified as having PMI as the preferred term. The preferred terms means that from our analysis of the article, PMI was the term used most prominently in the article. In this category of articles, Coleman and Cotton (2010) provided one of the most robust and directly stated definitions:

The term person with a mental illness, or PMI, is used to denote anyone whose behavior at the time in question appears to be influenced by the presence of significant mental distress or illness. It may be that the person is experiencing a persistent and severe illness such as schizophrenia, or it may be that they are experiencing a transitory period of distress and are temporarily experiencing symptoms that may be expected to abate, as in the case of an acute anxiety problem. For the purpose of this article, the essential factor is that at the time of the police interaction, the person's mental state is impaired to the extent that their response to their environment is negatively affected. (p. 54)

In this definition, we see an emphasis on the appearance of mental distress or illness and someone with an impaired response to their environment. Other articles offering more specific definitions touch on similar characteristics, but often with their own twist. For example, Oliva and Compton (2008) provided this definition and setup:

Mental illnesses are prevalent conditions that are associated with substantial disability and are often undiagnosed, untreated, or undertreated. Families and friends of people with mental illnesses also are affected by these disorders, especially when they are unable to facilitate treatment initiation due to individual-level factors (e.g., impaired insight), family- and community-associated obstacles (such as insufficient social supports), system barriers (e.g., inadequate community mental health services), or societal pressures, including stigma. Situations in

which a loved one with a mental illness is in crisis but not engaged in treatment can contribute markedly to family frustration and strained relationships. Occasionally, families of individuals with mental illnesses may be confronted with no alternative but to involve law enforcement during a crisis. (p. 38)

In this use, we see an emphasis on mental illness as something debilitating that leads to crisis.

In other articles using PMI, we can see how the term is defined through its operationalization. Livingston et al. (2014), for example, defined their inclusion criteria as the following:

current diagnosis of schizophrenia, schizoaffective disorder, other psychosis, or bipolar disorder (self-reported); (b) previous contact with police (self-reported); (c) age 19 year or older; (d) able to speak and understand English; and (e) cognitively capable of providing research consent. (p. 335)

Here we see mental illness defined as a self-reported diagnosis of a specific set of disorders. Tyuse (2012), studying police calls, focused on those involving “severe mental illness” and included a slightly different set of illnesses: “(1) call involved a person experiencing or having a history of severe mental illness (e.g., schizophrenia, depressive disorder, bi-polar disorder) and (2) call involved a suicide threat or suicide attempt” (p. 468). It is worth noting that the label severe mental illness is typically reserved as a distinction about the level of impairment and not one based specifically on type, as people can have a serious mental illness that is not causing severe impairment (SAMHSA, 2016). Watson and Angell (2013) also focused on types of diagnosis, but specified it in terms of people with an Axis 1 diagnosis based on the DSM-IV (American Psychiatric Association, 2000). Axis 1 includes all diagnostic categories within the DSM except personality disorders.

The articles just discussed represent those that provided a direct definition or operationalization of PMI, but as noted, a number of articles did not provide one, and so understanding their definition required a closer read. For example, there was a number of articles about training police officers that use vignettes that we can use to infer something about how PMI is being conceptualized. For example, Stanyon, Goodman, and Whitehouse’s (2014) training evaluation included vignettes depicting delusions, suicide, self-harm, and a negative reaction to psychotropic medications. Bahora, Hanafi, Chien, and Compton (2008) focused on the impact of training modules on depression, schizophrenia, cocaine dependence, and alcohol dependence. Watson,

Corrigan, and Ottati (2004) also used vignettes in their study, using schizophrenia as the marker of illness (also see Demir, Broussard, Goulding, & Compton, 2009).

In another set of articles, we can infer the definition of PMI through the program being evaluated. Cowell, Hinde, Broner, and Aldridge (2015), for example, in their research on a jail diversion program, focused on individuals with serious mental illness:

“Program eligibility was restricted to people with serious mental illness, operationalized as a diagnosis of bipolar, major depression, schizophrenia, or schizoaffective disorder, and a misdemeanor offense” (p. 58). Lord, Bjerregaard, Blevins, and Whisman (2011), in their study of specific CIT programs, offered this definition:

According to the standard operating procedures for these agencies, certified officers will respond to calls that “indicate the potential” for a person with a mental illness to be involved. The policy defines mental illness as an illness which lessens the capacity of an individual to exercise self-control or judgment to the degree that it is advisable for the person to be under treatment or supervision of a mental health professional, although the individual may not have a diagnosis from a doctor or other medical professionals. (pp. 393-394)

In this version, we see an emphasis on impaired judgement at a level that would suggest the need for treatment or supervision.

