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POLICE AS FRONTLINE MENTAL HEALTH WORKERS:
THE DECISION TO ARREST OR REFER TO MENTAL HEALTH AGENCIES

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE
UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

IN
SOCILOGY
AUGUST 1995

By
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Dissertation Committee:
Gene Kassebaum, Chairperson
Harry Ball
Karen Joe
Susan Meyers Chandler
Kim Marie Thorburn
DEDICATION

One of the qualities that makes the United States an economic and political world leader is our highly competitive nature. We have structured a society that generously rewards hard work and success. However, the mark of a truly great nation is one that values all its citizens, including those who cannot compete; in this, the United States falls short of greatness.

This research is dedicated to those individuals whose daily struggle to survive is met with disgust and hostility. Those persons who have a mental illness and are living on the streets of "paradise" are a reflection of who we are as a society. I sincerely hope that we can learn to view our reflection with compassion and understanding.
ACKNOWLEDGEMENTS

I am deeply indebted to the Honolulu Police Department for their cooperation and support in conducting this research. Without exception, all of my interactions with the department have been courteous and accommodating. I truly believe that all of the department’s personnel with whom I dealt in the course of this research are dedicated to protecting and serving the public, including those persons who have mental illness. I am especially indebted to Chief Michael Nakamura, Major Robert Au, Major Herbert Okemura, Captain Mike Chastain, Major Richard Fuji, Major Steven Watarai, Major Jerold Brown, Major Boisse Correa, Major Charles Duncan, the watch commanders from each of the eight police districts, and the patrol officers who participated in this research. The same debt of gratitude is owed to Sharon Black, director of Project Outreach, whose dedication and efforts on behalf of the homeless and homeless mentally ill is an inspiration.

I had an exceptional dissertation committee. For the past seven years, Gene Kassebaum has served as not only chair of my thesis and dissertation committees, but has been a willing mentor. I was fortunate to benefit from Harry Ball’s expertise concerning the legal system and wealth of knowledge about Hawaii’s history of law enforcement; Karen Joe’s knowledge of qualitative methods, theory, and tremendous support; Susan Meyers Chandler’s profound understanding of the issues concerning persons who have a mental illness and society’s response to those issues; and Kim Marie Thorburn’s perspective of the problems associated with incarcerating persons who have a mental illness, and her passion for social justice.

During the course of this research many friends had words of encouragement and support, but no more so than my supervisor, Alan Shimabukuro. Alan is the most gifted
manager I have ever known: he empowers his staff and leads by example. His guidance was critical to the successful completion of this research.

I can honestly say that I could not have completed this research and all that preceded it without the love, support, and meticulous editing of my wife and best friend, Trish Riley. Not only do I owe her more than a few nights of not doing the dishes while I studied, or lost weekends in reading or writing, or blurry vision from reading and re-reading my work, but the greatest gift was the knowledge that pursuing this goal was as important for her as it was for me. I am truly blessed.
ABSTRACT

Most large cities in the United States are currently faced with an array of problems associated with a growing number of individuals who have a mental illness and who are often living on the streets, or at least are no longer confined in closed mental institutions. Whenever behavior in public violates community standards or laws, such behavior becomes subject to law enforcement. The police are increasingly required to intervene in behaviors of individuals with diagnosed mental illness, being placed in a role which requires them to mediate the interests of local politicians, their own departmental policies, merchants, private service providers, hospitals, the general public, and individuals who may need mental health services.

Police officers have a limited number of dispositional options but a great deal of discretion concerning which options to invoke. Research on police discretion has examined the degree to which police "criminalize" the mentally ill, act as gatekeepers to the mental health system, and, in a broader sense, invoke police sanctions rather than clinical authority. The purposes of this research are threefold: to measure the distribution of the dispositional options which police select in dealing with persons with a mental illness who commit an act for which they could be cited or arrested; to measure why police make the decisions they do; and to measure police workload involved in invoking the various options for dealing with persons with a mental illness.

Over half of the encounters between police officers and those with a mental illness resulted in an informal disposition, 20 percent resulted in the officer taking no action (a heretofore unmeasured outcome in studies of police discretion), and 15 percent resulted in arrest. During the study period, officer-suspect encounters ranged from 0 to 500 minutes in
duration, with an average of 36 minutes per encounter. Multivariate logistic regression analysis specifies models which best predict these three dispositional outcomes. Explanatory variables which appear in each model include the number of years an officer has served on the police force and the severity of the offense; other significant variables include whether the suspect was known on sight or known to have a criminal history. Qualitative analysis offers additional insights into the factors which influence the decision making processes of law enforcement officers.
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PREFACE

In the early nineteenth century, the United States began to develop publicly supported, institutionalized systems for accommodating the mentally ill. These systems, once referred to as almshouses, then asylums, evolved into the total institutions known as state hospitals. The state hospital provided a segregated environment, with varying levels of security and custodial care, for relatively long periods of time. During the first century and one-half of their existence, the population of state hospitals increased at twice the rate of the general population.

By the mid-1950s, the tremendous costs of confining large numbers of mental patients, criticisms of the conditions in the state hospital, and the development of new psychotropic medication, combined to shift the focus away from the large state hospitals to smaller, community-based outpatient services. The creation of alternative forms of general welfare support, especially Social Security, the beginnings of the development of a system of community mental health centers, and a growing awareness of social justice inspired by the Civil Rights Movement led to the now well-documented deinstitutionalization, or perhaps more accurately, transinstitutionalization, movement. This movement led to a dramatic reduction of the census of the once large state hospitals and moved a large number of persons with a mental illness into general hospital emergency rooms, single occupancy hotels, care homes, sidewalks, doorways, and public parks.

During the past 20 years, the increase in the number of persons with a mental illness who are homeless and the legal restrictions concerning involuntary commitment except in cases of imminent danger to self or others has resulted in increased pressure for the police to handle, often repeatedly, large numbers of persons with a mental illness. There is a
There are several competing forces at work. First, it is deemed constitutionally questionable and therapeutically pointless to arrest, prosecute, and sanction a person who has committed a minor violation simply by virtue of his or her mental illness. Similarly, it is likewise pointless to release to the streets a disturbed and publicly disruptive person who a medical resident has determined does not meet the "imminent danger to self or others" standard for commitment.

The study reported here inquires into how police attempt to define their responsibility and deal with cases of public deviance where mental illness or acute disturbance due to alcohol or other drugs, in association with psychiatric disorder, are apparently involved. The police are required to intervene in the behavior of individuals with diagnosed mental illness, being placed in a role which enjoins them to mediate the interests of local politicians, their own departmental policies, merchants, private service providers, hospitals, the general public, and persons with a mental illness. The wide-ranging demands that different elements of society place on the police department are not lost on police officers. As one officer stated:

We are not social workers, but, then again, we are. You know, if you wear the uniform, I don't care who you are, they expect you to have the answer, or, at least, point you in the right direction. And there's just some days when you get hit with them, you either can't think or you just don't know what agency to refer these people to. And, more and more, the public has come to expect it.

Police officers have a limited number of dispositional options but a great deal of discretion concerning which options to invoke. Research on police discretion has examined the degree to which police "criminalize" the mentally ill, act as gatekeepers to the mental health system, and, in a broader sense, invoke police rather than clinical authority. The purposes of the research are threefold: to measure the distribution of the dispositional options...
which police select in dealing with persons with a mental illness who commit an act for which they could be cited or arrested; to measure why police make the decisions they do; and to measure police workload involved in invoking the various options for dealing with a person who has a mental illness.

The research combines quantitative and qualitative methods in several aspects. This is the first research which addresses the issue of police discretion in dealing with the mentally ill in which: 1) the police record their dispositions and the reasons for their actions, rather than a separate observer; 2) the dispositional options include both informal sanctions and situations in which the police officers choose to initiate no action, in addition to referral to either the criminal justice and mental health systems; and 3) police officers are asked to describe their experiences in dealing with persons with a mental illness, the dispositional options which were available, and the circumstances under which they are most likely to invoke these options.

The first chapter, Introduction, examines the background for the study, including a brief review of the literature documenting the deinstitutionalization, or transinstitutionalization, movement. Chapter 1 also reviews the issues related to police discretion, the theoretical framework for the research, and the research hypotheses.

Chapter 2, Law Related Issues Regarding Police Interaction With Persons Who Have a Mental Illness, examines the law related issues regarding police interaction with persons who have a mental illness. The chapter analyzes the sources of police powers and duties, policy-related factors, matters related to liability, and the authority to make emergency apprehensions of persons with a mental illness for the purpose of evaluation and hospitalization.

Chapter 3, Methodology, describes the setting in which the research takes place and includes a description of the quantitative and qualitative methods of the study.
Chapter 4, Quantitative Analysis, includes three parts. The first part reports the univariate statistics based on the completed incident coding forms. The second part includes the bivariate statistics, which are used to test the eight research hypotheses. The third part of the quantitative analysis chapter uses multivariate techniques to develop a model for explaining police behavior.

Chapter 5, Qualitative Analysis, utilizes information from interviews with police officers to explain what the police did and why they did it.

Chapter 6, Conclusions and Recommendations, first discusses the meaning of the quantitative and qualitative analyses. Following the conclusions are a series of recommendations for improving the situation which has placed police officers as frontline mental health workers.

Following the text are three appendices: Appendix A, a copy of the incident coding form used by police officers to collect the data used in the research; Appendix B, a list of interview questions used for the qualitative analysis; and Appendix C, a list of the variables used for the quantitative analysis. A list of References is included after the appendices.
CHAPTER 1
INTRODUCTION

A. Background of the Study

The institutional treatment of persons with a mental illness has a long and cyclical history (Goldman and Morrissey 1985; Durham 1989). With the waning influence of the church in 17th and 18th century Europe came the institutional segregation of the mentally ill. The secular response to idleness and immorality was viewed as more appropriate than the exorcism or death which "cured" demonological possession. By the early 19th century, medical treatment led to relatively more humane treatment of those considered mentally ill rather than deviant.

Squalid conditions in almshouses and jails prevailed in the treatment of the mentally ill in the United States until the late 19th century. The advancement of new medical models, the reform movement led by Dorothea Dix, and the economy of building large institutions resulted in the development of state-run custodial institutions (Scull 1984; Bassuk and Gerson 1978; Goldman and Morrissey 1985; Morrissey and Goldman 1986).

Following World War II, the emphasis on treating persons with a mental illness began to shift from warehousing to release in the community. The resulting deinstitutionalization movement has been well documented (e.g., Morrissey 1982; Warren 1982; Goldman et al. 1983; Teplin 1983; Scull 1984). The net result of deinstitutionalization was an increase in the number of mentally ill persons in the community.

Four events led to the significant reduction in state mental hospital resident populations and to a corresponding increase in the number of persons with a mental illness in
the community. First, developments in the use of new psychotropic medications allowed for better management of patients, many of whom could eventually be treated on an outpatient basis (Scull 1984; Brown 1985; Morrissey and Goldman 1986; Durham 1989). Second, a rapid increase in the number of patients in state mental hospitals during the first half of the 20th century placed a tremendous financial burden on states, necessitating population reduction efforts (Bassuk and Gerson 1978; Warren 1981; Scull 1984; Brown 1985; Morrissey and Goldman 1986; Durham 1989). Third, the system of community mental health centers (CMHCs), created by the Community Mental Health Centers Act of 1963, had a net widening effect. Rather than absorbing the deinstitutionalized population of former state mental hospital patients, the CMHCs extended services to previously untreated individuals and were unable to absorb the chronic population (Bassuk and Gerson 1978; Warren 1981; Scull 1984; Steadman et al. 1984; Goldman and Morrissey 1985; Brown 1985; Curtis 1986; Morrissey and Goldman 1986; Durham 1989; Jemelka et al. 1989). In addition to diminishing services to the chronic population due to net-widening, federal support for mental health treatment has declined since 1975 (Teplin 1991) and Medicaid coverage for outpatient treatment has been frozen since 1965 (Bassuk and Gerson 1978). Finally, there was an enormous increase in the volume and complexity of mental health law, from civil commitment to the insanity defense (see Wexler 1981), making it more difficult to involuntarily institutionalize the mentally ill (Abramsom 1972; Gudeman et al. 1979; Bonovitz and Bonovitz 1981; Curtis 1986; Durham 1989; Jemelka et al. 1989).

The increased number of persons with a mental illness in the community raised new concerns. On the one hand, former institutional residents whose disability prevented them from exercising decisions concerning where and how to live were viewed as the victims of unintended harm (Curtis 1986; Durham 1989). On the other hand, the sometimes bizarre and
disruptive symptoms of mental illness resulted in a public perception of the mentally ill as violent and dangerous (Shah 1975; Fracchia et al. 1976; Steadman and Cocozza 1978; Durham 1989; Toch and Adams 1989; Harris et al. 1993). From a sociological perspective, these public perceptions are a critical variable in the study of deviance, especially as they relate to the mentally ill: deviance is not a property inherent in certain forms of behavior but rather a property conferred upon those behaviors by an audience which determines whether the behavior is labeled deviant. In this respect, the manner in which a community sifts out and codes the details of behavior to which it is a witness is a more relevant subject for sociological research than the actual behavior which is witnessed (Erikson 1962; Becker 1963; Szasz 1974).

Society has typically responded to public concerns institutionally: deviance can be defined as conduct generally thought to require the attention of social control agencies. In 1939, Penrose documented what has come to be known as "Penrose's Law": an inverse relationship exists between prison and mental hospital populations (Steadman et al. 1984, note 2; Teplin 1983). Since Penrose, much has been written about the criminalization, transinstitutionalization, or transmigration of the mentally ill (e.g. Abramson 1972; Conrad 1975; Whitmer 1980; Bonovitz and Bonovitz 1981; Warren 1981; Teplin 1983, 1984a, 1991; Monahan and Steadman 1983, 1984; Steadman et al. 1984; Morrissey and Goldman 1986; Steadman and Morrissey 1987; Lowman et al. 1987; Arboleda-Florez and Holley 1988; Belcher 1988; Freeman and Roesch 1989; Jemelka et al. 1989; Fischer 1992). The criminalization hypothesis has been tested using a number of methods, with conflicting results, most of which have serious shortcomings (see Teplin 1983).

The most important issue concerning the criminalization of the mentally ill is not whether jail or prison sentences can be legally justified. In most cases, if not all, the legal
justification is present: the offender is both culpable and competent. In Hawaii, approximately 12 percent of the incarcerated population have a mental illness (Department of Public Safety 1995). Furthermore, the issue is not the deprivation of treatment, given the general availability of mental health services in prisons (Jemelka et al. 1989; Toch and Adams 1989). The most important issue concerns the setting in which the needs of society (including protecting the public and punishing those who break the law) and the needs of persons with a mental illness (including treatment and personal safety) can best be served (McGarry and Bendt 1969; Abramson 1972; Monahan 1973; Alexander 1993). While mental health services are generally available in prisons, such a setting may not be the best place in which to carry out the humane management of the mental illness. The incarcerated mentally ill are often preyed upon by other inmates and may not receive therapeutic or recreational activities (Thorburn 1991; Ventura and Jacoby 1991). The important policy questions, then, relate to 1) the process of labeling the individual as primarily disturbed and secondarily criminal or primarily criminal and secondarily disturbed, and 2) the dispositional options available to the police and the courts.

B. Police Discretion

The carceral continuum begins with the police (Foucault 1977). Whether acting in their capacity as protectors of public safety or providing care and protection to those who are unable to do so for themselves (parenthood), the police are placed in a role variously described as "psychiatric medics" or "forensic gatekeepers" (Menzies 1987), "streetcorner psychiatrists" (Teplin 1984b), and "amateur social workers" (Cumming et al. 1965). In this role as frontline mental health workers, police exercise a tremendous amount of discretion.
There has been a great deal of research on police discretion: a bibliography published in 1984 (Center) listed over 140 titles in the area of discretion in general, factors affecting discretionary judgment, criminal justice field procedures, control of discretion, and substantive problems. Substantive analyses of police discretion include juveniles (Piliavin and Briar 1964; Werthman and Piliavin 1967; Black and Reiss 1970; Dunford 1977; Lundman et al. 1978), drug users (Stoddart 1982), high speed pursuits (Homant et al. 1993), sexual assault (LaFree 1981), public drunkenness (Lundman 1974), traffic law violators (Lundman 1979), and interpersonal violence (Smith 1987; Worden 1989).

Analyses of the factors which affect police discretion in making arrests include race (Black and Reiss 1970; Black 1971; Lundman et al. 1978; LaFree 1981; Smith and Visher 1981; Fishman et al. 1987; Bridges et al. 1987), poverty and social marginality (Cicourel 1968; Thornberry 1979; Shrover and Einstadter 1988), the knowledge and skills of the police officer (Dunford 1977; Bayley and Garofalo 1989), the seriousness of the offense (Black 1971; Lundman et al. 1978; Smith and Visher 1981; Smith and Klein 1983; Smith 1987), the suspect's demeanor (Piliavin and Briar 1964; Black and Reiss 1970; Black 1971; Reiss 1971; Lundman 1974; Lundman 1979; Smith and Klein 1984), the rule, or behavior, of the law (Skolnick 1966; Bittner 1970; Daudistel and Sanders 1974; Black 1976; Gottfredson and Hindelang 1979; LaFree 1981), the desires of the complainant (Black and Reiss 1970; Black 1971; Lundman 1979; Smith and Visher 1981; Smith and Klein 1983; Smith and Klein 1984), police attitudes and values (Cumming et al. 1965), policy issues and organizational norms (Niederhoffer 1967; Lundman 1979; LaFree 1981; Worden 1989; Homant et al. 1993), presence of bystanders (Lundman 1974; Smith and Visher 1981; Smith 1987), the relationship
between suspect and officer (Sykes and Clark 1975; Sykes and Brent 1983), and neighborhood characteristics (Smith 1986).

Police do not spend very much of their time in criminal law enforcement; in fact, most of their time is spent in activities of which there is no formal record (see e.g. Black and Reiss 1970; Reiss 1971; Bittner 1974). Goldstein (1960) described police decisions not to invoke the law as determination of "the outer limits of law enforcement" (p. 545), that is, setting the limits of the extent to which laws are actually enforced. Goldstein argues that such low visibility activities as nonenforcement of the law should be evaluated as to their impact on the administration of criminal justice: while choosing not to invoke the law may further some of the objectives of the criminal process (e.g. not overwhelming jails and courts with minor offenses, not labeling youthful offenders for acts of indiscretion), such acts may also hinder others. Goldstein was particularly concerned that a police decision to ignore offenses

...usually precludes the prosecutor or grand jury from deciding whether to accuse, judge or jury from determining guilt or innocence, judge from imposing the most 'appropriate' sentence, probation or correctional authorities from instituting the most 'appropriate' restraint and rehabilitation programs, and finally parole or pardon authorities from determining the offender's readiness for release to the community (p. 562).

Goldstein did not advocate that police discretion be eliminated, but simply that any meaningful appraisal of police conduct should include an evaluation of all aspects of decision making.

LaFave (1962) raised similar concerns about police nonenforcement of the law, including the lack of review for low visibility actions and the lack of sufficiently defined standards provided by the legislature for when laws need not be enforced. Some discretion is necessary: police must interpret the legislative mandate of ambiguously worded statutes and there are not enough resources to enforce all the laws against all the offenders. Police learn how to exercise this discretion through experience, including the knowledge of which cases the prosecutors will not charge or which the judge will not convict or impose a meaningful
sentence. Like Goldstein (1960), LaFave advocates that the recognition of police discretion be expressly recognized so that its exercise can be "delimited, principles to govern its exercise ...be established, and effective means of control...be discovered" (p. 239).

The tacit recognition of police autonomy in enforcing the law formed the basis for Worden's (1989) multivariate analysis of the situational and attitudinal factors which affect police behavior. Worden analyzed police behavior in three situations: traffic enforcement, aggressive preventive patrol, and dispute resolution. Among the findings of Worden's research is the importance of situational factors versus attitudinal factors. For example, the factors which affect an officer's enforcement of traffic laws include the amount of discretionary time and the volume of traffic in their assigned areas; an officer's attitudes had a relatively small influence. Worden also found that situational factors have more impact on officers' decisions to make arrests as compared to decisions to act informally: models based on situational factors were better at predicting arrest than other dispositions. One implication of these findings is that officers are more likely to interpret the situational cues in similar ways in circumstances which lead to arrest than other dispositional options.

Research on the factors which influence police discretion when dealing with suspects who may have a mental illness has generally focused on the seriousness of the offense and/or whether the manifestation of mental illness (especially dangerousness) meets statutory requirements of involuntary commitment. Based on ten months of field work observing police, Bittner (1967) found that police tried to avoid taking individuals to the hospital or placing them under arrest through the practice of "psychiatric first aid," except in situations involving attempted suicide, serious psychological disorder accompanied by distortions of normal appearance, and highly agitated or violent forms of disorder. However, Bittner did
not attempt to quantify the interactions between police and persons with a mental illness, either in terms of the nature of the mental illness or options available to the police.

Police handling of the mentally ill is both a legal issue and a medical one: police are constrained by the extent to which the law specifies who may be apprehended, either for a crime or compulsory mental treatment; however, much of the information that influences the law is based upon a medical model supplied by doctors. Thus, Matthews (1970) observed that police actions are colored by conflicting attitudes: persons with a mental illness are sick and should receive medical treatment, but to the extent that they are dangerous they should be taken into custody. Matthews concludes that the problem confronting police is more procedural than substantive, since the officer is limited by red tape, paperwork, and adequate community mental health facilities.

Persons with a mental illness who came to the attention of the police in Birmingham, Great Britain, from 1962-1973, were referred to a mental welfare officer for assessment (Sims and Symonds 1975). Police referrals into psychiatric care were most often made when individuals demonstrated assaultive behavior, suicidal gestures, alcohol and drug offenses, clothing removal, and bizarre public behavior. The authors also noted a sharp increase in referrals of the homeless and attributed much of this increase to urban disorganization: mentally ill patients are socially isolated and concentrated in decaying parts of the city with poorer housing and a lack of social services.

Monahan, Caldeira, and Friedlander (1979) compared samples of people subjected to arrest and to civil commitment. They found that police chose arrest in cases where the suspect's mental illness was thought to be not sufficiently severe or dangerousness not sufficiently demonstrated for commitment to be supported by hospital staff. In cases where police chose not to arrest, the decision was based on either a perceived lack of criminal intent
due to mental illness or the need for treatment, not incarceration. A record of prior hospitalization also influenced police discretion not to arrest.

In a 1981 study, Bonovitz and Bonovitz also found that police avoided invoking the penal code. While the number of mental-illness-related incidents increased 228 percent from 1975 to 1979, which Bonovitz and Bonovitz attribute to more restrictive civil commitment laws, police invoked the penal code only as a last resort. Suspects who demonstrated self-destructive tendencies, assaulted others, had escaped from the state hospital, and/or for whom emergency commitment proceedings had been initiated were referred for psychiatric intervention.