The final set of articles to discuss are those that are conducting research on officer perceptions and as such they are relying on the officers’ personal definitions of PMI. In an operationalization reflective of articles in this category, Morabito et al. (2012) wrote:

For this investigation, mental illness is defined based on the observations of officers. Research suggests that officers transporting individuals to crisis centers typically make accurate judgments on the need for mental health care (Strauss et al., 2005; Teplin, 1984). In this study, officers were asked to identify whether they were involved in incidents with adults with mental illness and asked them to describe their most recent incident through a series of structured and semistructured questions. No other information was used to determine the presence of a citizen with mental illness in the encounters recalled by the police. (p. 64)

In summary, we can see a significant amount of overlap in terms of the definitions and operationalizations provided, but also differences in terms of the illnesses listed (e.g.,

the inclusion of substance dependence, depression) and the extent to which impairment or distress is a specified feature. In terms of what they share, for most of these articles, despite using a broad term such as PMI, their definition or operationalization (explicit or implicit) was actually more narrow and tended to emphasize either the experience of crisis or a diagnosis of serious mental illness. To this point, it is notable that a number of articles use the terms PMI and *person with serious mental illness* interchangeably. For example, Lurigio, Smith, and Harris (2008) wrote that “the criminal justice system was never designed to solve the complex and devastating problems of people with serious mental illness (PWMI), particularly those afflicted with chronic brain disorders such as major depression, bipolar disorder, and schizophrenia” (pp. 295–296; see also McGriff, Broussard, Demir, Thompson, & Compton, 2010; Munetz, Fitzgerald, & Woody, 2006; Munetz & Griffin, 2006; Ralph, 2010; Reuland, 2010). The use of the term *chronic* is also misleading here because someone can have a serious mental illness but not be chronically affected by it. It should be noted that these confusions are not specific to this literature; SAMHSA (2016) recently released an information sheet in an attempt to clarify some of this misunderstanding.

As noted, another feature of the term PMI within a number of studies is that it is used to refer to an individual in a state where his or her illness is actively impairing his or her judgement and behavior. The concern with this assumption is that it is not reflected in the terminology itself, as some people with mental illness may be nonsymptomatic for much of their life. There are also some validity concerns in that many of the projects involve methodologies that do not allow for a direct validation of the extent to which those involved actually have a mental illness (as opposed to someone with abnormal behavior but not to a clinical degree, or experiencing an acute drug or stress reaction). These issues raise some questions about if the term PMI is actually the best term given its typical application in the literature, a point we will return to in the discussion.

The term *person in crisis* was another commonly used term in the literature, at a rate of 72%, but was less common as a preferred term, at only 8%. For those articles using it as a preferred term, definitions and operationalizations were varied. For example, Oliva et al. (2010) defined it with a specific emphasis on the experience of crisis and acknowledge roots outside of mental illness:

For the criminal justice worker, the term crisis would most likely refer to a situation in which an individual is having extreme difficulty coping with a personal

problem, event, or interpersonal situation (Romano, 1990). It is considered a crucial or decisive point in one's life that can be emotionally stressful and traumatizing (Everly & Mitchel, 1997). (p. 16)

Other articles defined it more generally as psychiatric emergencies (Scott, 2000), as calls radioed through dispatch as involving a mentally ill person (Steadman, Deane, Borum, & Morrissey, 2000), or calls coded by the police as related to "mental disturbance" (Teller, Munetz, Gil, & Ritter, 2006). Based on this analysis, person in crisis seems to have some of the same issues as PMI in that there is a lack of standard definition and validation concerns for those broader definitions and operationalizations because certainly not all calls involving people perceived as having mental illness are crisis situations.