Police have also been found (Sheridan and Teplin 1981) to refer individuals to psychiatric facilities when those individuals were seriously disturbed, exhibited assaultive, psychotic, suicidal, drug dependent or alcoholic behavior, and were publicly disruptive. Police referrals were most common during the 4:00 p.m. to 8:00 a.m. shift, suggesting that other local community services were not available to intervene on behalf of potential patients.

Teplin's (1984a, 1984b) study involving 1,382 police-citizen encounters found that arrest was a relatively rare event. Arrest rates of mentally disordered suspects were higher than for non-mentally disordered suspects, resulting in two possible explanations: police may use arrest as a means of disposing of the mentally ill via criminalization, or police may not recognize persons as mentally ill and arrest appears as an appropriate action. One factor which influenced the decision to arrest was the understanding by the police of the stringent admission criteria for the local psychiatric hospital. If the citizen did not fit the dangerousness criteria, and their deviance was too public or severe to be ignored, arrest was the only disposition available to the officer. Police also relied on their previous experiences with neighborhood characters to know how best to respond.
Using the same observational data, Teplin and Pruett (1992) found that a police officer's decision to arrest, hospitalize, or manage a mentally ill person informally was based less on psychiatric symptomatology than sociopsychological and structural factors. In general, informal dispositions were favored. Arrest was most likely to occur when the police had a signed complaint, when the citizen was thought to be too dangerous for the hospital, had pending criminal charges, was under the influence of alcohol or other drugs, or if the offense was serious.

Police in Toronto were found to routinely invoke labels of mental illness and dangerousness for suspects remanded for psychiatric assessment in a forensic unit (Menzies 1987). Police reports had numerous references to the suspect's psychiatric history, mental pathology, and clinical dangerousness. In this manner, police acted as "forensic gatekeepers" (p. 429) by using psychiatric assessment as a vehicle for ensuring the dual application of judicial and therapeutic interventions.

Steadman et al. (1984) examined the tendency for the relationship between the mental health and criminal justice systems to become blurred in situations where the police interact with potentially mentally ill individuals in the community. Based on admission data collected at hospital psychiatric departments, police referrals were frequently less disturbed than referrals from other sources. Police referrals were more likely to have displayed violent behavior than other referrals. The authors suggest that inappropriate police referrals were the result of the officers' desire to avoid arresting a person for publicly offensive behavior because of the minor nature of the offense and/or the conviction that the person does not belong in jail. They conclude that police are not trained to make clinical judgements and should be prepared to be overruled by clinicians.
In other research, police referrals to a psychiatric emergency department were much more likely to be hospitalized than patients referred by other sources (Sales 1991). Patients referred by police were more likely to be assessed as homicidal or a danger to self or others as a result of mental illness, and therefore meet the involuntary psychiatric hospitalization criteria. Sales concluded that, while the police are the source of a significant number of referrals to psychiatric emergency departments, they may apply overly narrow dangerousness criteria to screen mentally ill persons in the community and could appropriately refer more individuals.

In addition to the seriousness of the offense or the perceived dangerousness of the suspect, the priority of exercising discretion with the mentally ill is influenced by other demands on the police, including citizen influence. Teplin (1984b) found that police routinely obtained a signed complaint in situations where the suspect was thought to require psychiatric hospitalization. In such situations, the police were insuring arrest as an alternative disposition if the suspect did not meet the criteria for admission to the psychiatric hospital.

Organizational constraints also influence police officer discretion in dealing with persons with a mental illness. Cumming et al. (1965) found that police officers are limited in their ability to adequately resolve cases involving mentally ill suspects by a lack of professional training and a lack of knowledge of, and liaison with, social or medical agencies. The authors also found that police were necessarily restricted by the time of day when they receive calls to assist the mentally ill (usually after support agencies were closed), and the sheer volume of higher priority calls.

Teplin (1984b) also found organizational impediments for officers with both the police department and the hospital emergency room. Arresting persons with a mental illness was not considered an important exercise of police power and was not rewarded by the department.
Similarly, psychiatric referrals were discouraged by the scarcity of community placements and the strict criteria for admission.

Another important issue in police discretion involving persons with a mental illness centers on race and ethnicity. Research involving racial differences in involuntary hospitalization (Rosenfield 1984) has shown that powerless and culturally marginal individuals experience more severe reactions to their mental illness. Rosenfield found that for males, nonwhites were more likely to be involuntarily hospitalized than whites, controlling for the type and severity of the disorder. Nonwhite males were more often referred by the police than white males.

Recent research of coercive referral to mental health services (Takeuchi et al. 1993) has also found that nonwhite males are more likely to be involuntarily committed to mental hospitalization than non-minorities or females. The authors suggest that poverty status may largely explain racial and ethnic differences between coercive referrals to mental health clinics among African-American, Mexican-American, and white adolescents.

In this research, police are asked to determine whether a suspect 1) has a mental illness, and 2) what is the most appropriate action to take. The process of developing explanations of police behavior are guided by the theoretical framework described below.

C. Theoretical Framework

Previous research concerning the impact of a suspect's race, ethnicity, and socio-economic status on police discretion informs the selection of two complementary theoretical frameworks for this research. A labeling perspective is useful for explaining three aspects of deviance, two of which are appropriate for this research. First, labeling theory has been used
to describe deviant career formation (e.g., see Mahoney 1974 and Matza 1974). Perhaps the most well-known application of this aspect of labeling theory was articulated by Lemert (1951) in his formulation of the primary and secondary deviance model. Primary deviance involves original acts of socially unacceptable behavior which go undetected: the acts are not recognized by others as deviant, nor does the person who commits those acts consider himself or herself as deviant. At the point where the acts become repetitive, highly visible, and subject to social reaction, the actor may come to accept and incorporate the deviant identity. Secondary deviance occurs when the self-identified deviant commits acts as the result of this new, stigmatizing status.

The utility of labeling theory for explaining police involvement with the mentally ill is not found in the description of deviant career formation, however. This research is not concerned with how the deviant, in this case, a person who has a mental illness who exhibits publicly disruptive behavior, came to be deviant. The two aspects of labeling theory of greatest interest to this research concern the "... process by which the members of a group, community, or society (1) interpret behavior as deviant [and] define persons who so behave as a certain kind of deviant, and ([2]) accord them the treatment considered appropriate to such deviants" (Kitsuse 1962, p. 13).

The process by which police officers come to label certain individuals as certain kinds of deviants is not the direct object of this research, but the process does have important implications for explaining police behavior. The rules which govern the labeling process are developed by "moral entrepreneurs" (Becker 1963, p. 147), people who are concerned about social morality and who control the definitions of deviance. Becker (1963) identified two types of moral entrepreneurs: rule creators and rule enforcers. Becker argues that while the police do have strong opinions about moral and immoral conduct, they are much more likely
to take rules created by others and enforce those rules. As described in Chapter 5, Qualitative Analysis, police encounter individuals who have several possible "labels": homeless, alcohol and/or drug abuser, mentally ill, and, perhaps, criminal. Which label an officer chooses may determine whether the individual is treated as primarily disturbed and secondarily criminal or primarily criminal and secondarily disturbed.

The most important of aspect of labeling theory, as it relates to this research, is how the individual who has been labeled is dealt with by the police.

The most important consequence [of being labeled deviant] is a drastic change in the individual's public identity. Committing the improper act and being publicly caught at it place him in a new status. He has been revealed as a different kind of person from the kind he was supposed to be. He is labeled a 'fairy,' 'dope fiend,' 'nut' or 'lunatic,' and treated accordingly (Becker 1963, p. 32).

Certain labels, then, are more likely to result in a particular sanction than others. According to a labeling perspective, people will be treated consistently with previously applied labels (e.g. Kitsuse 1962; Mercer 1965; Rosenfield 1984): individuals who have a history (label) of mental illness or hospitalization will be treated as "mentally ill," while those with a criminal (label) history will be treated as "criminals." Moreover, different persons with the same label are likely to be treated in a similar manner: "... with the diagnostic designations assigned by official defining agents, [one] tends to assume that all individuals placed in a given category are essentially equivalent in respect to their deviance" (Mercer 1965, p. 69).

Rosenfield (1984) examined race differences in mental hospitalization and found support for a labeling perspective: nonwhite males were found to be involuntarily hospitalized more often than white males. After controlling for psychiatric condition, Rosenfield concluded that "... with regard to race and involuntary hospitalization, powerless
and culturally marginal individuals experience more severe reactions to mental illness" (Rosenfield 1984, p. 21).

Similar findings by Takeuchi et al. (1993) in the referral of minority adolescents to community mental health centers support a labeling perspective. Takeuchi et al. (1993) found that African-American adolescents were more likely than whites to be referred to mental health centers by an external agency. The variable most consistently and powerfully associated with coercive referrals was poverty status.

While labeling theory can be used to explain dispositions for those who are identified by the police as "mentally ill" or "criminal," the police frequently encounter individuals whose mental health and criminal histories are not known. Attribution theory explains how an individual's social characteristics affect the way other people interpret their deviance; in essence, attribution theory explains one way in which labels are assigned. According to attribution theory, people have established social categories which they use in characterizing new people and new situations. The process of attribution helps to simplify new encounters by facilitating the process by which those encounters have meaning.

Race/ethnicity has been found to be a powerful variable in determining the attribution of offenses (Fishman et al. 1987). Israeli students were shown photographs of male faces and were instructed to attribute any one of five offenses to the faces. Israeli Arabs were more likely than the other groups represented in the photographs to be identified as criminals. "The assignment of crimes to faces is directly related to the ethnic divisions in the country and reflects perfectly the social images that are associated with these divisions in the minds of the identifiers" (Fishman et al. 1987, p. 520).

Ventura and Jacoby (1991) tested attribution theory on police distribution of violent, mentally ill, misdemeanor offenders. In this context, "attribution theory suggests that
mentally ill offenders whose characteristics conform to criminal stereotypes would be arrested. Conversely, mentally ill offenders who do not 'look like criminals' would be referred for mental health treatment" (Ventura and Jacoby 1991, p. i). The research found that white, better educated, violent, mentally ill misdemeanants who had a moderate income and no prior criminal record were usually hospitalized, while nonwhite, less well educated, violent, mentally ill misdemeanants who were poor and had lengthy prior criminal records were usually jailed.

According to attribution theory, a person whose social characteristics are stereotypically associated with criminality (e.g. less education, poverty, minority status) is likely to be arrested and jailed for publicly offensive behavior, (that is, labeled primarily criminal and secondarily mentally ill) while an individual whose characteristics are stereotypically associated with mental illness (disheveled appearance, bizarre behavior) is likely to be hospitalized (that is, labeled primarily mentally ill and secondarily criminal). Attribution theory also suggests that, for the same publicly offensive behavior, someone who does not look "like a criminal" (e.g. better educated, moderate income, white) is more likely to be hospitalized than arrested.

The application of labeling and attribution theories is reflected in the research hypotheses, below. Police are required on a daily basis to make decisions concerning the referral of individuals to either the criminal justice or mental health systems; the research hypotheses guide the process of examining which factors influence the decision making process.
D. Research Hypotheses

The major research question to be addressed by this study is what factors influence police discretion when referring an adult who has a serious mental illness into either the criminal justice or mental health systems. Eight hypotheses will be tested in order to answer this question. Hypotheses 1 and 2 reflect a labeling perspective and Hypotheses 3 through 6, an attribution perspective. Hypotheses 7 and 8, while not grounded in either theoretical perspective, examine factors of interest: number 7 is frequently cited in the literature on police discretion and number 8 has important implications for training and understanding the nature of police work in general. All hypotheses except number 8 are grounded in prior research on police discretion, discussed earlier in this chapter.

Hypothesis 1: Adults with a serious mental illness and a known criminal history will be more likely to be arrested than apparently mentally ill persons without such a history.

Hypothesis 2: Adults with a serious mental illness and a known history of mental illness will be less likely to be arrested than apparently mentally ill persons without such a history.

Hypothesis 3: Adults with a serious mental illness who are aggressive, violent, or uncooperative are more likely to be arrested than receive the other dispositions available to the police.

Hypothesis 4: For adults with a serious mental illness, males will be more likely to be arrested than females.

Hypothesis 5: Adults with a serious mental illness who are employed full- or part-time are less likely to be arrested than apparently mentally ill persons who are unemployed.

Hypothesis 6: Adults with a serious mental illness who live in a private residence (house, apartment, condominium, or hotel) are more likely to receive an informal disposition than apparently mentally ill persons who live in a shelter or who are homeless.
Hypothesis 7: For adults with a serious mental illness, the strength of the relationship between the offense and arrest will increase with the severity of the offense.

Hypothesis 8: For adults with a serious mental illness, there will be an inverse relationship between the severity of the disposition and the number of years of experience for police officers.

The next chapter examines the law related issues regarding police interaction with persons who have a mental illness. The chapter will analyze the sources of police powers and duties, policy-related factors, matters related to liability, and the authority to make emergency apprehensions of persons with a mental illness for the purpose of evaluation and hospitalization.
CHAPTER 2

LAW RELATED ISSUES REGARDING POLICE INTERACTION WITH PERSONS WHO HAVE A MENTAL ILLNESS

The legal issues which influence police interactions with persons they suspect to have a mental illness are not clearly defined in one specific source. In order to understand the factors which affect police decision making, it is necessary to examine the sources of police powers and duties, policy-related factors, matters related to liability, and the circumstances under which police can make emergency apprehensions of persons with a mental illness.

A. Powers and Duties of the Police

During the past 40 years, the powers and duties of the police as defined by statute have changed little, becoming, if anything, more nebulous. In 1955, the Hawaii Revised Laws (HRL) provided that the chief of police "shall at all times diligently and faithfully discharge his duties and enforce all laws of the Territory and all ordinances of the city and county for the preservation of peace and good order, and the protection of the rights and property of all persons" (HRL § 150-9). Among the specific duties of the chief of police were the requirements that the:

. . . chief of police shall: (a) Preserve the public peace and prevent and suppress affrays, riots and insurrections; (b) Arrest and take before the nearest qualified magistrate for examination all persons who have committed or attempted to commit a public offense, and through any officer designated by him prosecute the same under the direction of the public prosecutor. . .

HRL § 150-10 (emphasis added).

The authority of the chief of police to perform these acts and duties was further vested in "any police officer under him" (HRL § 150-7).
The wording of this statute suggests that the Territorial Legislature did not want to provide police officers with discretion in matters related to arrest decisions. Specifically, HRL § 150-10 declares that the chief of police or his/her subordinates "shall" arrest all persons who violate, or attempt to violate, the law, not "may" arrest some persons.

In 1970, HRL Chapter 150 was renumbered to Chapter 52 of the Hawaii Revised Statutes (HRS). Minor changes were made to HRS Chapter 52 in 1970 and 1973, but none which address the powers to arrest or the issue of police discretion. In 1989, Act 136, Session Laws of Hawaii, which was introduced as Senate Bill Number (S.B. No.) 20, repealed HRS Chapter 52. The new chapter described the powers and duties of the chief of police in the following manner: "The chief of police shall have the powers and duties as prescribed by law, the respective county charter, and as provided by this chapter" (1989 Session Laws of Hawaii Act 136). The new chapter no longer describes the specific duties of the chief of police, including reference to arrest.

Act 136 was supported by the Senate Committee on Government Operations and the House Committee on Intergovernmental Relations and International Affairs. Both committees issued near identical Standing Committee Reports, citing the need to streamline and make uniform the law relating to all county police departments, and to eliminate "obsolete, conflicting and otherwise unnecessary provisions from the present law" (Standing Committee Report 443, Senate Journal p. 984, 1989 Legislative Session; Standing Committee Report 1023 House Journal p. 1211, 1989 Legislative Session).

The authority to arrest persons who violate the law is described in HRS Chapter 803. The sections of this chapter which are most relevant to the question of police discretion concern police power to make arrests without a warrant and how arrests are made. Hawaii Revised Statutes § 803-5 states:
[a] police officer or other officer of justice, may, without warrant, arrest and detain for examination any person when the officer has probable cause to believe that such person has committed any offense, whether in the officer's presence or otherwise.

The only substantive changes to this section since 1955 occurred in 1980: Act 105, Session Laws of Hawaii, changed the standard for making a warrantless arrest from "reasonable suspicion" to "probable cause."

While there is no legislative history to clarify exactly what the legislature intended by allowing that police officers "may, without a warrant" (emphasis added) arrest someone who has violated the law, it appears that the distinction made by HRS § 803-5 is that it gives police officers the power to arrest a suspect without first obtaining a warrant. That is, the decision facing an officer where there is probable cause that an individual has committed an offense is whether to a) obtain a warrant to make the arrest, or b) make a warrantless arrest; not making an arrest does not appear to be included as an option.

Hawaii Revised Statutes § 803-6 describes how arrests are made:

(a) At or before the time of making an arrest, the person shall declare that the person is an officer of justice, if such is the case. If the person has a warrant the person should show it; or if the person makes the arrest without warrant in any of the cases in which it is authorized by law, the person should give the party arrested clearly to understand for what cause the person undertakes to make the arrest, and shall require the party arrested to submit and be taken to the police station or judge. This done, the arrest is complete.

(b) In any case in which it is lawful for a police officer to arrest a person without a warrant for a misdemeanor, petty misdemeanor or violation, the police officer may, but need not, issue a citation in lieu of the requirements of (a), if the police officer finds and is reasonably satisfied that the person:

1. Will appear in court at the time designated;
2. Has no outstanding arrest warrants which would justify the person’s detention or give indication that the person might fail to appear in court; and
3. That the offense is of such nature that
there will be no further police contact on or about the date in question, or in the immediate future [emphasis added].

The only substantive change in HRS § 803-6(b) occurred as the result of 1988 Session Laws of Hawaii Act 179, when residency in the State of Hawaii was dropped as one of the factors which must be present before an officer can issue a citation in lieu of an arrest.

As a result of this statute, police officers do have discretion when they encounter a person who has committed a misdemeanor, petty misdemeanor, or violation: the officers can choose to issue a citation or make an arrest. Hawaii Revised Statutes § 803-6(b) does not give the police the authority to warn, counsel and release, or ignore an offender.

As stated in HRS Chapter 52 (see above), the powers and duties of the police are also defined in the respective county charters. The charter of the City and County of Honolulu sheds little light on the powers and duties of the police. Revised Charter of the City and County of Honolulu § 6-604 declares that

[t]he chief of police shall: (a) Be responsible for the preservation of the public peace; the protection of the rights of persons and property; the prevention of crime; the detection and arrest of offenders against the law and the enforcement, and prevention of violations of all laws of the state and city ordinances and all rules and regulations made in accordance therewith. . . . (d) Promulgate rules and regulations necessary for the organization and internal administration of the department. . . .

The ordinances of the City and County of Honolulu are silent on the powers and duties of the police department.

Police commissions for each county are provided by HRS § 52-1, which simply states: "A police commission is created for each of the counties. The composition, appointment, terms of office, staff, powers, duties, and functions of each police commission shall be prescribed by the charter of each county." The charter of the City and County of Honolulu invests four powers and duties in the police commission: to adopt rules necessary
for the commission to conduct its business and review rules and regulations for the administration of the police department; to review the department's annual budget and make recommendations to the mayor; to submit an annual report to the mayor and city council; and receive and investigate charges brought by the public against the department and its officers. The charter does not give the commission the power to set policy for the department, and specifically prohibits the commission from "interfer[ing] in any way with the administrative affairs of the department." Police discretion is clearly not a matter addressed by statute, county charter, or ordinance.

B. Policy-Related Factors That Influence Police Discretion With Regard To Arrest

There are three general areas which affect police decision making: public policy, police departmental policy, and informal policy. Public policy are those positions taken by the police department, police commission, and city/county government that describe the ways in which a particular issue will be addressed. Periodically, local government and its departments make statements that they will "crack down on drug dealers and prostitutes in Waikiki," or "work towards strengthening the laws regarding domestic violence." These are positions taken publicly to inform the community how the law will be applied and how it will impact people's lives.

The Police Department of the City and County of Honolulu has no formally stated public policy concerning how officers will interact with persons who have a mental illness and who violate the law. In conversation, district commanders of the department discuss striking a balance between protecting the public by arresting individuals who threaten citizens' safety, and wanting to help address the medical and psychological needs of the offenders. There are
several actions taken by the Honolulu Police Department, however, which more clearly indicate the department's public policy stance.

Arguably, the strongest position taken by the department involves the initiation of Project Outreach. The chief of police strongly supports the program, which acts as an intermediary between the department and the mental health system. Since its inception in 1992, Project Outreach has been successful in establishing relationships with the network of medical and social service providers, in making referrals to the providers, and assisting police officers divert the homeless and persons with a mental illness away from the criminal justice system. Without the advocacy of the chief of police, the program would not exist.

Police department efforts to decriminalize persons with a mental illness are also reflected in their participation in the Task Force on Individuals with Mental Illness and the Criminal Justice System (originally Task Force on the Mentally Ill in the Criminal Justice System). The Task Force is sponsored by the Mental Health Association of Hawaii and includes representatives from the office of prosecutor, public defender, the Judiciary, corrections, public and private service providers, the University of Hawaii, the Department of the Attorney General, and the Honolulu Police Department. The police department's commitment is reflected in the appointment of an assistant chief to the Task Force, as well as the director of Project Outreach.

Further evidence of the department's public policy stance for finding workable solutions to problems associated with police involvement with persons who have a mental illness is found in the support of the chief of police for this research. In a conversation with the chief prior to submitting a formal proposal to him, he stated that he would support any effort to help his officers and those members of the public who have a mental illness. Upon
formal approval, the chief communicated his strong support to the eight district commanders, who, in turn, gave unwavering support to this study.

An indication of the department's public policy towards persons with a mental illness is also found at the nexus of public and informal policy (discussed below): the department’s support for officers who employ informal, extra-legal solutions. In order for informal policies to exist and to be tolerated, they must be consistent with the department’s public policy. During interviews with officers (see Chapter 5, Qualitative Analysis), it was clear that the department supports, if not encourages, informal sanctions in certain situations. Non-arrest sanctions are consistent with a public policy position of decriminalizing situations involving persons with a mental illness.

Formal police policy instructs officers how to respond to the statute which gives them the authority to take persons with a mental illness into custody and transport them to a psychiatric facility for evaluation (see Section D, below). The policies outline under what conditions officers can take someone into custody and which application form is appropriate for a given case.