Discussion

There are a few main conclusions we want draw from the analysis. The first is that despite some nuanced framing throughout the literature, there is a lack of discussion around important issues such as homelessness, poverty, gentrification, and the rise of disorder focused policing strategies over the past few decades (e.g., stop and frisk, broken windows) and the role these factors play in bringing about increased contact between the police and people perceived as having a mental health problem. There is also a tendency to present deinstitutionalization in relatively narrow terms. These two features of the framing combine to shape the overall picture of the issue that is presented in the literature—a picture that emphasizes mental health to the exclusion of other important systemic processes and factors. The second main conclusion is that PMI is by far the most popular term in the literature, but the term is often being used misleadingly as a shorthand for people with serious mental illness in a state of impairment, or people who are suffering from acute mental distress.

These features of the framing and use of terminology combine to create a common narrative within the literature (with important exceptions of course). The standard narrative goes something such as this: Around the 1960s, mental health hospitals started to close and legislation around commitment changed. These changes led to an increase in individuals with mental illness in the community. Untreated mental health needs within this population led to crisis and to increased police contact, which frontline officers often have not had the training to manage, particularly with limited options for resolving these calls outside of arrest or apprehension. These factors combined to lead people who might otherwise be in a hospital to end up in the criminal justice system.

This narrative certainly has truth to it, but it is also a simplistic one. The risk with a simplified narrative such as this is that it is easy to take away from it that deinstitutionalization in and of itself is problematic and that having people with mental illness in the community is a central contributor to the issue (made worse by inadequate police training). The more simplistic narrative also underemphasizes that the whole point of a community-based mental health system is to get people out of hospitals and back into their communities to recover, and that this goal is important from both a clinical and a social justice perspective (Davidson, 2010; Davis, 2014; Farone, 2006; Warner, 2004). Further, the simplistic narrative overlooks that most individuals who experience mental illness in their lifetime (about 20% of the population) are unlikely to require hospitalization or have contact with the police as a result of the symptoms of that illness (National Institute of Mental Health, 2016).

Instead of this simplified narrative, we need a broader framing that helps to re-center the issue around the unique vulnerability experienced by people with serious mental illness and around problems with how we have executed the push toward community-based mental health over the last 60 years (not the effort itself). These problems include underfunding of community mental health services, gentrification processes that drive up housing prices in the urban cores where most services are located, stigma and discrimination that create barriers to employment and housing, and a rise in disorder-focused policing strategies that aim to push people viewed to be disruptive or disorderly out of public spaces (Amster, 2003; Grob, 1995; Schutt, 2011; Teplin, 1986). It is precisely these features of the issue that are highlighted in observational studies and through interviews with consumers or survivors that show that many police interactions involving people perceived as having mental illness are not related to crisis or violence at all, but are more about chronic vulnerability (Watson, Angell, Morabito, & Robinson, 2008; Wood et al., 2017). In fact, Wood et al.'s work documents the successful interactions that can extend from the ability of officers to recognize chronic vulnerability and to negotiate provisional outcomes, as well as use their local knowledge to find solutions beyond the criminal justice and mental health systems. Extending this argument, a broader narrative is important for thinking about additional partnerships and collaborations beyond the mental health system that can be helpful in facilitating better police-citizen interactions and outcomes. To this point, a recent meeting around this issue organized by SAMHSA emphasized the need for more cross-sector collaborations and a focus on how we can establish a continuum of care across systems for vulnerable people struggling with substance dependence and serious mental illness (Steadman & Morrisette, 2016).

Focusing specifically on terminology, there are also some concerns across the literature about the extent to which we are able to validate that the interactions actually involve people in a state of crisis or with a mental illness. Based on our analysis, we want to recommend that the literature move away from using PMI as a default term. We can understand why it can be helpful to use a terminology, such as PMI, that establishes a broad context to the issue of police contact with individuals in crisis and other types of calls where mental health, substance abuse, or disability shape the nature of the interaction. One reason is that this is often how frontline officers and police services are thinking about these calls—as a collection of calls broadly related to mental health that cause particular issues and challenges. Second, these are also all calls that can benefit from specialized training (e.g., CIT). However, as researchers and policymakers we also need to acknowledge there are risks to lumping interactions with diverse characteristics together under broad conceptual headings such as people with mental illness and mental health-related calls. We do not want to be overly prescriptive, as the subject matter is complex and the terminology we use is never going to be perfect, but overall we encourage researchers to strive for more precise language when possible.

If we are to get more specific and try to outline ways to introduce some additional precision into the literature, it would be ideal to strive for language that distinguishes between interactions connected to crisis or severe impairment, interactions connected to high levels of marginality (without crisis), and interactions connected to disorderly or disruptive behavior (without the presence of high marginality or crisis).