Police policy does not address the issue of police discretion. It is clear that police engage in selective enforcement of laws under some circumstances involving apparently mentally ill persons, however the lack of formal rules to guide that practice is somewhat surprising. Williams (1983) blames the "myth of full enforcement": police have infused themselves and the public with the idea that criminal laws are enforced impartially and that no choices are made in determining if or against whom laws will be enforced. The general tendency has been to consider the police in their law enforcement capacity as an organization performing ministerial, not discretionary, functions. To acknowledge selective enforcement policies would require the department to follow and defend those policies.
Much of what officers do in the course of their jobs is influenced by informal policy. Informal policies are communicated in a variety of ways, supplementing official training and formal policy. The importance of informal policies was suggested in the quantitative data collected for this study (see Chapter 4, Quantitative Analysis) and confirmed during the interviews which constitute the Qualitative Analysis in Chapter 5.

Police learn how to deal with persons who have a mental illness while on the job. Many officers learn that the official, statutorily prescribed actions are not always effective. Experienced officers communicate the appropriateness of informal sanctions to newer officers. These lessons take on the significance of policy.

There are significant differences between the eight police districts in how individuals with a mental illness are handled. These differences are not the product of formal policy, but come about in several ways. First, each district commander and his watch commanders communicate to the patrol officers certain problems that need to be addressed on particular beats. The problems may involve kids hanging out in a school yard late at night, people picking breadfruit from the tree outside the station, drug dealers in a parking lot, or the homeless sleeping in the baggage claim area at the airport. The police commanders actively identify community problems; they also hear about problems from residents, merchants, city council members, and state legislators. The emphasis placed on specific crime problems (usually based on seriousness) helps officers establish priorities in a very practical sense: not all laws can be enforced, not all crimes can result in an arrest, not all criminals can go to jail.

Individual patrol officers also have an understanding of the problems that exist on their beats. Residents and merchants communicate directly with the beat officer about how the officer should do his or her job.
Officers are also sensitive to messages from their peers. The appropriateness of an arrest is directly communicated to a police officer by the booking desk officer. During interviews, officers who had arrested seriously mentally ill offenders explained that they were usually rebuked for their decision. A booking officer does not have the authority to decide which arrestees to process; however, his or her preferences are made very clear, and respected.

Officers are also understandably sensitive to the demands imposed on their beat partners. Officers commented during the course of interviews that their decisions concerning how to respond to a mentally ill person who was violating the law were strongly influenced by how their beat partner would react. For example, if an officer wanted to take a suspect to the hospital for an emergency evaluation but knew it could take most of a shift (see p. 122, interview with officer from District 2), he or she would consider the effect on their partner. If a beat only has two people assigned to it, and one is sitting in a hospital emergency room with a mentally ill homeless person while his or her beat partner is responding to domestic violence cases or robberies or worse, the first officer's use of discretion is certain to be a topic of discussion. Knowing that one day he or she will rely on his or her partner in an emergency, an officer is likely to respond to an informal policy that is driven by concerns other than the formally stated department line.

C. Liability

Police officers, like most people, have concerns about liability and the threat of lawsuits against themselves and against their employers. This section examines the potential liability in tort, and the potential liability under Title 42 United States Code Section 1983 (the
1964 Civil Rights Act). A mitigating factor in these two areas of potential liability is qualified immunity, which will also be discussed.

There are many different types of torts, including torts to person or property, defamation, invasion of property, products liability, etc. The type of tort most likely to influence police discretion lies in the area of negligence. There are four elements which must be met in order to establish a prima facie case for negligence: the existence of a duty on the part of the defendant to conform to a specific standard of conduct to protect the plaintiff against unreasonable risk of injury; a breach of that duty; that the breach of the duty caused the plaintiff's injury; and damage to the plaintiff's person or property. The most important element of negligence in terms of potential liability for police officers is whether there exists a duty to protect specific individuals: either to protect persons who have a mental illness, perhaps from hurting themselves; or to protect other citizens from harm inflicted by a person who has a mental illness.

Generally speaking, there are two types of duty in negligence: general and special. A general duty is one that an official owes the public, and a breach of that duty causes injury to the public rather than to a particular individual. A special duty is one that an official owes to the particular individual who is injured. Some jurisdictions have adopted a general duty standard for its law enforcement officials, while other jurisdictions have adopted a special duty standard.

Under a general duty of care, a plaintiff must show that an officer owed him or her a duty the same as any other member of the public. For example, in Evett v. Inverness, 224 So. 2d 365 (Fla.App. 1969), suit was brought against a police officer for failing to apprehend an allegedly intoxicated motorist. The suit claimed that an officer had stopped an intoxicated driver for speeding but subsequently allowed him to continue driving on a public roadway.
The driver collided with an automobile driven by the plaintiff’s husband, who was fatally injured. The court found that the officer was not personally liable for damages because, even if the officer was negligent in permitting the intoxicated driver to proceed, such negligence was not actionable in tort since the officer owed a duty to plaintiff’s husband in no way different from that owed to any other member of the public.

In order to show a special duty, there must exist a special relationship between the city and the individual. In Williams v. State of California, 34 Cal.3d 18, 192 Cal.Rptr. 233, 664 P.2d 137 (1983), the court held that when the state, through its agents, voluntarily assumes a protective duty towards a certain member of the public and undertakes action on behalf of that member, thereby inducing reliance, the state is held to the same standard of care as a private person or organization. The court also found that the breach of duty may be an affirmative act which places the person in peril or increases the risk of harm to that person, or that the negligence may also constitute an omission or failure to act. It is important to note, however, that the court added that the existence of a special relationship did not impose liability on the government where the tortious act was discretionary, as opposed to ministerial, and therefore protected by qualified immunity (see discussion on immunity, below).

Hawaii has adopted a special duty standard for liability in Freitas v. City and County of Honolulu, 574 P.2d 529 (1978) and in Namauu v. City and County of Honolulu, 614 P.2d 943 (1980). In the former case, three brothers brought suit against the City and County of Honolulu and two police officers for injuries they suffered when they were shot by a fourth brother. Plaintiffs claimed that when the police were informed that the brother was heavily armed, had threatened them and several other individuals, had terrorized the neighborhood, and had a history of mental instability and violence, the police made no arrest and made only
a minimal investigation. The plaintiffs further contended that the police officers had a duty to protect the three brothers arising out of the likelihood of danger to them under circumstances known by the officers.

The court found that the plaintiffs failed to show the existence of circumstances which created a duty owed by the police officers, or the city, or both, to take some affirmative action for the protection of the plaintiffs. The court was unable to find what actions the officers could have taken which would have averted the harm to the plaintiffs, other than those of their generalized duty to apprehend offenders and to maintain order.

The ruling in *Namauu v. City and County of Honolulu* was similar to that in *Freitas*. Plaintiffs, relatives of the victim of a sexual assault and homicide by an escapee from the Hawaii State Hospital, claimed the police had a duty under HRS § 334-53 (1968) to apprehend the escapee. The breach of that duty gave rise to the injury and death of their relative and, as a result, an actionable claim.

The court held that the statutory provision which states that police shall assist in returning escapees to the hospital was intended to benefit administrators of psychiatric facilities and, as such, did not constitute a duty to protect a class of people from escaped patients. The court found that the failure of the police to provide protection is ordinarily not actionable, and plaintiffs failed to show the existence of circumstances which created a special duty owed by police officers to the victim.

The theory of governmental immunity as a defense to liability concerns the necessity of not hampering the functions of government or impeding established public policy. Absolute immunity is usually reserved, however, for the legislature, judiciary, and high-level executive officials. The Hawaii Legislature has waived immunity of liability for government employees in the State Tort Claims Act:
The State hereby waives its immunity for liability for the torts of its employees and shall be liable in the same manner and to the same extent as a private individual under like circumstances, but shall not be liable for interest prior to judgment or for punitive damages.

HRS § 662-2

The statute of limitations on a tort claim against the State is two years (HRS § 662-4).

The legislature enacted a more restrictive statute of limitations for liability damages than the City and County of Honolulu, whose ordinance, in pertinent part, states:

... [the person injured must] within six months after the injuries are received, give the chairman of the board of supervisors or the city clerk of Honolulu notice in writing of the injuries and the specific damages resulting, stating fully in the notice when, where, and how the injuries occurred, the extent thereof, and the amount claimed thereof.

Charter of the City and County of Honolulu § 46-72.

However, the Hawaii Supreme Court has ruled that the State Tort Claims Act is applicable to the counties. Pursuant to Salavea v. City and County of Honolulu, 517 P.2d 51 (1973) and Orso v. City and County of Honolulu, 534 P.2d 489 (1975), the six-month period of limitations for bringing a tort action against the city and county is superseded by the statute creating a two-year period of limitations. The statute providing for tort liability of the state and its political subdivisions was found to be the law of general applicability throughout the state on matters of statewide interest and concern.

The United States Supreme Court, in Harlow v. Fitzgerald, 457 U.S. 800, 102 S.Ct. 2727, 73 L.Ed.2d 396 (1982), established the test for qualified immunity. The Court held that

... government officials performing discretionary functions generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.

Id. at 2738.
The Court further defined qualified immunity in *Anderson v. Creighton*, 483 U.S. 635, 97 L.Ed.2d 523 (1987). Here, the Court held that

[w]hether an official protected by qualified immunity may be held personally liable for an allegedly unlawful official action generally turns on the 
'objectivelegal reasonableness' of the action, assessed in light of the legal 
rules that were 'clearly established' at the time the action was taken.

*Id.* at 3036.

Recently, the United States Court of Appeals, Ninth Circuit, divided the qualified immunity analysis into three areas. In *Erickson v. U.S.*, 976 F.2d 1299 (1992), the Court held that, in order to penetrate a qualified immunity defense, plaintiffs must show:

(1) the identification of the specific right allegedly violated; (2) the determination of whether that right was so 'clearly established' as to alert a reasonable officer to its constitutional parameters; and (3) the ultimate determination of whether a reasonable officer could have believed lawful the particular conduct at issue.

*Id.* at 1301.

The following two scenarios illustrate under what circumstances police officers face potential civil liability in tort. In the first scenario, a shop owner claims he or she is being threatened by a mentally ill person. After repeated calls to 911 and an investigation by the police, no arrest is made. Subsequently, the shop owner is attacked and injured by the same mentally ill person. In the second scenario, an officer suspects an individual is suicidal, but does not feel there is sufficient evidence to justify taking the person into custody and transporting him or her to a psychiatric facility. Subsequently, the person commits suicide. Would the failure to act in these situations expose the officers to liability? First, a court must determine whether the officer is protected by qualified immunity. Based on the court decisions cited earlier, police officers are protected by qualified immunity from civil liability under circumstances where they are performing discretionary functions and their conduct does
not violate clearly established statutory or constitutional rights of which a reasonable person would have known.

Officers are also exposed to potential liability under 42 USC § 1983, the 1964 Civil Rights Act. There is an enormous volume of law under this Act, virtually all of which relates to situations in which police exceed their authority, thus violating a person's civil rights.

In Gross v. Pomerleau, 465 F.Supp. 1167 (1979), suit was brought against the defendants pursuant to federal statute governing civil action for deprivation of rights. The suit claimed that an officer had stopped the plaintiff for improperly passing another motor vehicle, and, believing that the plaintiff was in need of mental evaluation and treatment, the officer placed the plaintiff under arrest and transported her to the police station. After several hours, the officer transported the plaintiff to the hospital for psychiatric screening and evaluation. The plaintiff claimed that the officer lacked the requisite probable cause to make the initial arrest and to order her committed to the psychiatric unit.

The Court held that the

... city police department's memorandum on its involuntary commitment procedures for admitting arrested individuals suspected of mental illness to psychiatric screening and evaluation unit at city hospital failed to incorporate provisions similar to statute governing Maryland's emergency admissions procedure, which attempted to give basic outline as to what was meant by 'mental disorder,' and which indicated that initial commitment may be permitted without any judicial hearing so long as subject demonstrates 'clear and imminent danger of causing grave and immediate personal injury to himself or others,' memorandum was unconstitutional procedure.

Id. at 1168.

The Court held that the memorandum failed to specify the criteria for assessing the symptoms of mental illness, thus applying a medical concept as a legal standard. Therefore, the absence of standards restricting police discretion in complying with the memorandum renders it overly vague.
The Court did not rule as a matter of law whether the officer qualified for a good faith immunity defense. The Court did state, however, that "in the event that he was acting in reasonable good faith reliance on . . . standard operating procedure, then he should be entitled to immunity, despite the unconstitutionality of the procedure which he was following" (Id. at 1175-1176).

The process by which persons in Hawaii who have a mental illness are involuntarily referred for psychiatric examination and treatment is controlled by statute. The next section describes the evolution of that statutory authority.

D. Emergency Apprehension, Emergency Hospitalization, and Involuntary Hospitalization

It is clear from the analysis in Section A, above, that police have the statutory authority to arrest persons who violate the law. Police also have the authority to refer persons with a mental illness to the mental health system. The only means by which the police can refer someone with a mental illness to the mental health system is via an emergency apprehension leading to a hospital emergency room. Therefore, one of the most important factors in understanding police discretion in referring persons with a mental illness to either the criminal justice or mental health systems concerns the statutory provisions for emergency apprehension, emergency hospitalization, and involuntary hospitalization.

These provisions 1) give police the authority to take into custody a person who has a mental illness who violates the law and transport that person to a hospital for an emergency psychiatric evaluation, 2) establish the criteria under which the hospital has the authority to hospitalize the person, and 3) establish the criteria under which the court can commit the person to a psychiatric facility. While the only statutory provision governing police conduct
involves emergency apprehension, police are affected by the criteria for emergency and involuntary hospitalization: if an officer takes a person to the hospital emergency room for an evaluation, and the person is released because he or she does not meet either the emergency or involuntary hospitalization criteria, the officer feels his or her time has been wasted. To avoid wasting time, an officer must make an emergency apprehension with the emergency or involuntary hospitalization criteria in mind. This section examines the evolution of the statutory provisions which influence a police officer’s decision to refer a mentally ill offender to the mental health system.

Session Laws of Hawaii 1967 Act 259, which repealed HRL Chapter 81, 1955 provided for two ways in which a person could be admitted to a psychiatric facility. The first required certificates of two licensed physicians stating that the person was "mentally ill or habituated to the excessive use of drugs or alcohol, to an extent requiring hospitalization" and an application made by one of the physicians, a spouse or guardian, any relative or friend, or "any responsible person" (HRS § 81-42(a)). This process allowed for the immediate apprehension of the patient, "without a warrant or further proceedings, by a police officer or by any employee of a psychiatric facility or ambulance service or by either of the certificating physicians" (HRS § 81-42(b)).

The second means for emergency admission in Chapter 81 allows for:

[a]ny police officer [to] take into custody and transport to a public psychiatric facility, any person apparently mentally ill and conducting himself in a manner which in a mentally well person would be disorderly, and make application for the examination, observation, diagnosis, and if appropriate, certification of the person

HRS § 81-43(c).
No additional criterion for emergency admission were discussed in Chapter 81. Section 81-43(c) provided that once the psychiatric facility accepted the person as a patient, the responsibility of the police officer was terminated.

In 1967, Act 259 was introduced as House Bill Number (H.B. No.) 212 and referred to the House Committee on Public Institutions and Social Services. The Committee issued two standing committee reports in support of H.B. No. 212, both of which stated that admission of the mentally ill to hospitals without a prior order of commitment would remove the stigma attached to mental illness by treating it more like any other illness. At the same time due process of law is allowed to the person involuntarily confined through service of notice of his right to a hearing by the Family Court.

Standing Committee Report 218, House Journal pp. 559 and 667, 1967 Legislative Session. Legislators also noted that H.B. No. 212 protected due process rights by providing a right to a hearing by the Family Court.

The bill was the result of years of study into the revision of the state’s mental health laws. The Committee on Public Institutions and Social Services specifically acknowledged the work of the Committee on Revision of Mental Health Laws, chaired by Judge Samuel P. King. The House Committee believed that H.B. No. 212 would "preserve individual rights and at the same time protect the community from mishaps involving people who are permanently or temporarily mentally ill" (Standing Committee Report 218, House Journal pp. 559 and 667, 1967 Legislative Session). The Senate, while less specific in the Standing Committee Report No. 603 issued by the Committee on Judiciary, supported H.B. No. 212.

Act 259 served two important functions. First, it clearly established that police have a role in making emergency apprehensions of persons with an apparent mental illness, applying very broad standards. Second, the legislation took an important step in recognizing the due process rights of persons who are detained involuntarily. However, it is questionable
that Act 259 successfully accomplished its goal; that emergency apprehension by the police
would be less stigmatizing than admission to a hospital with a prior order. The Legislature
may have been more concerned about protecting the public from "mishaps" by the mentally ill
than avoiding stigmatization.

In 1968, prior to 1967 Sessions Laws of Hawaii Act 259 taking effect, HRL § 81-43(c), 1955 was further amended to make that section more consistent with the changes to
HRL § 81-42(a) in Act 259 (see above). Act 6, Session Laws of Hawaii 1968 amended HRL
§ 81-43(c) to allow police officers to take the person to "any facility designated by the
director of health," rather than a public health facility (1968 Session Laws of Hawaii Act 6,
Section 5). Moreover, Act 6 expanded the criteria for which a person could be taken into
custody to include "any person apparently intoxicated and found under circumstances in which
he would be subject to arrest or in which his safety or property or the safety or property of
others is endangered because of his actions or condition" (1968 Session Laws of Hawaii Act
6, Section 5). Finally, HRL § 81-43(c) was amended so that after a patient was accepted by
the psychiatric facility, "the liability of such person to subsequent arrest and prosecution for
violation of any penal law" (1968 Session Laws of Hawaii Act 6, Section 5) was not affected.

The Standing Committee Reports of both the Senate Committee on Public Health,
Welfare and Housing and the House Committee on Public Health and General Welfare stated
that the primary purpose of the bill was to treat drunkenness and alcoholism as offenses which
dictate civil treatment programs rather than criminal system remedies (Standing Committee
Report 457, Senate Journal, 1968 Legislative Session; Standing Committee Report 591, House
Journal, 1968 Legislative Session). Both committees supported the bill, S.B. No. 78.

In addition to the intent expressed by the Legislature, one element of Act 6, Section 5
is of particular importance to the evolution of this area of the law. Even though stated in the
context of intoxicated persons, police were authorized to make emergency apprehensions in situations in which the person could be subject to arrest or where the person's safety or property or the safety or property of others is endangered. Herein are two elements of the current law regarding the emergency apprehension of mentally ill persons. First, police were now only authorized to take someone into custody when he or she committed an offense, not simply if the person was mentally ill and acting out. Act 6, Section 5 still allowed police to take into custody someone who was apparently mentally ill for acting in a disorderly manner (a violation), but it was a step leading to more limited police authority. Second, the Act adds the language that eventually becomes "danger to self and others."

A series of court cases in the 1970's led to major revisions in Hawaii's laws regarding emergency apprehension, emergency hospitalization, and involuntary hospitalization. In Humphrey v. Cady, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972), Justice Marshall comments that the Wisconsin statute concerning involuntary confinement for compulsory treatment seeks to balance a medical judgement that an individual is mentally ill and treatable, and a socio-legal judgement that the individual has the potential for doing harm to himself and others, with what amounts to an enormous deprivation of liberty.

A Federal appeals court adopted Justice Marshall's interpretation of the Wisconsin law in Lessard v. Schmidt, 349 F.Supp. 1078 (E.D.Wis.1972) (three-judge court). The Circuit Court recognized that, while the Supreme Court did not establish a degree of dangerousness that is required to deprive an individual of his or her liberty, Justice Marshall did imply that a balancing test was needed, and that the state must bear the burden of proof that the potential for doing harm to one's self or others outweighs the individual's constitutionally protected right against nonconsensual confinement.
The Supreme Court discussed the limits of a state to confine persons who have a mental illness in *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975). The Court held that Donaldson, who was neither dangerous to himself or others, had been deprived of his constitutional right to liberty as a result of his incarceration. The Court said:

A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in a simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom. . . Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. . . Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty.

*Id.* at 575-576, 95 S.Ct. at 2493, 45 L.Ed.2d at 406.

The Court, however, avoided several important questions in *O’Connor*. First, the Court did not feel it was necessary to decide whether mentally ill persons who are a danger to self or others have a right to treatment upon nonconsensual commitment. Second, the Court did not decide what procedures are required by the state in order to confine a mentally ill person.

With *Humphrey, Lessard, and O’Connor* as a backdrop, Hawaii’s landmark case *Suzuki v. Quisenberry* was decided by United States District Court Chief Judge Samuel P. King (411 F.Supp. 1113 (1976)). In 1973, Plaintiff Suzuki was picked up by a police officer in Waikiki and taken to the Queen’s Medical Center for psychiatric evaluation. She was examined by a physician who certified that Suzuki required hospitalization for 48 hours under HRS § 334-54(c). Suzuki was then examined by two physicians who, under HRS § 334-53(b) certified that she required further hospitalization “to detain the patient at the facility as long as
hospitalization is needed" (HRS § 334-53(b)). Suzuki objected to her hospitalization and retained counsel through the Legal Aid Society. Plaintiff was joined in her suit by Plaintiffs Alba and Doe, whose complaints paralleled Plaintiff Suzuki's complaint, against the Defendants: Walter Quisenberry, individually and in his capacity as Director of Health; Francis Keala, individually and in his capacity as the Chief of Police; and George Bolian, M.D., Director of Psychiatric Services, Queen's Medical Center.

It is interesting, if not ironic, that *Suzuki v. Quisenberry* would be heard by Judge King. As mentioned earlier in this section, Judge King chaired the Committee on Revision of Mental Health Laws, which was instrumental in the enactment of Act 259, Session Laws of Hawaii 1967. As Judge King, then with the Family Court of the First Circuit, State of Hawaii, noted: "Act 259 is a forward-looking piece of legislation. Its adoption places Hawaii in the forefront of states of the Union in this area" (King 1968, p. 48).

Six years later, the work of Judge King, his committee, and the Hawaii State Legislature was attacked by the Legal Aid Society, the Office of the Public Defender, and the American Civil Liberties Union on behalf of Plaintiffs Suzuki, *et al.* Judge King was persuaded by their arguments and compelled by case law to find that many of the provisions in Act 259 were unconstitutional.

Of greatest importance to this study on police discretion and the legal issues which inform police decision making is Judge King's finding that emergency, nonconsensual hospitalization of any person solely because he or she may be "mentally ill or habituated to the excessive use of drugs or alcohol, to an extent requiring hospitalization" (HRS § 334-53(a), 1968) is, on its face, a violation of the Fourteenth Amendment due process clause. Judge King's interpretation of recent cases, including those mentioned above, raised two concerns with Hawaii's mental health law: that the "medical model" for dealing with persons
with a mental illness adopted by 1967 Session Laws of Hawaii Act 259 provided procedures for hospitalizing a person with a mental illness that were too relaxed; and

that the diagnosis and treatment of mental illness leaves too much to subjective choices by less than neutral individuals . . . a state law authorizing the indefinite detention by force of an individual solely on the certificates of two physicians stating that the individual is so mentally ill that he needs hospitalization, cannot be sustained.


Judge King concluded that persons sought to be committed should, at a minimum, receive the following procedural safeguards: adequate prior notice, prior hearing before a neutral judicial officer, the right to effective assistance of counsel, the right to be present at the hearing, the right to cross-examine witnesses and to offer evidence, adherence to the rules of evidence applicable in criminal cases, the right to assert the privilege against self-incrimination, a consideration of less restrictive alternatives, a record of the proceedings and written findings of fact, appellate review, and periodic redeterminations of the basis for confinement.

In granting declaratory and injunctive relief to the Plaintiffs, Judge King expressly retained jurisdiction of the case pending amendatory legislation. In response to Judge King’s ruling in *Suzuki v. Quisenberry*, the Legislature of the State of Hawaii passed 1976 Session Laws of Hawaii Act 130. The first substantive change to Hawaii’s mental health law involved adding three new definitions:

‘Dangerous to others’ means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat.

‘Dangerous to self’ means likely to do substantial physical injury to one’s self, as evidenced by a recent act, attempt or threat to injure one’s self physically or by neglect or refusal to take necessary care for one’s own physical health and safety together with incompetence to determine whether treatment for mental illness or substance abuse is appropriate.

‘Dangerous to property,’ in the context of an emergency admission, means inflicting, attempting or threatening imminently to inflict damage to any
property in a manner which constitutes a crime, as evidenced by a recent act, attempt or threat.

1976 Session Laws of Hawaii Act 130, Section 1.

More importantly, Act 130 repealed HRS Chapter 334, Part IV (§§ 334-51 to 334-58) and replaced it with a new Part IV covering Admission of Psychiatric Facility. The new Part IV replaces the emergency admissions on certificates of two physicians (HRS § 334-53) and one physician (HRS § 334-54), with two emergency examinations and hospitalization procedures:

(1) A police officer may take into protective custody and transport to any facility designated by the director any person whom he has probable cause to believe is committing an offense due to apparent mental illness or substance abuse and appears to be imminently dangerous to property, to self or to others. The officer shall make application for the examination, observation and diagnosis of the person in protective custody. The application shall state or shall be accompanied by a statement of the circumstances under which the person was taken into protective custody and the reasons therefor which shall be transmitted with the person to some physician at the facility.

(2) Upon application of any licensed physician, attorney, member of the clergy, licensed health or social service professional or any state or county employee in the course of his employment, a judge may issue an ex parte order orally, or in writing, within forty-eight hours of the application stating that there is probable cause to believe a person is mentally ill or suffering from substance abuse and is imminently dangerous to self, to others, or to property and in need of care and/or treatment, giving the findings on which the conclusion is based and directing that a police officer or other suitable individual take the person into custody and deliver him to the nearest facility designated by the director for emergency examination and treatment. The ex parte order shall be made part of the patient’s clinical record.


The form for application under (1), above, became known as "MH1" (Mental Health 1), and the form accompanying an oral ex parte order became known as "MH2" (Mental Health 2).

Act 130, Part IV, also established three criteria for the examining physician to follow for emergency hospitalization: the patient is mentally ill or suffering from substance abuse, and the patient is imminently dangerous to self, to others, or to property, and is in need of
care or treatment (emphasis added). The emergency hospitalization provision required that the patient be released within 48 hours, unless that patient agreed to voluntary hospitalization or was hospitalized under the court-ordered, involuntary hospitalization provision. The same three criteria for emergency hospitalization applied to involuntary hospitalization, with the additional requirement that "no suitable alternative [is] available through existing facilities and programs which would be less restrictive than hospitalization" (1976 Session Laws of Hawaii Act 130, Part IV(b)(1)(C)). Involuntary hospitalization could not exceed 90 days without recommitment.

In response to Suzuki, Act 130 was replete with due process provisions, beginning with the decision to initiate emergency hospitalization. Since these provisions apply after an officer has released custody of the individual to the care of the hospital, they will not be discussed here. It is important to note that the criteria for emergency apprehension by the police, emergency hospitalization by a physician, and involuntary hospitalization by the court are essentially the same; the only difference is that police officers are not required to make decisions about when or where treatment occurs.

Introduced as Senate Bill Number 2709-76, Act 130 received a great deal of attention by the Legislature of the State of Hawaii. In its first standing committee report, the Senate Committee on Health referred to the finding in O'Connor v. Donaldson (1975) that a person cannot be deprived of liberty simply for having a mental illness (Standing Committee Report 286-76, Senate Journal 1976). The Committee felt it was necessary to include the requirement of dangerousness to self, to others or to property to justify a compelling state interest in order to deprive someone of their liberty.

The Committee on Health also cited Suzuki v. Quisenberry (1976) and Judge King's minimum due process safeguards. In fact, the ruling was issued immediately prior to the
legislative session, barely in time to submit S.B. No. 2709-76 before the cut-off date for introducing legislation. The bill went to Conference Committee to iron out some minor, non-substantive differences between the House and the Senate. In testimony in support of Senate Conference Committee Report Number 31-76, Senator Chong stated:

There is still a great deal of work that will need to be done in subsequent sessions in this area of mental health and the law. However, Mr. President, we are satisfied that the most urgent needs for legislation and procedures providing for due process and the protection of liberties have been met . . .

Senate Journal p. 694, 1976 Legislative Session.

On the House side, Conference Committee Report Number 28 received similar support. Speaking in support of the report, Representative Roehrig sounded similar to Judge King (1968):

We have had an opportunity to compare this with the law of other states and it is the opinion of the Attorney General’s staff that assisted us on this bill that we have put in refinements that are not found in any other law in this country and for this reason it appears as though this bill and this act will, in effect, be a landmark law in the United States and it’s a bill about which, I think, all the members of the House of this Legislature and all the people who worked on it can be proud of.


The most significant change to HRS Chapter 334 in 1977 Session Laws of Hawaii Act 76 concerned giving police the authority to take into custody and transport to a facility any person threatening or attempting suicide. Prior to enactment of Act 76, police could only take a person who was threatening or attempting suicide to a psychiatric facility if the person had already committed, or was in the process of committing, an offense under the criminal law.

Two additional, minor changes to sections of Hawaii’s mental health laws under consideration in this discussion occurred in 1977. The first concerned the definition of "dangerous to property": the phrase, "in the context of an emergency admission," was deleted. As pointed out in the legislative history, this was necessary since dangerous to
property was also part of the criteria for emergency hospitalization and involuntary hospitalization (Standing Committee Report 528, Senate Journal p. 1077, 1977 Legislative Session). The second concerned the process by which police can initiate an emergency admission by deleting the word "protective" from the phrase "[a] police officer may take into protective custody and transport to any facility designated by the director . . . " (HRS § 334-59(a)(1), 1976) (underlined portion deleted). There was no legislative history to explain this change.

Shortly after the 1977 legislative session, Judge King found that several new provisions of HRS Chapter 334 violated the Fifth and Fourteenth amendments to the United States Constitution, and granted Plaintiff's Motion for Summary Judgment (Suzuki v. Yuen, 438 F.Supp. 1106 (1977)). The case was renamed Suzuki v. Yuen to reflect the addition of George Yuen, the new Director of Health, as a Defendant.

Judge King held that the "dangerousness to property" provision was not a constitutional basis for committing an individual to a psychiatric facility for either emergency or nonemergency hospitalization. Relying, in part, on Humphrey v. Cady, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972) and Lessard v. Schmidt, 349 F.Supp. 1078, 1093 (E.D.Wis. 1972), Judge King cited a requirement that a specific finding of dangerousness to self or others must exist before commitment may occur, excluding dangerousness to property by implication.

The statutory criteria for involuntary hospitalization were also found unconstitutional because they were ambiguous to the degree of dangerousness to self or others. Again relying on Humphrey and Lessard, Judge King held that "[t]he proper standard is that which requires a finding of imminent and substantial danger as evidenced by a recent overt act, attempt or threat" (Suzuki v. Yuen, 438 F.Supp. at 1110) (emphasis in original).
In addition, Judge King found for the Plaintiffs where § 334- (b)(4)(G) (Session Laws of Hawaii 1976 Act 130) permitted temporary commitment based on "sufficient evidence," rather than the higher standard of "beyond a reasonable doubt," the standard he laid out in *Suzuki v. Quisenberry* (411 F.Supp. 1113 (1976)). Moreover, the provision of the statute which allowed temporary hospitalization where the patient refused to participate in a psychiatric examination was found to violate Plaintiffs' constitutionally protected right against self-incrimination.

The case was appealed to the United States Court of Appeals, Ninth Circuit, (*Suzuki v. Yuen*, 617 F.2d 173 (1980)), which issued its ruling in April, 1980. The Court upheld Judge King's rulings that the statute unconstitutionally permits commitment of a person who is dangerous to property and that the statute unconstitutionally fails to require a showing of imminent danger. The Ninth Circuit Court of Appeals also found that the statute does not violate a person's Fifth amendment right against self-incrimination and that the state need not base commitment on proof beyond a reasonable doubt.

While the Ninth Circuit Court of Appeals was considering the *Suzuki v. Yuen* appeal, the United States District Court, C.D. California issued an opinion in *Doe v. Gallinot*, 486 F.Supp. 983 (1979). The issue before the Court concerned the constitutionality of a statute which provided for involuntary commitment of persons alleged to be gravely disabled due to mental disorder. In the first part of a two-part ruling, Judge Ferguson held that the term "gravely disabled" was not unconstitutionally vague since it implicitly required a finding of harm to self, that is, the inability to provide for one's basic physical needs. In the second part of the ruling, the Court held that the application of the gravely disabled standard for involuntary commitment violated Plaintiff's due process rights by possibly requiring detention.
beyond the 72-hour emergency period. The ruling was affirmed by the United States Court of Appeals, Ninth Circuit in *Doe v. Gallinot*, 657 F.2d 1017 (1981).

The Twelfth Legislature of the State of Hawaii made two significant changes to the mental health laws with Acts 94 and 188, Session Laws of Hawaii 1984. The first change had to do with the definition of "dangerous to self":

... means the person recently has threatened or attempted suicide or serious bodily harm; or the person recently has behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded.


Committee reports in both the Senate and the House stated that the previous definition was difficult for the Family Court to interpret in a consistent manner (respectively, Standing Committee Report 648-84, Senate Journal, 1984 Legislative Session; Standing Committee Report 348-84, House Journal, 1984 Legislative Session). The definition is also reflective of the "gravely disabled" definition described in *Doe v. Gallinot*.

The second change, and more significant of the two, appeared in Act 188. In line with *Suzuki v. Yuen*, the legislature dropped the "danger to property" element from the involuntary hospitalization criteria (HRS § 334-60(b)(1)(B)). The element remained in the emergency apprehension and emergency hospitalization criteria, however: *Suzuki v. Yuen* did not address those aspects of the Hawaii statute.

The step towards adding the element of "gravely disabled" taken in Act 94, Session Laws of Hawaii 1984 was completed in 1985. Act 75, Session Laws of Hawaii 1985 added the following definition of "gravely disabled":

... means a condition in which a person, as a result of a mental disorder, (1) is unable to provide for that individual's basic personal needs for food,
clothing, or shelter; (2) is unable to make or communicate rational or responsible decisions concerning the individual's personal welfare; and (3) lacks the capacity to understand that this is so.

Session Laws of Hawaii 1985 Act 75, Section 1.

The "gravely disabled" element was then added to the imminently dangerous to self or others standard in the involuntary hospitalization criteria (HRS § 334-60.2(2)). The Act also replaced the words "he" and "himself" with the gender-neutral terms "the person" and "self" in the involuntary hospitalization criteria subsection.

The Senate Committee on Health and the Senate Committee on Judiciary each issued a standing committee report in support of the measure (Standing Committee Report 53 and 485, Senate Journal, 1985 Legislative Session, respectively). Both committees sought to include persons who were unable to care for themselves or to make decisions regarding their personal welfare to the involuntary hospitalization criteria. The Senate Committee on Health reported hearing favorable testimony from the Department of Health, the Family Court, the Hawaii Nurses Association, and the Hawaii Chapter of the National Association of Social Workers.

The House Committee on Human Services and Judiciary also reported hearing testimony from the organizations listed above; however, they also heard testimony in opposition from the Mental Health Association and the American Civil Liberties Union, as well as concern expressed by the Director of the Institute of Human Services over the definition of "gravely disabled." Both the House Committee on Human Services and Judiciary and the House Committee on Finance stressed that the bill under consideration was necessary, and that the requirements for commitment under the "gravely disabled" standard were precise, and provided the means to avoid criminalizing persons with a mental illness.

In 1986, Act 335 added a new definition to HRS § 334-1:

'Obviously ill' means a condition in which a person's current behavior and previous history of mental illness, if known, indicate a disabling mental
illness, and the person is incapable of understanding that there are serious and highly probable risks to health and safety involved in refusing treatment, the advantages of accepting treatment, or of understanding the advantages of accepting treatment and the alternatives to the particular treatment offered, after the advantages, risks, and alternatives have been explained to the person.

Session Laws of Hawaii 1986 Act 335, Section 1.

This element was then added to the emergency examination and hospitalization sections (HRS § 334-59(a)(1) regarding police-initiated custody and HRS § 334-59(a)(2) regarding oral ex parte), emergency hospitalization (HRS § 334-59(d)), and involuntary hospitalization (HRS § 334-60.2(2)).

In addition, the following criterion was added to HRS § 334-59(a)(1) concerning police-initiated custody for emergency examination and hospitalization:

[i]f a police officer has reason to believe that a person is obviously ill, the officer shall call for assistance from the mental health emergency workers designated by the director. Upon determination by the mental health emergency workers that said person is obviously ill, the person shall be transported by ambulance or other suitable means, to a licensed psychiatric facility for further evaluation and possible emergency hospitalization.

Session Laws of Hawaii 1986 Act 335, Section 2.

The House Committee on Judiciary amended the original Senate bill to delete "gravely disabled" as an element for emergency hospitalization, since it is not an emergency condition. When the bill went to Conference Committee, this element was left in the bill.

Both sides of the Conference Committee supported the legislation with the following reasoning:

[t]oo often, mentally ill individuals are ignored until their conduct can be described as criminal and their condition requires lengthy hospitalization. The police, called upon to control the mentally ill individual, may easily recognize that the misconduct reflects illness rather than criminal intent. Under the Act proposed by the bill, mental health workers will be summoned and the degrading process of criminalization can be avoided. Other equally but not necessarily obviously ill individuals may have to undergo an unfortunate process of further deterioration before they can be hospitalized for treatment.

Act 138, Session Laws of Hawaii 1992, added the element of "gravely disabled" to the emergency admission and hospitalization (HRS § 334-59(a)(1-3)) and emergency hospitalization (HRS § 334-59(d)) subsections. This Act brought those two subsections into line with the involuntary hospitalization criteria, which included the "gravely disabled" element in 1985 (Act 75).

The Senate Committee on Judiciary noted that the bill which became Act 138 was written "in response to Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980)" (Standing Committee Report 2650, Senate Journal p. 1180, 1992 Legislative Session). Proponents of the bill (not individually listed in the Report):

... believe that, as a result of Suzuki, the courts have been reluctant to enforce Hawaii’s civil commitment laws absent a finding that the individual is imminently dangerous, thereby forcing the individual to live on the streets or left in the care of family and friends who must watch the individuals decompensate to the point of becoming dangerous to themselves and others before obtaining treatment.


The Committee on Judiciary also stated that the Department of Health has decided to "further test the constitutionality of Hawaii’s laws as well as the Suzuki standard" of imminent danger, relying instead on the decision in Doe v. Gallinot, which upheld the "gravely disabled" standard used in California’s involuntary commitment statute (Standing Committee Report 2650, Senate Journal p. 1180, 1992 Legislative Session).

The statutes relating to police authority to take persons with a mental illness into custody for emergency examination and hospitalization seem clear: if a person is imminently dangerous to self or others, or is gravely disabled, or is obviously ill, or is threatening or attempting suicide, the police can act. Moreover, since passage of Act 335, Section 2,
Session Laws of Hawaii 1986, police should not be in the business of making the final determination of who should be transported to the hospital for an emergency examination; that responsibility was clearly placed on "... mental health emergency workers designated by the director" (Session Laws of Hawaii 1986 Act 335, Section 2). Police may be required to assist in the transporting of the person to the hospital, but the law was designed to reduce police involvement in dealing with persons who have a mental illness whose actions are more the product of illness than criminal intent.

While the definitions for gravely disabled and obviously ill require some interpretation and subjective judgement on the part of the officers, the police seem generally prepared to make those type of assessments. The path to the mental health system, via the hospital emergency room, should be clear. The police and hospital staff all have the same criteria to follow.

In practice, however, the path is anything but clear. Since 1986, the Family Court of the First Circuit has objected to all emergency and involuntary hospitalization criteria that do not include imminent danger. Relying on *Suzuki v. Yuen*, the Family Court supports criteria only in situations where the danger to self or others is imminent; based on *Doe v. Gallinot*, the "gravely disabled" criteria seems questionable.

The net result is that, while the standards for police to take someone into custody have not changed, the criteria for the hospitals to hold a person have changed. The hospitals are understandably not willing to commit someone involuntarily if that commitment would be subsequently challenged in court. Moreover, the police are reluctant to take someone to the hospital when there is a strong likelihood the person will be released because they do not meet the hospital’s criteria for admission.
There is some question whether Family Court is correctly interpreting the decision in *Doe v. Gallinot*: the holding regarding the "gravely disabled" provision concerned procedural matters, and the Ninth Circuit Court of Appeals did not rule specifically on the constitutionality of the "gravely disabled" standard. Subsequent to the *Doe* decision, at least seven states, including Hawaii, in the Ninth Circuit have passed emergency hospitalization statutes containing the "gravely disabled" standard. However, until a test case reaches the Ninth Circuit or United States Supreme Court, local police and hospital administrators must be aware of how Family Court will rule on their decisions. And the police must operate under very narrow criteria, exactly the opposite of what the legislature has tried to accomplish during the past 25 years.

In summary, there are a number of legal and policy issues of which police officers must be aware. In a very practical sense, there are two factors which have the greatest impact on police officer behavior when dealing with persons who have a mental illness. The first factor concerns the interrelationship between formal and informal policies of the police department: the lack of the former places greater importance on the latter. It is not in the best interest of the police department to have over 2,000 officers operating without formal guidelines. At the same time, formal policies can be very restrictive, requiring the department to follow and defend those policies. Informal policies govern the large number of low visibility decisions police make on a daily basis, and those policies are communicated and maintained by strong, internal, organizational norms.

The second factor is the constant awareness police officers must have of how the other organizations, with whom they must deal, function. For officers in the field, this means understanding the criteria applied by emergency room personnel and the courts for nonconsensual confinement. Knowing the law in this instance is not sufficient; officers need
to know how the law is currently being interpreted. Since the letter of the law on emergency
examination and hospitalization and the current interpretation of that law are not the same,
officers must use discretion in their encounters with persons who have a mental illness.

The next chapter describes the methodology for this research. Included in Chapter 3
are descriptions of the setting for the research, and the quantitative and qualitative methods.
A. Setting

The State of Hawaii is an island chain stretching 1,523 miles, consisting of eight major islands and 129 minor islands with a total area of 6,425 square miles and 750 miles of coastline. The state is located 2,557 miles from Los Angeles, California and 3,847 miles from Tokyo, Japan (Department of Business, Economic Development and Tourism 1994). There are five counties in the state: the City and County of Honolulu, which includes the island of Oahu and several small, sparsely inhabited offshore islands; the County of Hawaii, which includes the island of Hawaii; the County of Maui, which includes the islands of Maui, Molokai, Lanai, and Kahoolawe; the County of Kauai, which includes the islands of Kauai and Niihau; and the County of Kalawao, which includes the Kalaupapa Settlement on the island of Molokai.

The estimated statewide resident population of the state was 1,155,700 in 1992, with a de facto population of 1,272,100 (Department of Business, Economic Development and Tourism 1994). Based on the 1990 census, approximately one-third of the state's population is Caucasian, 22.3 percent Japanese, 15.2 percent Filipino, 12.5 percent Hawaiian, 6.2 percent Chinese, 2.5 percent African-American, 2.2 percent Korean, 1.4 percent Samoan, 0.5 percent American Indian, Eskimo, or Aleut, 0.5 percent Vietnamese, and 3.4 percent "other" races (including, for example, Thai, Laotian, and Tongan) (Department of Business, Economic Development and Tourism 1994).
The capital of the state is the City and County of Honolulu. As the name indicates, Honolulu is administratively organized in an unusual manner, where city and county functions are merged. The island of Oahu covers 597 square miles and is governed by one mayor, and one city council, and has one fire department, and one police department. There is no state police and the sheriff's department, which is a part of the State Department of Public Safety, is primarily involved with security for the courts.

The Honolulu Police Department divides Oahu into eight districts: District 1 covers downtown Honolulu; District 2, Wahiawa (Milibani to the North Shore); District 3, Pearl City (to Waianae); District 4, Kailua (to Kahuku); District 5, Kalihi; District 6, Waikiki; District 7, East Honolulu; and District 8, Waianae (see Figure 1, p. 56). In 1993, there were 2,275 employees in the Honolulu Police Department, including 1,741 sworn active-duty officers, 81 sworn reserve-duty officers, and 453 civilian individuals (Department of Business, Economic Development and Tourism 1994). The Chief of Police is appointed by the Police Commission, which is comprised of seven individuals appointed by the mayor and approved by the city council for a term of five years.

Two programs currently assist the police in their involvement with persons with a mental illness. In November 1992, the Honolulu Police Department initiated Project Outreach. The project was designed to assist the department in dealing with homeless and mentally ill persons who came into contact with the police. The project staff consists of one outreach worker, located in the Chinatown substation of District 1. The outreach worker provides the following services: assisting officers with crisis intervention and assessment of the homeless and mentally ill; making referrals to social service agencies and facilitating implementation of those referrals; monitoring individuals referred to other agencies to

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Figure 1. Oahu Police Districts

 Castle Medical Center

 The Queen's Medical Center
measure compliance; and preparing daily documentation and periodic written reports (Plotkin and Narr 1993).

The Crisis Response System Program (CRSP) is a private, not-for-profit organization which provides crisis intervention and operates a 12-bed shelter with access through informal arrangements for more bed space. The CRSP receives calls from the police, board and care homes, hospital emergency rooms, and mental health workers. They have a staff of eight and 24-hour-a-day back-up by a psychiatrist. They primarily respond to suicide attempts and acute crises involving the severely disabled mentally ill and/or alcohol and substance abusers. The CRSP team will evaluate an individual and, if possible, avoid hospitalization by contacting a case manager or working with the psychiatrist to stabilize the person. If the person needs hospitalization (that is, they meet the involuntary commitment criteria), CRSP will try to obtain an oral _ex parte_ order (MH2) and transport the person to the hospital emergency room.