Distinguishing among these types of interactions is valuable for research and practice because each type has its own precipitating factors, preferred strategies for frontline responders, and policy implications. For example, a high volume of calls involving disorderly behavior without crisis or high marginality points toward a public education and anti-stigma response more so than a mental health or criminal justice one. This suggestion does not necessarily require a massive shift in the language we are using. For most literature on CIT and diversion programs involving mental health services, it will only involve a shift from PMI to a term such as person in crisis or experiencing acute impairment as this likely covers most of the calls that CIT officers are responding to.

Despite making this argument, we also recognize that distinguishing between interactions may not always be possible and that it is often necessary to reflect on these types of calls in a general sense. For example, the research may be reflecting on trainings or responses that are designed to cover different types of interactions, or

relying on the categorization of officers or dispatchers without perfect information. In these instances, we recommend that researchers use terminology that reflects this uncertainty such as people thought to have mental illness, people perceived to have a mental health problem, calls flagged as mental health related, or interactions linked to crisis or impairment (for examples, see Steadman et al., 2000; Steadman & Morrisette, 2016; Watson, Ottati, Draine, & Morabito, 2011).

Finally, another set of literature reflects on the experiences of people who self-identify as having mental illness or who are consumers of mental health services and their interactions with police. Certainly, in these instances, a mental health-related label is appropriate, with consumer being a good choice as it treats the issue as a service need rather than a personally defining characteristic and is in line with the language used by National Alliance on Mental Illness and other patient advocacy groups (for examples, see Bonkiewicz, Green, Moyer, & Wright, 2014; Kirst et al., 2015; Lord et al., 2011).

Conclusion

In conclusion, our analysis of the research literature surrounding police interactions involving people in crisis or perceived as having mental illness finds a diversity of terminology and frames. These terms and discussion points highlight the complexity of the issue, but more can be done to place the current situation in a broader context that recognizes forces and trends beyond the mental health system and the need for better police training. Through this broader framing, we see more opportunities for research to drive the development of innovative responses for improving the quality of interactions and the outcomes for all those involved.

Furthermore, we intend this analysis, not as a proscriptive last word on terminology and framing, but rather as a contribution to the wider conversation about how to study and make sense of mental health-related police interactions. We recognize that changes in language and discourse are often gradual and that there are a number of limitations to our recommendations. These include that this work is cross-sector and that there are different standards and expectations around language within and between police services and mental health providers; that language around these concepts is contested and constantly evolving; and that productive conversations about mental health are just beginning in many police services and that there is still significant ground to cover before it might be reasonable to start a conversation about the fine tuning of language. Overall, though, we are optimistic about the ability of researchers to improve our precision around the topic and through this continue to

contribute to nuanced and innovative discussions and policy developments among police services, policymakers, and the public.

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Tables

Table 1. Number of sources using particular term and frames

Framing	Sources	Terminology	Sources
Criminalization	44	Acute episode	1
Deinstitutionalization	27	Apprehended mental health patient	1
Disorder policing	10	Behavioral crisis	2

ER overcrowding	2	Consumer	61
Gentrification	2	Distressed individual	2
High rates of mental health in population	10	Emotionally disturbed person	8
Homelessness	15	Individuals in need of mental health treatment	1
Inadequate mental health supports	7	Individuals with psychiatric care	3
Inadequate social assistance	9	Mental case	1
Increased access to drugs	1	Mental disturbance	40
Increased general contact	3	Mental health related encounters	3
Person as needing assistance	22	Mental patients	4
Person as offender	10	Mentally disordered citizen	3
Person as victim	5	Mentally ill	83
Person as witness	3	People in crisis	66
Shifts in policing	8	People thought to have mental illness	2
		People with mental disturbance	4
		People with mental health challenges	1

		People with mental health problems	4
		People with mental illness	88
		People with mental illness in crisis	12
		People with serious mental illness	53
		Persons displaying signs of mental illness	2
		Service recipient	5
		Subjects	56

Footnotes

1. While Arksey and O'Malley (2005) referred to this approach as a scoping study rather than a scoping review, we agree with Pham (2014) that "scoping review" more accurately captures that this is a review of literature rather than a study per se. [↵](#)