There are other organizations actively involved in issues related to persons who have a mental illness. These organizations are not directly involved in assisting the police, but their work is important to the setting in which the police function. A major player in the field of mental health services is the Hawaii State Department of Health (DOH). Three divisions within the Behavioral Health Services Administration of DOH provide a range of mental health services.

One of the primary functions of the Adult Mental Health Division is to operate the community mental health centers, which provide outpatient counseling and treatment for adults with a mental illness. The division also operates the Courts and Corrections Branch and the Diversion Program, which work with the courts to divert persons with a mental illness who have been arrested out of the criminal justice system; and the Hawaii State
Hospital. Prior to 1994, the Adult Mental Health Division provided services in the state’s correctional facilities; the role has now been assumed by the Health Care Division of the Department of Public Safety.

The Alcohol and Drug Abuse Division of DOH receives federal and state funds for substance abuse treatment. The division uses these funds to purchase services to provide treatment for alcohol and drug abuse.

The Child and Adolescent Mental Health Division of DOH provides outpatient services to children and adolescents. The services are delivered by teams located in the community mental health centers. In addition, the division contracts with private inpatient service providers.

The Mental Health Association of Hawaii is a strong advocate for persons who have a mental illness and their families to obtain services from community mental health centers and other mental health service providers. In addition to providing help for individuals, the Mental Health Association is involved in public policy advocacy, including lobbying the legislature.

Among the efforts of the Mental Health Association is the coordination and staffing of the Task Force on Mentally Ill Persons and the Criminal Justice System.

The Task Force seeks to improve the coordination of services and develop better ways to help mentally ill persons who now are inappropriately involved in the criminal justice system. The Task Force includes more than 80 representatives [of] government and nonprofit agencies, as well as consumers, family members, mental health advocates, and mental health service providers. (Mental Health Association of Hawaii 1995, p. 7).

A number of other organizations advocate for the mentally ill. The Coalition to House Homeless People with Mental Illness is working to build a "safe haven" for the homeless mentally ill. This facility would provide medical services and housing. Homeless Solutions, Incorporated, operates four homeless shelters on Oahu. The Hawaii State Alliance
for the Mentally Ill and the Oahu Alliance for the Mentally Ill are advocacy groups for the mentally ill. Other organizations providing services and support for persons who have a mental illness include United Self-Help, the Waianae Coast Community Mental Health Center, Inc., and Protection and Advocacy Agency of Hawaii.

B. Methodology

Studies which attempt to explain police officers’ use of discretion have generally employed either quantitative or qualitative methods. To date, much of the research on police behavior has relied on quantitative methods to explain bivariate and, less often, multivariate relationships between police actions and potential causal factors. These studies have three major shortcomings: 1) the analyses have only nominally explained the variation in police behavior; 2) most studies fail to include explanatory variables which cross levels of analysis, including the individual officer, the specific situation, the organizational structure of the police department, community influences, and legal constraints; and 3) most studies have examined only the formal dispositions available to the police (see Sherman 1980; Mastrofski and Parks 1990).

Qualitative methods have involved direct observation, interviews, and the use of hypothetical situations to explain police behavior (Sherman 1980; Mastrofski and Parks 1990). The goal of much of this research is to understand the cognitive processes involved in police decision making. There are at least three criticisms to this research: 1) asking police to explain their decisions may alter future actions; 2) debriefing data may not be reliable; and 3) debriefing data may not be valid (Mastrofski and Parks 1990).
Teplin (1984a; Teplin and Pruett 1992) addresses many of these shortcomings by combining quantitative and qualitative methods to study police discretion in referring adults with a mental illness. In order to avoid the criticisms concerning data collection raised by Mastrofski and Parks (1990), Teplin utilized herself and five clinical psychology doctoral students as observers. For each police-citizen encounter which involved at least three verbal exchanges, the observers completed an incident coding form describing police behavior and a symptom checklist to assess the presence of mental disorder in the citizen. In order to promote cooperation with the police officer and reduce possible influence, the observers did not use tape recorders or take extensive notes. The observers later used a dictaphone to reconstruct the observation period, including impressionistic data, descriptions of police-citizen encounters, and the reasons underlying police decision making. Combining methodologies made it possible to better explain variations in police behavior by including sociopsychological and structural factors and by examining informal dispositions.

Teplin's research design is the most comprehensive attempt to explain police discretion in referring adults with a mental illness into mental health care or for processing in the criminal justice system to date. This design is inadequate, however, to fully understand the factors which affect police discretion: 1) the data on police encounters were limited to encounters with citizens in which at least three verbal encounters occurred; 2) informal dispositions, which outnumber both arrests and psychiatric referrals, were not disaggregated and quantified; 3) no data were collected on an officer's decision to do nothing; 4) information concerning the reasoning behind the police officer's decision making was dependent on the recollection and interpretation of the observer; and 5) it is not possible to measure the impact of an observer on an officer's behavior. These design shortcomings are addressed by this research.
The first step in this study involved interviews with three individual officers and one focus group comprised of eight officers, all from the Honolulu Police Department. The purpose of the interviews and focus group was to understand the nature and extent of the problem faced by the department concerning individuals who have a mental illness in the community who violate the law. Officers described their experiences in the field, including the types of offenses involving persons who have a mental illness, descriptions of typical encounters, dispositional options, the appropriateness of those options, and what other options would be desirable. Officers were also asked if they would be willing to collect data on their encounters with persons who have, or are suspected of having, a mental illness; without exception, the officers said they would be willing.

There are two major components of this study: one quantitative, one qualitative. The quantitative component employed an incident coding form which was completed by the police officer each time he or she encountered an individual who committed an offense for which he or she could be cited or arrested and whom the officer believed to have a mental illness (Bonovitz and Bonovitz 1981) (see Appendix A). The coding form includes the date, time, and place of the encounter; the circumstance(s) which precipitated the encounter (e.g. citizen or business complaint, direct observation); the age, sex, race/ethnicity of the person with a mental illness; whether the individual is known to the police officer and is known to have a criminal history or history of mental illness; a general assessment of socio-economic status (the type of housing in which the person resides and employment status); the outcome of the encounter (that is, which dispositional option was exercised by the police officer) including the date, time, and location; the reason(s) for invoking the particular dispositional option; and the age, sex, race/ethnicity, and years of experience of the police officer.
The coding form also includes a list of behavioral characteristics to describe the officers' observations concerning the demeanor of the individual. The list of behavioral characteristics is a compilation from forms used by the Maui County Police Department for intake screening, the Department of Public Safety of the State of Hawaii for admissions screening, and the Commission on Corrections, Office of Mental Health of the State of New York for suicide prevention screening guidelines. Descriptions of behavioral characteristics were recorded rather than results of a standardized psychiatric screening instrument such as the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III), Research Diagnostic Criteria (RDC), Feighner et al. criteria, or other instruments (e.g. see Teplin 1984b, 1985; Singerman et al. 1981; Robins et al. 1981; Helzer et al. 1981; Stoltzman et al. 1981).

There are three reasons supporting the use of a behavioral characteristics checklist over a standardized psychiatric instrument. First, police officers are not trained to administer a screening instrument. Second, asking police officers to evaluate an offender's behavior against a standardized set of criteria may influence the subsequent disposition of the offender. While these two concerns could be addressed by a third party acting as an observer, as in Teplin's (1984a) research, a third reason is the most important: this research is equally interested in incidents in which a person suspected of having a mental illness commits an offense for which he or she could be cited or taken into custody which does not result in police intervention, as it is with those incidents in which the police do intervene. Clearly, one of the options available to police is to decide to do nothing at all. In such cases, the police may not come into direct contact with, and therefore will not be able to interview, persons for whom the completion of an incident form is intended. One outcome of this
research will be a better understanding of what types of behavior, as observed and defined by police officers, are likely to lead to the various dispositional options available to the police.

One concern about this study design which merits discussion is the appropriateness of the police completing the incident forms rather than trained researchers completing the forms. The primary issue concerns whether the police are qualified to determine whether an individual has a mental illness in order to initiate an incident form. All the police officers interviewed prior to data collection stated they could usually tell if an individual has a mental illness by observing the individual's behavior. Many of the police officers recognize "the regulars" (Teplin 1984b). Moreover, "policemen confront perversion, disorientation, misery, irresoluteness, and incompetence much more often than any other social agent" (Bittner 1967; p. 280). As such, police officers are constantly called upon to observe and act based on an accumulation of training and experience in the field (see Bittner 1973; Black 1976; Banton 1964; Niederhoffer 1967). Furthermore, the assessments that officers are required to make for this research are no different than those required under HRS § 334-54.

It is probable that police are more likely to commit errors of omission rather than errors of inclusion: the more severe the symptoms, the greater the probability that the police will correctly identify the fact that a particular person has a mental illness. As in Teplin's study (1984a), "the focus [is] on identifying those persons who were visibly suffering from the more severe forms of mental illness (e.g., schizophrenia, major affective disorders, etc.)" (p. 797). The inclusion of only those who have a severe mental illness in this study is proper since the full range of dispositional options are only available to the police in situations where the suspect might be appropriate for an emergency room evaluation and/or involuntary commitment.
The most important argument in support of this methodology is that the officer is only reporting incidents which directly relate to the research question. When an officer observes an individual that he or she suspects has a mental illness violating an ordinance or statute, the officer from that point has a recognized set of options not available in situations where the violator does not have a mental illness. The officer takes that set of dispositional options into the situation, and, based on a number of variables measured by this study, makes a determination of what to do. The predetermination of mental illness (or, at least, the suspicion of mental illness) is important to answering the question "Are the police criminalizing persons with a mental illness?" If an officer does not think the person has a mental illness, the results will be skewed in the direction of non-mental-health-system dispositions. Furthermore, no data will be collected in situations where an independent observer might consider a suspect to have a mental illness while the officer does not.

One final argument can be made in defense of placing the responsibility for data collection with the police officers. Virtually everything that is known about the incidence and nature of crime is gleaned from official police reports. Police receive extensive training in how to complete incidence and arrest forms: not only do the data collected and recorded by officers inform policy and staffing decisions within police departments, but they also serve as a critical element in the prosecution of criminal suspects. Many police officers express dislike at paperwork, but few, if any, fail to recognize the importance of completing forms in a timely and accurate manner.

A secondary issue concerning the appropriateness of the police completing the incident coding form is whether the police will actually take the time to do the work. Police do not like to do paperwork; some officers may resent having to do "more work" and will not complete the form. Moreover, officers may have too much work to justify taking the time to
complete an incident coding form for this research. In addition, officers with a high caseload of more serious offenses may not take the time to deal with a person who has a mental illness and is publicly disruptive, and thus, the incident forms may not reflect the prevalence of mentally ill persons who violate the law. However, the patrol officers in the focus group all stated they would do additional work if filling out the forms would help define and solve the problems they deal with. The chief of police, district commanders, and watch commanders pledged their support and that of their patrol officers.

Still, some officers will choose not to participate. Undercounting the actual frequency with which officers deal with persons who have a mental illness and who violate the law is one potential problem associated with officers not completing forms. Another is selection bias; that is, officers who complete the forms and the situations in which they are involved may differ significantly from encounters which do not result in an incident form being completed. However, the goals of the study do not require 100 percent participation by the patrol officers. In order to accomplish the goals of the study (see Preface, page xii-xiii), it is necessary that the forms reflect the relative distribution of the various options and how much time is required to invoke each disposition. Interviews with police officers and data from previous research will determine whether the information from the incident coding forms accurately reflects the experiences of police officers.

The incident coding form (see Appendix A) was designed to resemble the incident reporting form currently used by the Honolulu Police Department in order to reduce the need for extensive training and to make the collection of data more manageable for the police officers. The coding form underwent several revisions as a result of meetings with the commander of District 1 and the director of the department's Project Outreach.
Permission to conduct this study was obtained from the chief of police, who, in turn, communicated that permission to the eight district commanders. During the month of January, 1994, several meetings were held with the commander of District 1, who was willing to act as a liaison to his counterparts in the other districts and help facilitate the research project.

During the first two weeks of February 1994, the incident coding form was field-tested in District 1. In-service training on the use of the form was conducted during second and third watches, involving 46 patrol officers. The only question raised during the in-service concerned the section which included information on the officer's age, sex, race/ethnicity, and years in the department. Of greatest concern was the identification of race/ethnicity. Two weeks prior to the in-service, several articles appeared in the local newspaper which suggested that Honolulu Police Department officers treated African-Americans more harshly than other citizens, and police were concerned that the data would be used to support those accusations. Officers were assured that there was no presumption of racism, and, to allay those concerns, were told to leave blank the section on ethnicity if they were still concerned.

The officers who field-tested the form found it easy to use and completed the forms accurately. No changes were made to the form as a result of the field test.

Meetings were held during the month of July 1994 with each of the eight district commanders to describe the research project and to enlist their support. Without exception, all were interested in participating; each commander stated that police intervention with persons who have a mental illness placed a burden on their officers and expressed frustration with the dispositional options at their disposal. Each commander volunteered his support and committed the support of his officers. In addition, meetings were held with the watch commanders in Districts 3, 4, 5, and 6 at the request of the district commanders. In those
districts, the respective commanders felt that the project could be promoted better by the researcher.

During the first week of August 1994, in-service was provided at each watch (6:30 a.m., 2:30 p.m., and 10:30 p.m.) in each district, except District 6 (the district commander is an outspoken advocate for services for the homeless and persons with a mental illness; he felt that he and his watch commanders could be effective in providing in-service and promoting the project). The in-service consisted of describing the purpose of the project (to study what decisions police officers make when they encounter a person with a mental illness who is doing something for which he or she could be cited or arrested, and to measure police workload as it relates to persons with a mental illness) and reviewing the form, line by line. In response to questions, officers indicated that they understood under which circumstances a form should be generated and what data were requested.

During the question-answer period of the in-service in Districts 1 and 5, concerns were again expressed regarding the collection of data on the race/ethnicity of the officer. As with the officers involved in the field test, assurances were made that there was no agenda to identify racism and that officers who were uncomfortable could leave the section blank. In the other districts, this point was stressed during the in-service and no further concerns were expressed. Officers were encouraged to use the form during the subsequent week and communicate any problems to their watch commander. No problems were encountered.

Data collection ran for one month, beginning on August 15 and concluding on September 14, 1994. Forms were distributed by the watch commanders, and each district assigned personnel to collect the completed forms. Completed forms were collected on a weekly or biweekly basis from each district substation. Analysis of the data collected by the police officers is described in Chapter 4.
The second component of this study involved structured and semi-structured interviews with patrol officers, the results of which are reported in Chapter 5. From November 1994 to January 1995, 11 police officers from five of the eight police districts were interviewed. The officers were selected by either the district commander or their watch commander. Ten of the eleven officers were male, with an average age of 32.4 years and 5.5 years of experience. All but one interview was tape recorded; the total running time of the interviews is 6 hours, 15 minutes.

The interviews were designed to be structured (see Appendix B for a list of interview questions); however, most interviews did not follow the structured format. All the officers interviewed wanted to talk, including the one officer who did not want to be tape recorded. It is interesting to note that the one officer who did not want to be recorded had the least amount of experience, 1.5 years. None of the other officers hesitated when asked if they could be tape recorded. Overall, the officers had a great deal to say about their involvement with persons with a mental illness, all with a strong undercurrent of frustration. Officers were asked about their perception of the problems presented by persons with a mental illness in their district, descriptions of their encounters with, and responses to, persons with a mental illness, and the impact of police policies on their discretion. For each interview, the officer’s age, sex, race/ethnicity, and years in the police department were recorded.

The next chapter reports the quantitative analyses based on the incident coding forms completed by police officers. Included in Chapter 4 are univariate statistics, bivariate statistics and hypothesis testing, and multivariate analyses.
CHAPTER 4
QUANTITATIVE ANALYSIS

From August 15 through September 14, 1994, police officers submitted a total of 155 incident forms. Seven forms were found to have missing information that 1) was critical to the study (e.g. offense committed, disposition, time and date of occurrence) and 2) could not be supplied from police records of the incident. The number of valid forms used in this analysis totals 148.

Data from the incident forms were coded (see Appendix C for variable list) and entered into a system file created by the QED procedure in SPSS/PC+ Version 5.0. After all the data were entered and checked for accuracy, univariate, bivariate, and multivariate analyses were conducted using the SPSS/PC+ software. After reporting the univariate statistics, the chapter will explore the collection of those data with a qualitative analysis of the interviews with police officers.

A. Univariate Statistics

Table 1 reports the basic information contained on the incident coding form (see Appendix A). Included as basic information are the district in which the incident occurred, the specific offense, the location of the offense, the source of the call, the disposition, the day of the week, the time of day, and the amount of time the officer spent with the suspect.
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<th>District</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downtown (#1)</td>
<td>10</td>
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</tr>
<tr>
<td>Wahiawa (#2)</td>
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<td>10.1</td>
</tr>
<tr>
<td>Pearl City (#3)</td>
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<tr>
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<td>10.8</td>
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<tr>
<td>Waianae (#8)</td>
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<td>Disorderly Conduct</td>
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</tr>
<tr>
<td>Contempt</td>
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<td>6.1</td>
</tr>
<tr>
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<td>4.1</td>
</tr>
<tr>
<td>Trespass 2°</td>
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<td>3.4</td>
</tr>
<tr>
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<td>1.4</td>
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<tr>
<td>Harassment</td>
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<tr>
<td>Theft 3°</td>
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<tr>
<td>Smoking in Public Place</td>
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<td>Assault 2°</td>
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Table 1. Basic Information (cont.)

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<td>Arrest-Police Cell Block</td>
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<td>MH1/Oral Ex-Parte</td>
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<td>Voluntary Transport</td>
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<td>Call Support Agency</td>
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<td>Saturday</td>
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<th>Time of the Day</th>
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<th>PERCENT</th>
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</thead>
<tbody>
<tr>
<td>First Watch (10:30 p.m.-6:30 a.m.)</td>
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<td>33.1</td>
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<tr>
<td>Second Watch (6:30 a.m.-2:30 p.m.)</td>
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<tr>
<td>Third Watch (2:30 p.m.-10:30 p.m.)</td>
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<table>
<thead>
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<tr>
<td>0</td>
<td>23</td>
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<tr>
<td>1-10</td>
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<td>11-30</td>
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Table 1. Basic Information (cont.)

<table>
<thead>
<tr>
<th>Amount of Time Per Incident (Minutes)</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>31-60</td>
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<td>61-90</td>
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<td>10.1</td>
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<td>91-120</td>
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<tr>
<td>121-500</td>
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</table>

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Table 1 reveals that slightly more than half of the completed forms originated from District 5, all but one of which from the beats in and around the Honolulu International Airport. There are several explanations for the high percentage of completed forms originating from the airport. District 5 has a substation located at the airport. As a result, the airport is not simply one beat in a much larger district, where one or two officers occasionally patrol. The location of the substation at the airport gives a continual police presence. Moreover, the homeless and homeless mentally ill represent a greater proportion of the airport officers' duties than in other districts. The airport officers are not concerned with traffic or parking, most drug interdiction is handled by specialized narcotics details; airport officers are primarily concerned with visitor safety and airport security. As a result, the officers have more time to deal with problems created by disruptive individuals.

The presence of the homeless, many of whom are also mentally ill, at the airport is a fairly recent development. The airport is seen by many homeless people as a safe, clean place to stay, largely due to the presence of the airport police. Moreover, individuals can easily earn a few dollars by returning the carts used to carry luggage. As evidenced by the forms returned by police at the airport, the officers struggle to balance the rights of
individuals to be in a public place and trying to accommodate businesses at the airport who are concerned about the effects of "unsightly" people on tourism. Given the number of homeless mentally ill individuals at the airport, the fact that the homeless mentally ill stand out more at the airport than virtually any other location on the island, and the continual presence of officers whose job is to a great degree focused on monitoring the homeless mentally ill, it is not surprising that a large number of incident forms would originate from the airport.

Nearly half (45.3 percent) of the incident forms indicated that the suspect was committing no criminal offense at the time the officer made his or her observation. Since the instructions, both printed on the form (see Appendix A) and during the in-service training, call for the completion of a form each time a person who is suspected of having a mental illness commits an offense for which he or she could be cited or arrested, the indication that no crime was committed appeared problematic. After the first forms were returned with this classification, officers were asked why they completed a form if no offense was committed. Officers stated that they felt this was the most appropriate classification because there was no intent to violate the law. A common scenario involved a person who was sleeping in the airport: when asked to move along, the person complied. The officers remarked they could justify a charge of vagrancy, or miscellaneous public disturbance, but felt the larger issue concerned the intent to violate the law and whether anyone was in danger of harm.

There is a subtle, but important, distinction made by these officers. On the one hand, the officers understand that they have the authority to detain and instruct citizens who violate the law. Police also realize that definitions of certain violations are sufficiently blurry to allow a great deal of flexibility in making stops and issuing orders (e.g. see Bittner 1990; Banton 1964). On the other hand, police officers (at least many of those who participated in
this study) are reluctant to invoke the law, or even reluctant to recognize that the law applies in certain circumstances (at least with this population).

The offense most often noted by officers was disorderly conduct, Hawaii Revised Statutes (HRS) § 711-1101. Disorderly conduct is a violation, unless "it is the defendant's intention to cause substantial harm or serious inconvenience, or if he persists in disorderly conduct after reasonable warning or request to desist" (HRS § 711-1101(3)). Overall, 39.2 percent of the offenses involved violations or petty misdemeanors, 12.9 percent misdemeanors, and 1.4 percent class C felonies.

The greatest number of police/civilian contacts occurred at the Honolulu International Airport: 73, 49.3 percent of all contacts. Seventeen of the 148 contacts (11.5 percent) occurred on the street, and 14 (9.5 percent) happened at a private business.

Most (66.2 percent) of the police-civilian encounters were the result of police patrols, followed in frequency by "other" calls (16.2 percent), which included private security employees, passers-by, and anonymous calls. Calls from merchants accounted for only 4.7 percent of police-civilian contacts, while self-referrals and calls from neighbors and friends each accounted for 4.1 percent.

More than half (52.0 percent) of the dispositions were categorized as informal; situations in which the officer took no formal action, usually involving a type of "counsel and release." The second most frequently employed dispositional option was no action (20.3 percent), followed by arrest (14.9 percent).

The police transported 14 suspects to a hospital emergency room, 9.5 percent of all dispositions: 5.4 percent involved an MH1 or MH2 (oral ex parte), 2.7 percent were voluntary transports (the suspect agreed to go to the hospital), and 1.4 percent were the result of an arrest in which the officer took the suspect to the hospital. An inventory of hospital
emergency room admissions during the study period revealed that 75 patients were brought to The Queen's Medical Center (The Queen's Medical Center 1995). This figure represents all of the patients brought in by police, including physical injuries. The hospital was not able to disaggregate MH1, MH2, and voluntary transports from their records without a manual search. During the same period, 20 patients were brought to Castle Medical Center (Castle Medical Center 1995) by police officers: 15 on oral *ex parte*, 1 on MH1, and 4 courtesy transports.

Most of the incidents involving the police and persons who have (or were suspected of having) a mental illness occurred on Tuesday, Wednesday, or Thursday. The fewest number of incidents occurred on Friday, Saturday, or Sunday.

The greatest number of incidents occurred during third watch, which runs from 2:30 p.m. until 10:30 p.m.: 64, 43.2 percent of the total. First watch, 10:30 p.m. until 6:30 a.m. generated the second greatest number of incident forms: 49, 33.1 percent of the total.

Twenty-three of the interactions (15.5 percent) took no measurable time, and another 41 (27.7 percent) took 10 minutes or less. The average police-time for all 148 incidents was 36.3 minutes, with a median time of 15 minutes, a range of 0 to 500 minutes, and a total time spent of 5,376 minutes (89.6 hours).

The disposition with the greatest mean time was the MH1/MH2: 145.0 minutes. The amount of time for this disposition ranged from 40 to 500 minutes, with a median time of 102.5 minutes. Arresting a suspect took the second greatest amount of time, ranging from 10 to 130 minutes. The average amount of time involved in an arrest was 64.2 minutes, with a median time of 64.0 minutes. Informal dispositions ranged in time from 5 to 300 minutes. The average amount of time spent on an informal disposition was 23.3 minutes, with a median time of 15.0 minutes.
Most of the no action dispositions took zero minutes (the actual median time). The average amount of time spent on the 30 no action dispositions was 4.3 minutes, with a range of time from 0 to 65 minutes.

Univariate reporting of the reasons for the various dispositions is not very meaningful: knowing the reason without matching it to a disposition yields little information. Therefore, an account of the reasons officers gave for their actions will follow in the section on bivariate analyses.

Table 2 includes information on the characteristics of the suspects encountered by the police. The information includes the suspect's age, sex, race/ethnicity, whether the suspect was known on sight by the officer, whether the suspect was known to have a criminal history, whether the suspect was known to have a history of mental illness, residence type, employment status, and behavioral characteristics.

<table>
<thead>
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<th>Age</th>
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<td>31-35</td>
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Table 2. Suspect Characteristics (cont.)

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**Known on Sight**

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**Known Criminal History**

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Table 2. Suspect Characteristics (cont.)

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<td>Apartment/Condominium</td>
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<td>Shelter</td>
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<tr>
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<td>Self-employed</td>
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<td>0.7</td>
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<tr>
<td>Missing</td>
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<td><strong>Behavior</strong></td>
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<td>Assaultive/Violent</td>
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<td>Loud/Obnoxious</td>
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<td>Bizarre</td>
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<td>Crying/Tearful</td>
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<td>Confused</td>
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<td>18.9</td>
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<td>Passive</td>
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Table 2. Suspect Characteristics (cont.)

<table>
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<th>Behavior (cont.)</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>Intoxicated (drugs or alcohol)</td>
<td>43</td>
<td>29.1</td>
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<tr>
<td>Scared</td>
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<tr>
<td>Incoherent</td>
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<td>10.8</td>
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<td>Cooperative</td>
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<td>29.7</td>
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<tr>
<td>Injuries to Self</td>
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<td>3.4</td>
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<tr>
<td>Embarrassed/Ashamed</td>
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<td>4.1</td>
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<td>Depressed</td>
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<td>Agitated</td>
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<td>17.6</td>
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<tr>
<td>Untidy</td>
<td>50</td>
<td>33.8</td>
</tr>
<tr>
<td>Non-communicative</td>
<td>15</td>
<td>10.1</td>
</tr>
</tbody>
</table>

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*: Includes mixed race/ethnicity. For example, a suspect who was described as White, Filipino, Chinese, Black, Thai was classified as "other." Even though the instructions on the forms asked officers to circle only one race/ethnicity, 20.3 percent of the forms indicated more than one race/ethnicity.

Suspects ranged in age from 17 to 84 years. The mean age was 42.2 with a median of 39. Only 17.6 percent of the suspects were over the age of 50 years.

Nearly two-thirds (64.2) of the suspects were male, 35.1 percent female, and one incident form did not include information on the suspect's sex. The greatest number of suspects were Caucasian, followed by Hawaiian/part-Hawaiian and Filipino.

Many (63.5 percent) of the suspects were recognized by the officers, while 36.5 percent of the suspects were previously unknown to the officers. The majority of the suspects (56.1 percent) were known to have a criminal record and 50.7 percent were known to have a history of mental illness.
Nearly three of every four suspects were homeless, and only 2 percent lived in a shelter. Just under 15 percent of the suspects were residents in a single-family dwelling, with an additional 6.8 percent who lived in an apartment or condominium.

Most of the suspects encountered by the police were unemployed: 86.5 percent. Only 6.1 percent of the suspects were known to be employed either full- or part-time.

The conduct most frequently presented by suspects included loud and obnoxious behavior and untidiness, followed by being cooperative and drug and/or alcohol intoxication. Most of the suspects displayed multiple symptoms/behaviors: the incident forms for 22 suspects listed one behavior; two behaviors were circled for 45 suspects; three behaviors for 35 suspects; four behaviors for 24 suspects; five behaviors for 10 suspects; six behaviors for 8 suspects; seven behaviors for 2 suspects; nine behaviors for 1 suspect; and zero behaviors for 1 suspect.

The incident reporting form included four characteristics of the officer who completed the form. While it may be possible to determine approximately how many individual officers completed forms by comparing individual characteristics and handwriting, no such effort was made. These data represent officers completing forms, not individual officers participating in the study (that is, an officer who completed five forms will be counted five times). The univariate statistics for the officer characteristics are reported below in Table 3; however, the greatest meaning for those data are described in the bivariate and multivariate analyses.
Table 3. Officer Characteristics

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-25</td>
<td>12</td>
<td>8.1</td>
</tr>
<tr>
<td>26-30</td>
<td>27</td>
<td>18.2</td>
</tr>
<tr>
<td>31-35</td>
<td>37</td>
<td>25.0</td>
</tr>
<tr>
<td>36-40</td>
<td>35</td>
<td>23.6</td>
</tr>
<tr>
<td>41-50</td>
<td>22</td>
<td>14.9</td>
</tr>
<tr>
<td>Missing</td>
<td>15</td>
<td>10.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>11</td>
<td>7.4</td>
</tr>
<tr>
<td>Male</td>
<td>120</td>
<td>81.1</td>
</tr>
<tr>
<td>Missing</td>
<td>17</td>
<td>11.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaiian/part-Hawaiian</td>
<td>33</td>
<td>22.3</td>
</tr>
<tr>
<td>Caucasian</td>
<td>30</td>
<td>20.3</td>
</tr>
<tr>
<td>Japanese</td>
<td>11</td>
<td>7.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>8</td>
<td>5.4</td>
</tr>
<tr>
<td>African-American</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Filipino</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Korean</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Other Asian</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Other Mixed Asian</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Other*</td>
<td>29</td>
<td>19.6</td>
</tr>
<tr>
<td>Missing</td>
<td>20</td>
<td>13.5</td>
</tr>
</tbody>
</table>
Table 3. Officer Characteristics (cont.)

<table>
<thead>
<tr>
<th>Years in the Police Department</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1.9</td>
<td>11</td>
<td>7.4</td>
</tr>
<tr>
<td>2.0-3.9</td>
<td>23</td>
<td>15.5</td>
</tr>
<tr>
<td>4.0-4.9</td>
<td>25</td>
<td>16.9</td>
</tr>
<tr>
<td>5.0-5.9</td>
<td>30</td>
<td>20.3</td>
</tr>
<tr>
<td>6.0-8.9</td>
<td>19</td>
<td>12.8</td>
</tr>
<tr>
<td>9.0-24.9</td>
<td>14</td>
<td>9.5</td>
</tr>
<tr>
<td>25.0-28.0</td>
<td>12</td>
<td>8.1</td>
</tr>
<tr>
<td>Missing</td>
<td>14</td>
<td>9.5</td>
</tr>
</tbody>
</table>

N 148

*: For example, one officer circled White and Japanese; another officer wrote in Hawaiian, Portuguese, French, German, Irish, English; several officers circled Other, but did not write in their race/ethnicity.

The average age of the officers completing forms was 34.7 years, with a median age of 34. The youngest officer was 24, the oldest 50. Fifteen officers, 10.1 percent of the total, did not complete the age section of the form.

Most of the officers were male: 81.1 percent, versus 7.4 percent female. Seventeen officers, accounting for 11.5 percent of those who return forms, did not complete the section of the form for officer sex. There was a fairly equal distribution of officers by race/ethnicity between Hawaiian/part-Hawaiian, Caucasian, and "other."

Officers ranged in years of experience from 1 to 28. The average number of years in the department was 7.9, with a median of 5 years.
B. Bivariate Statistics

Bivariate analyses of the data presented above are used for hypothesis testing (see Research Hypotheses, Chapter 1, p. 17-18): each of the eight hypotheses are stated as bivariate relationships. The CROSSTABS procedure was used to run the analyses in SPSS/PC+ Version 5.0. Bivariate relationships which have an *alpha* level of .05 or less (*p* ≤ .05) are considered statistically significant for the purpose of hypothesis testing.

The first hypothesis tests a labeling perspective and states: "Adults with a serious mental illness and a known criminal history will be more likely to be arrested than apparently mentally ill persons without such a history." To test this hypothesis, each of the eight dispositions available to the police were transformed to dichotomous, dependent variables (coded 0=No, 1=Yes) and crosstabulated with the dichotomous independent variable of known criminal history (also coded 0=No, 1=Yes). In addition to obtaining cell frequencies, the procedure yielded two measures for testing the hypothesis: the Pearson chi-square (*χ*²) test for independence and the phi (*φ*) coefficient measure of association. Table 4 shows the relationship between the known criminal history with each of the eight dispositions available to the police.
Table 4. Relationship Between Known Criminal History and Dispositions

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Known Criminal History</th>
<th>No</th>
<th>Yes</th>
<th>$\chi^2$</th>
<th>$\phi$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Arrest - Police Cell Block</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>19</td>
<td></td>
<td>9.62*</td>
<td>.25*</td>
</tr>
<tr>
<td><strong>Arrest - Hospital ER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>2</td>
<td></td>
<td>.50*</td>
<td>.10</td>
</tr>
<tr>
<td><strong>Voluntary Transport</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>2</td>
<td></td>
<td>1.00b</td>
<td>.02</td>
</tr>
<tr>
<td><strong>MH1 - Oral Ex Parte</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>59</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>2</td>
<td></td>
<td>.14c</td>
<td>.15</td>
</tr>
<tr>
<td><strong>Call Support Agency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>64</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>83</td>
<td>0</td>
<td></td>
<td>.44d</td>
<td>.09</td>
</tr>
<tr>
<td><strong>Informal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
<td>41</td>
<td></td>
<td>.52</td>
<td>.06</td>
</tr>
<tr>
<td><strong>No Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>49</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>69</td>
<td>14</td>
<td></td>
<td>1.35</td>
<td>.10</td>
</tr>
<tr>
<td><strong>Other Disposition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>64</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>80</td>
<td>3</td>
<td></td>
<td>.63*</td>
<td>.06</td>
</tr>
</tbody>
</table>

$N = 148$

*p < .01
Among those who were arrested, 86.4 percent were known to have a criminal history. The only bivariate relationship of statistical significance was that in which a suspect with a known criminal history was arrested and taken to the police cell block. The chi-square value of 9.62 was significant with \( p = .00192 \); the value for phi (.25) was also statistically significant. Prior research on police discretion has not utilized an officer's prior knowledge of a suspect's criminal record to explain the officer’s decision to invoke a given disposition. However, these results are what would be expected from a labeling perspective and are consistent with general descriptions of how police view suspects (Kitsuse 1962; Mercer 1965; Daudistel and Sanders 1974; Black 1976; Sykes and Brent 1983; Bittner 1990). Therefore, we cannot reject the hypothesis that there is a stronger relationship between known criminal history and arrest than the other dispositions available to the police.

However, it is important to note that while the chi-square value indicates that the relationship is not due to chance, it does not measure the strength of the relationship. When squared, the value of phi can be interpreted as a proportional reduction in error (PRE) measure (see Endnote 2). The result is that knowing a suspect has a criminal history reduces the error in predicting the suspect will be arrested by only 6.25 percent (.25\(^2\)).

One of the factors which influences the explanatory value of knowing whether a suspect with a criminal history will be arrested is the nature of the offense: it is logical to assume that a suspect who commits a felony or who has a warrant for his or her arrest is more likely to be arrested regardless of whether the criminal history is known to the officer. This, indeed, is the case: of the 22 suspects who were arrested during the course of this...
study, 8 (36.4 percent) had outstanding warrants for contempt and, of course, all were known to have a criminal record.

The second hypothesis, which tests a labeling perspective, states: "Adults with a
serious mental illness and a known history of mental illness will be less likely to be
arrested than apparently mentally ill persons without such a history." This hypothesis is
tested by measuring the bivariate relationship between known history of mental illness and a
dichotomous variable for the non-arrest/arrest option. The results are found in Table 5.

Table 5. Relationship Between Known History of Mental Illness and Non-Arrest/Arrest

<table>
<thead>
<tr>
<th>Known History of Mental Illness</th>
<th>No</th>
<th>Yes</th>
<th>( \chi^2 )</th>
<th>( \phi )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>6</td>
<td>5.66*</td>
<td>.20*</td>
</tr>
<tr>
<td>No</td>
<td>57</td>
<td>69</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\( N = 148 \)
\( ^* p \leq .02 \)

During the course of this study, 92.0 percent of the suspects police identified as
having a mental illness were the subject of a disposition other than arrest. The bivariate
relationship between known history of mental illness and the non-arrest/arrest option was
statistically significant (\( p = .02 \)), and therefore, we cannot reject the hypothesis. However,
the relationship is not particularly strong: the PRE interpretation of phi (\( \phi^2 \)) suggests that
knowing a suspect has a history of mental illness reduces the error in predicting the non-
arrest/arrest dispositions by 4 percent. The influence of prior knowledge of a suspect's
history of mental illness on the police officer's decision to invoke a given disposition has been
discussed (esp. Matthews 1970; Teplin 1984b), but not quantified.
The third hypothesis tests an attribution perspective, and states: "Adults with a serious mental illness who are aggressive, violent, or uncooperative are more likely to be arrested than receive the other dispositions available to the police." Police officers had the opportunity to select any of 17 behaviors (see Appendix A) to describe suspects for this study. To test this hypothesis, the bivariate relationships between the dichotomous dependent variable, arrest/non-arrest, and the two behavioral variables are measured: assaultive/violent behavior and uncooperative. The behavioral variables were coded 0 if the behavior was not present and 1 if the behavior was present. The relationships are displayed in Table 6.

Table 6. Relationship Between Behavior and Arrest/Non-Arrest

<table>
<thead>
<tr>
<th>Behavior</th>
<th>No</th>
<th>Yes</th>
<th>$\chi^2$</th>
<th>$\phi$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assaultive/Violent Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>114</td>
<td>16</td>
<td>5.52*</td>
<td>.19*</td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncooperative Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>14</td>
<td>5.13*</td>
<td>.19*</td>
</tr>
<tr>
<td>Yes</td>
<td>20</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N = 148
*p < .02

Suspect demeanor has been found to influence the outcome of interactions with the police (e.g. see Goldstein 1960; La Fave 1962; Bittner 1967, 1974; Matthews 1970; Lundman 1979; Monahan et al. 1979; Bonovitz and Bonovitz 1981; Sheridan and Teplin 1981; Smith and Visher 1981; Teplin 1984b; Menzies 1987): suspects who are cooperative and passive are generally less likely to encounter coercive sanctions than those who are violent and
aggressive. The relationship between a suspect's assaultive/violent behavior and arrest is significant at an *alpha* level of .02. The relationship, however, is not strong: one-third of the suspects who were assaultive or violent were arrested, and the PRE interpretation of phi suggests that knowing a suspect is assaultive or violent reduces the error in predicting arrest by 3.6 percent.

Similarly, the relationship between a suspect's uncooperative behavior and arrest is also statistically significant, but not strong. Of the 28 suspects who were uncooperative, 28.6 percent were arrested, with a PRE interpretation of phi equal to 3.6 percent. However, based on the relative strength of the relationship between both assaultive/violent behavior and uncooperative behavior on the likelihood of arrest, the third hypothesis cannot be rejected.

Hypothesis 4, which tests attribution theory, states: "For adults with a serious mental illness, males will be more likely to be arrested than females." The results of testing the relationship between the dichotomous variables of suspect's sex and the arrest/non-arrest options are found in Table 7.

**Table 7. Relationship Between Suspect Sex and Arrest/Non-Arrest**

<table>
<thead>
<tr>
<th>Suspect Sex</th>
<th>Arrest</th>
<th>( \chi^2 )</th>
<th>( \phi )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>No</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Yes</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Yes</td>
<td>16</td>
<td>.74</td>
</tr>
<tr>
<td>Female</td>
<td>No</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Yes</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Among the 22 suspects who were arrested and taken to the police cell block, 72.7 percent were male, 27.3 percent female; 11.5 percent of the male suspects were arrested, as were 16.8 percent of the female suspects. Slightly more than one-third (35.4 percent) of the suspects in the study were identified as female.
The bivariate relationship between suspect sex and arrest is not statistically significant; therefore, we can reject hypothesis number 4. It appears for these data that males are treated no more severely than females. This finding is consistent with, though stated differently than, Visher's (1983) research: females are treated no more leniently than males.

The fifth hypothesis also evaluates an attribution perspective, and states: "Adults with a serious mental illness who are employed full- or part-time are less likely to be arrested than apparently mentally ill persons who are unemployed." This hypothesis is tested by comparing a dichotomous dependent variable for informal disposition (coded 0=No, 1=Yes) with three employment statuses transformed to dummy variables: employed full-time (coded 0=No, 1=Yes), employed part-time (coded 0=No, 1=Yes), and unemployed (coded 0=No, 1=Yes). The results are found in Table 8.

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Informal Disposition</th>
<th>( \chi^2 )</th>
<th>( \phi )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full- or part-time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>60</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>2</td>
<td>3.37</td>
</tr>
</tbody>
</table>

\( N = 139 \)

The employment variable is highly skewed: excluding cases where the police officer did not know the employment status, 93.5 percent of the suspects were unemployed. For the nine suspects who were employed full- or part-time, two (40 percent) were dealt with informally. This relationship was not significant for chi-square, phi, or Fisher's Exact Test (which is computed by SPSS/PC+ instead of phi where cell frequency is five or fewer cases): \( p = .07 \). Based on this bivariate analysis, we can reject the fifth hypothesis. Employment
status has not been used as an explanatory variable in previous research on police discretion in dealing with the mentally ill, and, because of the skewness, employment is not a useful explanatory variable in this research.

Attribution theory is measured by the sixth hypothesis, which states: "Adults with a serious mental illness who live in a private residence (house, apartment, condominium, or hotel) are more likely to receive an informal disposition than apparently mentally ill persons who live in a shelter or who are homeless." To test this hypothesis, two bivariate relationships will be measured using the dichotomous dependent variable of informal dispositions (coded 0=No, 1=Yes): one combining three residence types (house, N=22; apartment or condo, N=10; and hotel, N=1), the other combining two residence types (shelter, N=3 and homeless, N=109). The results of these analyses are found in Table 9.

Table 9. Relationship Between Residence Type and Informal Dispositions

<table>
<thead>
<tr>
<th>Residence Type</th>
<th>Informal Disposition</th>
<th>No</th>
<th>Yes</th>
<th>χ²</th>
<th>φ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>49</td>
<td>66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>22</td>
<td>11</td>
<td>5.94*</td>
<td>.20*</td>
</tr>
<tr>
<td>Shelter/Homeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>25</td>
<td>11</td>
<td>8.79**</td>
<td>.24**</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>46</td>
<td>66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N = 148
*p ≤ .01   **p ≤ .003

One-third of the suspects who lived in a private residence were handled informally. The relationship is significant, with an alpha level equal to .01. Approximately 4 percent of
the error in predicting an informal disposition is reduced by knowing that the suspect resides in a single-family dwelling, apartment or condo, or hotel.

Nearly 60 percent (58.9 percent) of the suspects who lived in a shelter or who were homeless were treated informally, resulting in a significance level of .003. The value of phi corresponds to a PRE value of 6 percent.

Based on these analyses, it appears that suspects who live in a shelter or who are homeless are more likely to be treated informally than those who live in a house, apartment or condo, or hotel. Therefore, we can reject the seventh hypothesis. Residence type has not been used as an explanatory variable in previous research on police discretion in dealing with persons with a mental illness.

The data on employment status (Table 8) and residence type (Table 9) are both skewed, though the latter is not as profound as the former. These data do illustrate, however, an important feature of police work as it relates to dealing with persons who have a mental illness. The mentally ill people that police are dealing with are almost exclusively the homeless, unemployed mentally ill. Persons with a mental illness who live in a private residence and who may be employed are more likely to have a support system to help prevent publicly disruptive behavior, or have a private physician who can intervene.

Hypothesis number 7 states: "For adults with a serious mental illness, the strength of the relationship between the offense and arrest will increase with the severity of the offense." To test this hypothesis, the 19 offenses for which suspects came to the attention of the police (see Table 2) were grouped into five categories and coded as follows: 0=None; 1=Violation; 2=Petty Misdemeanor; 3=Misdemeanor; and 4=Class C Felony. Disorderly conduct (HRS § 711-1101), which can be treated as either a violation or a petty misdemeanor,
is coded as a violation.\textsuperscript{4} Table 10 reveals the relationship between severity of offense and arrest/non-arrest.\textsuperscript{5}

Table 10. Relationship Between Severity of Offense and Arrest/Non-Arrest

<table>
<thead>
<tr>
<th>OFFENSE</th>
<th>NO</th>
<th>YES</th>
<th>$\chi^2$</th>
<th>Tau-\textit{y}\textsuperscript{a}</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>67</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violation</td>
<td>45</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Misdemeanor</td>
<td>7</td>
<td>2</td>
<td>68.76*</td>
<td>.47*</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>5</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class C Felony</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\begin{itemize}
  \item N = 147
  \item *p < .001
\end{itemize}

\textsuperscript{a}: Goodman and Kruskal’s tau-\textit{y} is an appropriate measure of association for nominal variables. Unlike lambda, which is concerned with predicting the mode of the dependent variable and is thus affected by skewness, Goodman and Kruskal’s tau-\textit{y} is concerned with predicting the distribution of the dependent variable. Like lambda, Goodman and Kruskal’s tau-\textit{y} has a PRE interpretation; also like lambda, two values are computed, one with the row variable as dependent, the other with the column variable dependent (Loether and McTavish 1988; Norusis 1992). The value for tau-\textit{y} in Table 10 is for arrest/non-arrest as the dependent variable.

The relationship between the severity of the offense and the decision to arrest or not is both highly significant and moderately strong. The PRE interpretation of Goodman and Kruskel’s tau-\textit{y} suggests that errors predicting whether someone will be arrested can be reduced by 47 percent by knowing the severity of offense. These results are consistent with other studies (e.g., see Goldstein 1960; La Fave 1962; Bittner 1967, 1974; Matthews 1970; Lundman 1979; Monahan et al. 1979; Bonovitz and Bonovitz 1981; Sheridan and Teplin 1981; Smith and Visher 1981; Teplin 1984b; Menzies 1987) and, based on the bivariate relationship, we cannot reject the hypothesis.
It is interesting to note that only one-third of those who committed a class C felony were arrested. An examination of those three cases reveals that the suspect who was arrested and taken to police cell block committed the offense of assault in the second degree (HRS § 707-711), which involves causing bodily injury to another person with a dangerous instrument. The other two felonies did not involve bodily injury: one suspect was arrested on an escape in the second degree charge and returned to the state hospital; and one suspect was arrested for disorderly conduct and taken to the hospital emergency room.

The eighth, and final, hypothesis, states: "For adults with a serious mental illness, there will be an inverse relationship between the severity of the disposition and the number of years of experience for police officers." The expectation is that the more years of experience an officer has, the more likely he or she will utilize informal dispositions. In order to test this bivariate relationship between informal dispositions and years of experience, it is necessary to transform both variables into ordinal level measures. Dispositions were ordered and coded by relative degree of severity: 1 = No Action, 2 = Informal, 3 = Call Support Agency, 4 = Voluntary Transport, 5 = MH1, 6 = Arrest to Hospital ER, and 7 = Arrest to Police Cell Block. Years of experience were grouped to approximate a normal distribution of those officers who participated in the study and were coded as they appear in Table 3. Missing data were not included.

In addition to the chi-square test of independence, three separate measures of association appropriate for ordinal level data were used: gamma, Somers’ d, and tau-b. Gamma is a frequently used measure of association. Gamma is a symmetric measure: no distinction is made between the dependent and independent variable. The computation of gamma excludes all tied scores; that is, where all possible values of both variables are considered in pairs, those that are tied are not taken into account with gamma.
Somers' d is calculated both as a symmetrical measure and each variable dependent.

Somers' d takes into account ties on the dependent variable and all untied pairs.

Tau-b is a symmetric measure, but, unlike gamma, takes into account ties on variable X or variable Y, but not ties on both variables. All three measures of association are PRE measures (for a good discussion of gamma, Somers' d, and tau-b, see Loether and McTavish 1988 or Norušis 1992). Table 11 compares the three measures of association.

Table 11. Relationship Between Severity of Sanction and Police Officer Years of Experience

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>86.59</td>
<td>42</td>
<td>.0006</td>
</tr>
<tr>
<td>Gamma</td>
<td>-.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somers' d</td>
<td>-.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tau-b</td>
<td>-.27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N = 134

The chi-square value indicates this relationship is highly significant: the probability of getting a chi-square value of 94.45 with 49 degrees of freedom by chance are roughly 1 in 1,667. While the three measures of association vary in strength, all three share the same sign. Interestingly, an officer’s experience has not been used previously to explain which disposition they choose to invoke. Prior research has come close in several instances, examining an officer’s skill in dealing with aggressive behavior (Bayley and Garofalo 1989), an officer’s age in deciding to engage in a high speed pursuit (Homant et al. 1993), the age differential between officer and suspect (Sykes and Brent 1983), mean number of years of officer experience as a property of police agencies (Smith and Klein 1983), and learning how to handle cases through on-the-job training (Niederhoffer 1967). Based on the data in Table 11, we can conclude: 1) the relationship between severity of sanction and police officer years of experience...
of experience is an inverse one (that is, as years of experience increase, the level of severity tends to decrease); 2) the reduction in the amount of error in predicting the level of severity by knowing the officer's years of experience is reduced in the range of 24 percent to 35 percent, the mid-point of which is approximately equal to the value of tau-b; and 3) we cannot reject the hypothesis which states there is an inverse relationship between the two variables.

This relationship is explored further in the qualitative analysis section of the next chapter. What this analysis seems to suggest, however, is that more experienced officers either have a greater repertoire of ways of dealing with mentally ill persons that do not require formal sanctions or, at least, are more comfortable utilizing those options. An alternative explanation is that the more experience an officer has, the less likely he or she will want to "waste" time dealing with the mentally ill. However, additional analysis reveals that this is not the case: an officer's experience is not significantly related to the amount of time the officer is willing to spend with someone who has a mental illness ($\chi^2 = 205.0, df = 186, p = .16$). There is a significant relationship between an officer's age and the amount of time he or she spends invoking a given disposition, but the relationship is direct: the older an officer is, the more time he or she spends with a suspect ($\chi^2 = 148.0, df = 120, p = .04$).

There are three additional bivariate relationships which are both statistically significant and interesting from the standpoint of trying to explain police discretion in imposing various dispositions. The first relationship involves the eight dispositions (including "other") and the eight police districts. The district in which an incident occurred may actually be a proxy for two explanations of police discretion: differing policies among districts within the same department and differing community pressures. The actual source(s) of inter-district differences will be explored in the qualitative analysis section of the next chapter.
Few studies have examined either of the two explanations of police discretion. The influence of departmental organization and policies was studied by Skolnick (1966; delegated versus unauthorized discretion), Reiss and Bordua (1967; organizational structure, leading to a reactive versus a proactive strategy and a subordinate structure), Lundman (1979; organizational norms), and Smith and Klein (1983; police agency types and degree of bureaucratization). Several studies have addressed the influence a particular community may have on police decision making: Erikson (1962; community norms setting the boundaries for deviant behavior), Kitsuse (1962; shifting the focus from the forms of deviant behavior to the process by which the police and the community define and respond to publicly offensive behavior), and Smith (1986; influence of neighborhood characteristics). In addition to the chi-square statistics, values are reported for Cramer's V (which is computed by SPSS/PC+ for phi in tables larger than 2 X 2) and Goodman and Kruskal's tau, with disposition as the dependent variable. The results are reported below in Table 12.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>106.76</td>
<td>42</td>
<td>.00000</td>
</tr>
<tr>
<td>Cramer's V</td>
<td>.35</td>
<td></td>
<td>.00000</td>
</tr>
<tr>
<td>Tau</td>
<td>.15</td>
<td></td>
<td>.00000</td>
</tr>
</tbody>
</table>

N = 148

The relationship between disposition and police district is both significant and revealing. An examination of the crosstabulations reveal that 45.5 percent of the 22 arrests took place in District 6 (Waikiki), and 64.9 percent of the 77 informal dispositions and 66.7 percent of the 30 no action dispositions occurred in District 5 (Kalihi-Airport).
Approximately 12-15 percent of the error in predicting disposition is reduced by knowing the
district in which the event took place.

A second bivariate relationship of interest concerns disposition and the race/ethnicity
of the suspect. While race has been shown to be an important explanatory variable in a
number of studies (e.g. Black and Reiss 1970; Black 1971; Lundman et al. 1978; LaFree
1981; Smith and Visher 1981; Fishman et al. 1987; Bridges et al. 1987), race/ethnicity does
not appear overall to be an important factor in predicting who will receive the different
sanctions in this study. Table 13 compares the three most commonly-used dispositions (arrest
to police cell block, informal, and no action) with the three most commonly-identified groups
(Caucasian, Hawaiian/part-Hawaiian, and Filipino).

Table 13. Relationship Between Disposition and Suspect's Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Caucasian</th>
<th>Hawaiian/part-Hawaiian</th>
<th>Filipino</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of All Suspects</td>
<td>47.6</td>
<td>12.4</td>
<td>9.7</td>
</tr>
<tr>
<td>% of All Arrests</td>
<td>50.0</td>
<td>9.1</td>
<td>4.5</td>
</tr>
<tr>
<td>% of All Informal Dispositions</td>
<td>51.4</td>
<td>10.8</td>
<td>5.4</td>
</tr>
<tr>
<td>% of All No Action Dispositions</td>
<td>56.7</td>
<td>13.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Chi-Square</td>
<td></td>
<td>233.81 (91 df)*</td>
<td></td>
</tr>
<tr>
<td>Cramer's V</td>
<td></td>
<td>.48*</td>
<td></td>
</tr>
<tr>
<td>Tau</td>
<td></td>
<td>.11</td>
<td></td>
</tr>
</tbody>
</table>

N = 145
* p ≤ .00000

Caucasians are slightly more likely to be arrested than their numbers in the general
population would predict, while Hawaiians/part-Hawaiians and Filipinos are somewhat less
likely. Caucasians are also more likely to be treated informally or have no action taken,
while both Hawaiians/part-Hawaiians and Filipinos are less likely to be treated informally, but
more likely to have no action taken. However, the differences for Filipinos between their overall representation among suspects and percentage of all informal and no action dispositions is more dramatic than for Hawaiians/part-Hawaiians.

Both chi-square and Cramer’s V are significant; the PRE interpretation of Cramer’s V equals a 23 percent reduction in error. However, tau was not significant (.09) with disposition dependent, but was significant (.08, \( p = .00007 \)) with suspect’s race dependent. Lambda values (not reported in Table 13), with disposition dependent, were also weak (.07, or 7 percent proportionate reduction in error).

In order to better understand the relationship between suspect’s race/ethnicity and disposition, each race/ethnicity category was transformed into a dummy variable (0=No, 1=Yes) and crosstabulated with disposition. Only two race/ethnicities were significantly related to disposition: Filipino (\( \chi^2 = 24.95, 7 \text{ df}, p = .0008; \phi = .41, p = .0008; \tau \text{ (disposition dependent)} = .02, p = .006 \)) and Tongan; however, there was only one Tongan, for whom a support agency was called. In general, then, it is safe to say that the suspect’s race/ethnicity did not play an important role in choosing dispositions.

A significant relationship also exists between the police officer’s age and disposition: \( \chi^2 = 281.47, 168 \text{ df}, p = .00000; \text{Cramer’s V} = .55, p = .00000; \tau \text{ (disposition dependent)} = .39, p = .00000 \). This is not surprising, given the facts that 1) years of police experience is significantly related to disposition (see the discussion of Hypothesis 8, above), and 2) police officer’s age is strongly correlated to years of police experience: Pearson product-moment correlation coefficient equals .76 with an alpha level of .001 (ungrouped data)\(^7\).

What is surprising is that the relationship between the police officer’s age and severity of the disposition is much weaker than years of experience and is positive. When officers’
ages are grouped (see Table 3) and crosstabulated with dispositions ranked by severity (see Hypothesis 8), the results are those found in Table 14.

Table 14. Relationship Between Severity of Disposition and Police Officer’s Age

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>62.36</td>
<td>28</td>
<td>.0002</td>
</tr>
<tr>
<td>Gamma</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somers’ d</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tau-b</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N = 133

While the relationship between severity of disposition and age of officers is statistically significant, it is not important. Years of experience in police work is a much stronger variable in explaining which dispositional option will be invoked than the age of the officer.

One final set of bivariate relationships is worth mentioning. The most controversial aspect of data collection for police officers concerned recording their own race/ethnicity. This concern centered around the possibility of claims of differential treatment based on race. This concern proved to be unfounded. The relationship between officer race/ethnicity and disposition severity was not significant, nor was the relationship significant when controlled for the race/ethnicity of the suspect.

The primary weakness of trying to understand police discretion to impose various dispositional options through bivariate analysis is that any given situation involving a police officer and a citizen who has a mental illness is influenced by a number of factors simultaneously. While the bivariate analyses indicated that some factors have more explanatory power than others, the best model for explaining police behavior is developed...
through a process of simultaneously analyzing the effects of multiple independent variables. This process of multivariate analysis is discussed in the section below.

C. Multivariate Statistics

A police officer's decision whether to arrest a suspect or invoke any of the other available dispositions is influenced by more factors than can be successfully analyzed by bivariate techniques. In order to measure the effects of numerous factors simultaneously and independently, it is necessary to utilize multivariate statistical techniques.

Separate analyses will be done for each of the three most frequently occurring dispositions: arrest, informal, and no action. Since the dependent variables are dichotomous and the independent variables categorical or continuous, the data are analyzed using logistic regression, which is designed for use with a dichotomous dependent variable. In logistic regression, parameters of the model are estimated using a maximum likelihood procedure. The logistic coefficients can be interpreted as the odds of an event, such as arrest, occurring. For example, a logistic coefficient of known criminal history has a value of 1.17; when the value of known criminal history changes from 0 (no known history) to 1 (known history), and the values of the other independent variables are held constant, the log odds of arrest increase 1.17. Logistic regression also produces significance levels for each coefficient and a goodness of fit of the model classification table. The table compares predictions based on the model with the observed outcomes and yields a percentage of correctly predicted outcomes (Norusis 1990).

For each of the three dispositions, the parameters of several different models were estimated by manipulating the entry of the independent variables. All independent variables
that were statistically significant in bivariate relationships with the dependent variables were eligible for entry into the models; in addition, non-significant but theoretically relevant independent variables were also included in the development of models. Redundant or strongly correlated independent variables were entered separately, but not together: both officers' age and years of experience (Pearson's Product-Moment Correlation = .76, \( p \leq .001 \)) were tested in models, but were not included in the same model; similarly, only the district with the most explanatory power was included in each model (that is, a single model would not include variables for "not in Waikiki", "not in Waianae", and "not in Downtown").

Table 15 compares four models which estimate the likelihood of arrest.

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 ( N = 134 )</td>
</tr>
<tr>
<td>Misdemeanor Offense</td>
<td>4.17*** (.86)</td>
</tr>
<tr>
<td>Officer Years of Experience</td>
<td>-.26* (.13)</td>
</tr>
<tr>
<td>Known Criminal History</td>
<td>1.85** (.89)</td>
</tr>
<tr>
<td>Occurred in Waikiki</td>
<td></td>
</tr>
<tr>
<td>Percent Correctly Classified</td>
<td>93.28%</td>
</tr>
</tbody>
</table>

Note: All models estimated with constant (not shown). Standard errors in parentheses.

* \( p < .05 \)  ** \( p < .01 \)  *** \( p < .001 \)

All four models are highly accurate in predicting which suspects will be arrested, and all are parsimonious. Model 1, which correctly classifies 93.28 percent of the cases, is the most accurate and relies on only three variables: whether the offense was a misdemeanor,
officer's years of experience (inversely related to arrest), and whether the suspect was known to have a criminal history.

Of the 134 cases used for this analysis, 98.25 percent of those not arrested were correctly classified and 65.00 percent of those who were arrested were correctly classified. Model 1 included two false positives (predicted to be arrested who were not) and seven false negatives (predicted not to be arrested who were). Diagnostics of the residuals (classification errors) indicate that Model 1 does not work well in cases where the suspect was arrested for a violation or petty misdemeanor, or a class C felony: six of seven and one of seven false negatives, respectively. Both false positives committed misdemeanors, one of whom had a known criminal history.

Table 16 compares four models that predict which suspects receive an informal disposition. The models do not fare as well as those that predict arrest; informal sanctions are not applied as consistently as the formal, arrest sanction.
Table 16. Multivariate Logistic Regression Models of Informal Sanctions

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>N = 134</td>
</tr>
<tr>
<td>Violation Offense</td>
<td>1.99** (.62)</td>
</tr>
<tr>
<td>No Offense</td>
<td>1.42* (.60)</td>
</tr>
<tr>
<td>Occurred in Waikiki</td>
<td>-2.69** (1.08)</td>
</tr>
<tr>
<td>Shelter Resident or Homeless</td>
<td>.89 (.47)</td>
</tr>
<tr>
<td>Officer Years of Experience</td>
<td>-.04 (.03)</td>
</tr>
<tr>
<td>Misdemeanor Offense</td>
<td>-1.58 (.84)</td>
</tr>
<tr>
<td>Percent Correctly Classified</td>
<td>76.87%</td>
</tr>
</tbody>
</table>

Note: All models estimated with constant (not shown). Standard errors in parentheses. * p < .05 ** p < .01 *** p < .001

Model 1 correctly classified 76.87 percent of the cases using five explanatory variables. Suspects who committed a violation or no offense, lived in a shelter or were homeless, and were in a district other than Waikiki, were the most likely to receive an informal sanction. The likelihood of this outcome was increased the fewer years an officer had with the police force, though the inverse influence of years of experience did not contribute as much to this model as the model predicting arrest.

A total of 71.64 percent of those who did not receive an informal sanction were correctly classified, while 82.09 percent of those who did receive an informal sanction were correctly classified. Nineteen suspects who were predicted to receive informal sanctions did not (false positives), and 12 suspects received informal sanctions who were not expected to
(false negatives). Analysis of the residuals reveals that including two offense categories (violation offense and no offense) strengthens the overall model. Those categories also account for nearly all of the false positives: all of the cases were either violations or there was no offense. On the other hand, most of the false negatives involved petty misdemeanors or misdemeanors; those cases involving a violation or no offense either took place in Waikiki, or involved a suspect who was not a shelter resident or homeless, or both.

Combining the two variables to produce one dichotomous variable, where 1 = either a violation or no offense and 0 = petty misdemeanor, misdemeanor, or class C felony, results in a logistic regression model which correctly predicts 75.37 percent of the cases, making it the second most accurate model. It may make some practical sense to combine the variables: the violation offense and no offense categories are similar in terms of level of severity, and, by combining them, all of the false positives are accounted for with the same variable. However, the indication on the form that no crime was committed is important in a theoretical sense and should not be subsumed in a category which includes violation offenses. There is little doubt that officers could have cited any or all of the individuals for whom the "no offense" designation applied; however, the officers approached the situation as if there was no intent to commit a crime, and, therefore, no official sanction was required.

During the course of this study, 20 percent of the officers took no action when they observed a person who they suspected had a mental illness doing something that could result in a citation or an arrest. The multivariate analysis involving the no action disposition is found in Table 17.
Table 17. Multivariate Logistic Regression Models of No Action

<table>
<thead>
<tr>
<th>Explanatory Variables</th>
<th>Models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>N = 134</td>
</tr>
<tr>
<td>Known on Sight</td>
<td>1.71**</td>
</tr>
<tr>
<td></td>
<td>(.61)</td>
</tr>
<tr>
<td>Officer Years of Experience</td>
<td>.09**</td>
</tr>
<tr>
<td></td>
<td>(.03)</td>
</tr>
<tr>
<td>No Offense Committed</td>
<td>1.46**</td>
</tr>
<tr>
<td></td>
<td>(.51)</td>
</tr>
<tr>
<td>Suspect Intoxicated</td>
<td>-1.11</td>
</tr>
<tr>
<td></td>
<td>(.71)</td>
</tr>
<tr>
<td>Percent Correctly Classified</td>
<td>82.84%</td>
</tr>
</tbody>
</table>

Note: All models estimated with constant (not shown). Standard errors in parentheses. *p < .05  **p < .01

Model 1 is the most parsimonious and accurate, successfully classifying 82.84 percent of the no action cases. Model 2 is equally accurate, but uses an additional variable with no net effect. Suspects who are known on sight, described by Teplin (1984b) as "neighborhood characters" and "quiet, unobtrusive 'mentals,'" (p. 170) and those who the police felt had no intent to violate the law are most likely to escape any type of police sanction. It is interesting to note that years of police experience has a positive effect on the probability of no action, whereas the effect was negative for informal dispositions and arrests. This effect suggests that younger officers are the most likely to engage persons with a mental illness, even if the result is an informal disposition, while officers with the most years of experience are the most likely to ignore, or take no actions against, persons with a mental illness.

The first model correctly classified 97.14 percent of the cases which did not involve no action and only 31.03 percent of those in which no action was taken. Model 1 created three false positives -- suspects who were predicted to receive no action who did not -- and 20
false negatives -- suspects who were predicted to receive a disposition other than no action who, in fact, received a no action disposition.

By plotting diagnostic statistics of the residual values on a casewise basis, it is possible to determine why the model does not apply to specific suspects. The three suspects who were predicted to receive no action actually received an informal disposition; otherwise, they fit the profile (known on sight, high number of years of experience, no offense committed). For the 20 suspects incorrectly classified as not receiving a no action disposition who, in fact, did, eight committed an offense, five were not known on sight, and nine of the officers had a low number of years of experience. Two suspects were not known on sight and committed an offense, yet no action was taken; one of the two also involved an officer with four years of experience, resulting in the most divergent residual.

Each of the three dispositions examined, using multivariate logistic regression, included an officer's years of experience and severity of offense variable in their respective models. An officer's lack of experience contributed more to the model predicting arrest than an informal disposition, while a more experienced officer was the most likely to take no action. The severity of the offense was directly related to the severity of the sanction: the model for the arrest disposition included misdemeanor offenses; informal dispositions included violations or no offenses; and no action included no offense. Knowledge of the suspect was an important explanatory variable in two models: a known criminal history was a factor in predicting arrest, while being known on sight (a "regular") contributed to the no action model.

While not measured directly, the bivariate and multivariate analyses revealed several important institutional components in understanding the conditions under which police invoke the different dispositions available to them. The finding that officers with the most experience
are the least likely to direct persons with a mental illness to either the criminal justice or mental health systems suggests that those options are either ineffective or discouraged, or both. Moreover, the finding that arrests were the most common in Waikiki while informal dispositions were used almost exclusively at the airport supports the findings from the qualitative analysis: there are important differences in police policies and practices at the district level. Moreover, the interview data explained the differences in community pressures placed on the police in the two districts, differences which were significant in the bivariate and multivariate analyses.

The next chapter analyzes the content of interviews with 11 police officers. The interviews were designed to explain and expand upon many of the results presented in this chapter.
ENDNOTES

1. Fisher's Exact Test is substituted for $\chi^2$ when the expected cell frequencies in two by two tables are too small. SPSS/PC+ automatically computes Fisher's Exact Test when expected cell frequencies are less than 5 (Norusis 1992; Loether and McTavish 1988; Bailey 1987).

2. Phi is a particularly useful measure of the strength of the relationship between two dichotomous variables. First, it is mathematically related to measures of association used for other levels of measurement, making it useful for comparisons. Second, phi can be given a proportional reduction of error (PRE) interpretation: the value of phi squared can be interpreted to mean how much the independent variable helps reduce error in predicting values of the dependent variable (Monette et al. 1990). SPSS/PC+ computes an observed significance level for phi based on the Pearson chi-square probability (Norusis 1992).

3. For this analysis, the arrest option includes only those arrests in which the suspect was taken to the police cell block. Included with the non-arrest options are the two arrests in which the suspect was diverted to the mental health system: one was an escapee from the state hospital and one was taken to the hospital emergency room. In the latter incident, there was no indication whether the suspect was taken to the cell block after the hospital, or released to the custody of the hospital. However, in both of these cases, the intent of the police officer appears to be to invoke a mental health system response versus a criminal justice response. This distinction is central to the purpose of the study.

4. HRS § 711-1101 describes disorderly conduct as a violation except in situations where "it is the defendant's intention to cause substantial harm or serious inconvenience, or if he persists in disorderly conduct after reasonable warning or request to desist (State of Hawaii 1985, p. 267). The intent of the statute appears to treat disorderly conduct as a violation unless these more extreme circumstances exist. In cases involving persons who have a mental illness, it is arguable that the suspect lacks intent; moreover, more suspects were described as cooperative (29.7 percent) than uncooperative (18.9 percent). The view that this group of suspects tends to be cooperative was also supported in interviews with police officers. Therefore, it seems more appropriate to include the offense of disorderly conduct with violations than petty misdemeanors.

5. The arrest options includes only those arrests in which the suspect was taken to the police cell block. See note 3, above.

6. Goodman and Kruskal's tau is a suitable, asymmetric measure of association for nominal variables. Tau is designed to predict the distribution of the dependent variable, whereas lambda, another common measure of association for nominal variables, is concerned with predicting the mode of the dependent variable. In
general, this makes lambda a poor choice for data which has pronounced skewness, such as the disposition variable (Loether and McTavish 1988; Norušis 1992).

7. The Pearson product-moment correlation coefficient is a symmetric measure of the strength of the linear relationship between interval level variables (Norušis 1992; Loether and McTavish 1988).
Eleven police officers from five of the eight police districts participated in structured and semi-structured interviews (see Appendix B for a list of interview questions). All of the interviews except one were tape recorded and transcribed verbatim. Overall, the officers were eager to talk and share their experiences of dealing with persons who have a mental illness.

All of the officers interviewed felt they could tell if someone was seriously mentally ill. The majority (63.5 percent) of the persons the police encountered were recognized by the officers, were known to be "criminals" (56.1 percent), and known to be "mentally ill" (50.7 percent). If the person was not known to the officers, and not known to have the label of "mentally ill," the officers could tell by talking with the person. An officer at the airport (25 years old, male, Caucasian, one and one-half years of experience) stated that mentally ill people are: "Homeless, disoriented, easily agitated. You can tell by the way they talk to you -- go off on tangents. One girl said she was being picked up by her dead brother, only I knew he was alive." Officers said they were usually able to differentiate between mental illness and alcohol and drug intoxication by smell and by examining the eyes. Officers were not sure they could detect the co-occurrence of mental illness and substance use:

Well, with the odor, of course, and then in asking them questions you can pretty much determine if they've got all their decks stacked or not. Uh, then we've got the others who are confusing to me when I don't smell any alcohol and their eyes are not glassy and they are talking to themselves. Or someone out there. I have a couple of those on the beat. They're walking down the street and they're talking (District 2, 33-year-old Caucasian male, four years of experience).
The officer in District 5, Airport, added that a distinction can be made between drug and alcohol use by giving "[a]n eye test -- if they can follow a pencil with their eyes." He also stated that certain cues can help distinguish if someone is mentally ill or using drugs:

"Behavior of someone on ice [crystal methamphetamine] is jittery."

Officers’ experiences in talking with the homeless led the officers to believe that most homeless people are thought to be mentally ill. The process by which officers give meaning to their work supports an attribution/labeling perspective. The presence of certain attributes, which officers associate with homelessness, results in a label of "mentally ill." The officers do not need to interview the person, as described on the previous page, to assign a label. An interview with four officers (27 to 32 years of age, three to seven years of experience, three Caucasians and one African-American) from District 1, illustrates this point.

You say you think a large number of the homeless have some form of mental illness?

Oh yeah. There is a lot with drug and alcohol dependency that we deal with in the downtown/Chinatown area.

And they’re homeless by choice. Because they want to spend their money on the drugs and that whole story. But I would say a large majority, even on to IHS [Institute for Human Services, a homeless shelter].

Fort Street Mall [a pedestrian mall in downtown Honolulu].

Exactly, I mean, a lot of them are to some degree.

A lot of it was caused by...

A lot of it was brought on by drugs or whatever cause their mental illness. Yeah, right, sure, sure. I’m not saying they were all born mentally ill. I don’t know how they got that way but, yeah, sure. You go to these trespass cases and these theft, shoplifting cases and these guys are, there’s something wrong with them.

Do you get many mentally ill people who aren’t homeless?
Usually they have doctor’s care already and stuff, so if they are starting to freak out the family knows they are not taking their medication, they call the doctor.

We do have a lot, but they’re mainly above the freeway; that’s where the majority are.

Not too many. You know, not as much calls to a home.

Most of it’s street.

But to find the questions to that you are talking to the wrong people. We don’t work on the mountain. There are, from what I’ve heard, plenty up there.

Oh, I worked Kahala for a few years and Hawaii Kai, and stuff, and Kaimuki. And you do get some, right.

Yeah, it’s like there’s a remedy for that: the family is usually around.

Yeah, the family usually takes care of it. He has a regular doctor, they call the doctor, "Doc, he’s freaking out." "Ok, we’ll send someone," whatever they do. And worst case scenario, they’ll send us if the person is getting violent. But then everything is cool, because the family’s already got the doctor, in contact with the doctor, per the doctor, take him to Queen’s. The doctor’ll meet you there -- he’s going to do everything. It’s not like a big problem and a lot of your time, you know, where you’re trying to find somebody to say, "Yeah send him to one." You know, it’s already prearranged. It’s a lot easier to deal with when you’ve got someone in that situation.

One officer from District 2 (Wahiawa, 37-year-old Caucasian male, nine and one-half years of experience) stated, in further support of an attribution/labeling perspective, that "[t]o me, anyone curled up in a doorstop has a little bit of a mental problem." The officer also added that only the most obviously ill are easily recognizable: "[w]e’re not psychiatrists."

None of the officers stated that they had received training on how to recognize and deal with the mentally ill:

We didn’t actually have that much training. I think back to recruit school and I really don’t remember any block of training on how to deal with mentally ill or what we should do. It’s all been in-service from our supervisors, our sergeants, and you know, cause we get a lot of our training from on going
in-service type stuff. But as far as our training coming in...and...I don’t remember.

An officer from Kaneohe (38-year-old Caucasian male, nine years of experience) provided a good description of how officers learn to deal with persons who have a mental illness:

...trial and error, and sometimes, what I try to do is what is in the best interest of this person. I already know they got mental handicap. So I try to look at the best interest for them. Options for them. Now, like I say, if it’s a criminal offense where they want to hurt somebody or, you know, in the act of doing so, or they are going to hurt themself, I got no options. Like, I have to take them through that route, yeah. Anything other than that, even if they made a criminal offense but they’re not hurting nobody or hurting themselves, then it opens a little more options as far as taking care of this person. By looking at the best interest, what is the best interest, you send them through the system and it’s going to be a revolving door and they’re going to be out. You know, they’re not going to show up in court, they’ll be a bench warrant or whatever it is, the prosecutor is not going to pursue the case 'cause the businesses are not going to pursue it either. So these people are back out there again. And then, uh, I found one house up, 'cause in Kaneohe we got a lot of houses where the mentally ill, like an outpatient thing. Which is, at least they have a place they can go, so they can go in their room, their little domain, and if we have a problem with them on the street for whatever reason, and then if the situation fits, taking them back to the home. Have somebody talk to them over there, you know, fine, great. If they don’t have a place like that to go we end up chasing them from business to business to business. Until they finally commit one assault or something, and then we got to grab 'em. But it’s too late.

So when you have younger officers in here do they learn from guys like you?

Yeah, you gotta learn, yeah more than likely try to adopt what you’re trying to do. I stress to them that anytime they’re going to hurt somebody or hurt themselves, you cannot, you’re not out of options, but the one option I would do is take them to go see a doctor, psychiatrist, something to help them. That’s all we got, number 1. You know, if there’s other options down the line, then we can do that. Calling Sharon [Black], we can do that. Or we can use other, you know, if they’re not bothering nobody, and they just want to “Where you want to go? You want to go to the park? You taking medications?” You gotta talk to these people, if they’re taking medication, like that. “You was alright when I talked to you yesterday, do you remember? Are you taking your medication?” You know, I mean, kind of make them feel good, too, yeah. And there’s only those that you run into constantly and they give you a hard time about it. They’re not taking their medication, they’re not listening to you and that kind.
Without exception, all police officers credited on the job training as the source of their knowledge.

Officers pointed out that official sanctions can be punishing for both the officer and the suspect: arresting and taking a suspect to the police cell block often results in the arresting officer incurring the wrath of the officer at the booking desk, while taking a suspect to the emergency room on an MH1 often results in a long wait before the case can be seen by a doctor.

Yeah, like I said, ‘T’ a prime example, if he doesn’t come, I don’t believe personally that he comprehends trespassing, or he comprehends that he is littering.

How do you trespass [charge] someone like that? He doesn’t understand what you tell him. So how do you do that?

You can’t.

You’re kind of screwed either way. Say you arrest the person who’s obviously off the wall. You bring him to the desk and as soon as the desk officers take a look at the person, they are going to tell you to take that person to the hospital. And as soon as get him to the hospital, the doctor starts to interview him, and they say this person is off the wall — we’re going to keep him, then you got to TOT [transport] ’em and then they are released, and, yeah released them to the hospital, they going to get arrested anyway. So a lot of times you bring them in on the mental condition and know what they did...

And keep them for four hours at the hospital and let them back out.

Yeah, you get that attitude from the hospital too, because like, immediately upon entering the hospital with some of these guys that, hey, they [hospital emergency room staff] start shaking their heads going ‘Oh, him again.’ They’re so familiar with these guys, you know, and they’ll talk to them, like, maybe they’ll hold him for four hours or something and then ‘OK, see ya’, you should be OK,’ and so, what do they want us [the police] to do? You know, we’re doing it, and it’s an old story, right. We’re doing our job, but nobody else is following through. For whatever reason...they don’t got rooms in the hospital, or, I understand they’ve got their problems too, but as far as I see it these people aren’t doing their job. But these guys are getting released right back out again. What else can we do?
It's not the new ones. It's not all some new ones. It's the constant, frequent, same person.

And these are the same guys that are shoplifting, that are doing other things because they can't get a job, they don't have no money, you know, the whole deal. But they go into the grocery store, and they take food, and get arrested for shoplifting. So you get a lot of these guys with 10, 15, 20 arrests for shoplifting and, really, they're mentally ill. That's why they are doing it. So, we could avoid a lot of these other problems, you know, we could cut down on a lot of other things, if they had a place for these people, that could help these guys. (Four officers, District 1)

The officers not only feel that time is wasted waiting for an evaluation, but that their beat partner is left alone. One officer from District 5, Airport (29-year-old Caucasian female, five and one-half years of experience) described this dilemma as follows:

Uh huh. And there's days when we can't afford to do that. Our manpower is so limited. We've got one guy on the desk and there's two of us on the road. You know. If we go to a scene, depending on a case, you want back up, you want cover, right? Or if there's just a lot of pieces coming down, one man cannot handle them all. If I'm down there at the hospital for five hours, my buddy's over here calling me every name in the book. 'Cause he needs help. So a lot of times the manpower has a lot to do with what, whether we choose to handle a situation. That is true islandwide. That is true wherever you are. It's, you got to weigh the picture. Can I afford to be out this many hours, even on a simple arrest, can I afford to be out booking this person this many hours, with this many people on the road. Is it worth officer safety? Is it worth whatever else might happen out there?

One of the most important findings of the quantitative portion of this study is that 72 percent of police involvement with the mentally ill who violate the law is non-official (that is, there is no official record for the informal or no action dispositions). This finding is supported and explained by the interviews. There is a significant amount of institutional pressure from both the police department and the emergency rooms for police officers to solve the problems associated with the mentally ill on an informal basis. It is important to note that the pressure itself is informal. According to the officers, there is no police policy to divert the mentally ill from the criminal justice system. The only influence of police policy described by the officers involved how to execute an MH1 or MH2. Similarly, there is no
formal policy with either of the two hospitals which conduct emergency evaluations (Castle Medical Center and The Queen's Medical Center) to make officers wait hours before seeing the people officers bring in (see p. 125, interview with officers from District 1 and p. 127, interview with officer from District 5). In cases involving the emergency apprehension of the mentally ill by the police, the only guidelines under which the hospitals operate relate to the involuntary commitment statute: is the patient a danger to himself or herself or others?

For police officers, on-the-job training that stresses informal dispositions occurs in two ways: one, an officer gains experience by trying the various formal dispositions, and is discouraged by the time and ineffectiveness of those solutions; and two, those experienced officers pass on the knowledge of "how the systems work," or, more appropriately, do not work, to new officers. And the lesson, at least in terms of the formal options, seems to be "[y]ou're kind of screwed either way."

There are very clear differences between police districts and how they deal with the mentally ill. The most important difference concerns overall workload. The officers who work in downtown Honolulu and Chinatown have a large number of mentally ill persons on their beat, but spend a smaller percentage of their time dealing with that population than with other activities. As one officer from District 1 stated: "...we've got such a drug problem in Chinatown that we've got theft [sic] and burglaries and robberies, and all kind of, you know, gambling and anything you can think of we've got downtown that homeless, mentally ill people is not at the top, you know, of the list."

The situation at the airport is much different. Officers at the airport acknowledged that the homeless and the homeless mentally ill are a major part of their job. Officers at the airport interact a great deal with the mentally ill and had the time to complete the data
collection forms for this study. The following excerpts from an interview with a female officer from District 5, Airport, describes the situations at the airport.

Almost half of all form turned in froms the whole island were from the airport.

I believe that. We have a lot of them who stay here.

Ok.

Plus we have the time to deal with it. The other officer, he’s busy handling x amount of other cases. He necessarily doesn’t have time to stop and fill out a survey form. While here, since the homeless is at least half of our work, that is something we are knowledgeable in. We take the time to fill out the form.

Ok. Do you get the impression that the homeless people themselves are different here than in Waikiki or in Chinatown? Do you see a different kind of person?

Personally, no. I think the only difference is that they are looking for something a little different. Most of them that come here are smart enough to realize that a: they have a Constitutional right that lets them into a public place, b: it’s a lit, 24-hour security provided environment. It also has rest rooms, facilities available to them, it has a source of income. If they so desire, they need a dollar for bus fare or whatever, they can round-up a few carts, throw them in the back in the rack, and they’ve got some money for the day. So you got a lot of things provided for you right here at the airport. And I’ve had several of them tell me they come here because they don’t feel safe at IHS. They’re safer here.

The biggest problem we have here was, oh, several months back when they changed the routine in an effort to try to control a situation, ’cause basically it’s been getting out of hand out here. Ah, they enforced a new regulation in the airport, where, if you weren’t ticketed, you could not get past the security points after midnight. In other words, between the hours of midnight and five a.m., only ticketed people were allowed behind the security counters. So what this would cause is all the homeless would have to come forward and regroup in the lobbies. So basically at night, if you wanted, if someone came down here at night at 1 a.m., you’re going to see them all over the lobbies, all over the baggage claims, and that is partially because of that regulation. And when we first enforced that, it was an interesting couple of weeks. We were challenged on it, we were, you know, this is where I’ve always slept, this is where I’m sleeping tonight. Some understood, some tested it, some would try us. We actually had to make a couple of arrests on it. Then, once they accepted the rule, they haven’t been any problem on that particular regulation. So, they pretty much, like I said before, that the ones that reside here in a sense, are familiar enough with the system that they pretty much
play by the rules. They know who to talk to, who not to talk to, who’s going
to call the police, who isn’t, what they can get away with and can’t get away
with.

One consequence of the intense work by the police with the homeless at the airport is
that officers get to know what to expect from certain people. As a result, the police are better
able to effect reasonable solutions.

I would say the regulars are cooperative. Those that have been here long
enough to develop, they consider this to be their residence in a so to speak,
they’ve developed a rapport, they understand the routine.

Now I was talking with a lady, she calls herself __, actually she calls herself
Mrs. __, I’ve absolutely no idea if that’s her name. She only has a ring on
her finger that says __. And she’s up here and she’s definitely off her
rocker. And I can’t remember what she was doing. She’s giving them a
problem at the security check point. And that’s another thing, the homeless
carry a lot of stuff. You go into an airport, all that stuff has to go on the
screening belt and it really does cause a lot of problems. But I was dealing
with her for some reason and she was off. She was off. She was talkin’
about, she wanted me to take her panties for evidence, something about stain
resistance ability was gone and, then here basic thing was she had to get a
hamburger. She had enough money, she wanted to go to Burger King and get
a hamburger. So I’m thinking, ok, cool, I’ll leave her stuff here and I’ll get
her in, get her hamburger, and get her out and she’ll be fine. Right? It
wasn’t that easy. She was kinda of...And then, I don’t know what happened.
At some point in time she snapped and she’s basically yelling at me. We
went into Burger King and she all the equipment in the cash register and stuff
were some sort of electronic recording device that was recording everything I
said and the CIA is going to come back and get me and a whole bunch of
weird stuff. And I’m not, I’m just like, ok, you know, let’s get your
hamburger and go away. And then she kept swearing at me and carrying up
and down and how she told me to shut up. I mean really getting belligerent.
Everybody in the airport’s watching, I mean, like, what’s she going to do
next. I’m just trying to coax her out of the airport because it not, basically
it’s not worth my time to... Obviously I wouldn’t have taken that from the
average citizen. And I wouldn’t ever allow any of that stuff. But my main
objective at that point in time was to get her hamburger and get out there on
the counter and I figured if she got what she originally set out for, she’d sit
down and eat it and she’d be distracted. It would not have been worth the
time to arrest her. Cell block would have had a fit when I brought her down
there ’cause she’s one of our raunchier ones, right. And what would you
have arrested here for? Disorderly, harassment. She would come right back
tomorrow morning, she’d of been released and come right back here. If I’d
of MH’d her, it would have been crazy. The hospital would have had a fit.
You got this person, he's carrying on a conversation with who knows who, right, there's some other person. They have some bizarre conversations. They may be very harmless, but they're, you know. One lady, shoot, I forget what her name is. She talks to me all the time 'cause she's always complaining someone has shaved her eyebrows, and put aluminum foil, antenna in her hair, and they're turning her into a receiver, and, you know, all these type of conversations. Some of them have family. Some of them actually family that comes down here on certain days of the week and they, you know, touch base and meet and blah, blah, blah but they won't go home with them. Or junior doesn't want them to go home, I don't know. If you do get a chance to come down, if you are at all interested, I think you'll find them very interesting. We have an older lady, who actually uses a wheelchair. Her legs are really bad. She's a sweet thing. But she stays here 'cause this is where she wants to be. And certain mornings of the week we'll see her up there, oh, I think it's down by Qantas, maybe a bit more up. And the same people come visit her. They sit there doing their knit, their crocheting, bring her candy, whatever. Carry on conversations. Then those people go wherever it is they go, and she goes...It's so funny, because every once in awhile, you see somebody pushing her. Somebody, the public, somebody in the airport, a tourist, has come in and says, "Oh, you need some help? Are you trying to get to such and such?" "Oh yeah. Take me down to gate such." And they'll wheel her down. You know, she's got a ride down to whatever and she pushes herself back to the center. Yeah. They're here because they want to be here. Then there's the crazy ones. A lot of alcohol ones.

The officers in District 5, Airport, also had the motivation to complete forms: the commander of the airport substation wanted to document the caseload of his officers. There is also some not-so-subtle pressure on the officers to do what they can to make the arrival and departure of visitors a pleasant experience. Airline and airport employees ask police to move the homeless out of baggage claim areas and the airport lobbies. The police are not insensitive to these demands and usually take the initiative without being asked.

In some respects the demands placed on officers in Waikiki are similar to those placed on officers at the airport. Waikiki is vital to the state's economy, and merchants do not want individuals who are disheveled, smelly, or acting in a bizarre manner to discourage customers. Police are asked to move these people away from stores and/or make arrests; however, merchants are rarely willing to press charges.
In general, the homeless and homeless mentally ill are less noticeable in parts of downtown, especially Chinatown, than at the airport or Waikiki. Someone who is slumped in a doorway or not wildly disruptive is not likely to attract a great deal of attention in Chinatown, nor is that person as likely to come to the attention of the police as someone who is selling drugs or sex, or who is drunk and disorderly.

The researcher's interview with the officers in Waikiki clarified why 10 of the 22 arrests occurred in their district, eight for contempt of court. The officers have initiated a program to identify the homeless and homeless mentally ill and link them up with services. Part of the identification process involves a criminal record check, which shows up any outstanding (bench) warrants. Once faced with the information that the individual has a warrant for his or her arrest, the officer is compelled to take the individual into custody. The officer who was interviewed in Kaneohe stated that he tries to avoid individuals who have outstanding warrants because he feels it is generally counter-productive to arrest the mentally ill. Officers in other districts do not routinely run criminal record checks and, therefore, are unlikely to know when bench warrants are issued.

Wahiawa and Kaneohe are more rural than the other districts in which officers were interviewed. The interviews conducted in these two districts revealed a much more relaxed, unhurried approach to dealing with persons who have a mental illness. The three officers interviewed were generally willing to spend more time with persons who have a mental illness and more willing to provide personal service to those individuals. The officer from Kaneohe who was interviewed usually asks the person where he or she wants to go, and is more willing to transport the person to his or her home or to that of a friend or relative, to the doctor, or to the hospital. In both districts, the officers were willing to talk to an individual until the individual calmed down, recognizing that "we have more time out here."
You got to have patience, too. Well, when I was in college I was in psychology. It's different from what you read in the books from reality. But then a lot of this you've got to be using psychology when you're talking to them. When you're talking to them [?]... You can get angry with them, screaming at them, you ain't getting nowhere. So whatever they do to you, scream at you or whatever, you just gotta be calm. You know, them screaming, yelling, swearing, whatever it is, and you just sit there talking calm to them. Once you do that towards them they, they want you to be upset, they want you to get all angry. 'Cause now they have control over you, that's the way I think. So I talk to them nicely, I don't let them get me all wound up. Oh, yeah, inside you frustrated, right, but you cannot show them that. You just to keep on playing the games with them. You know, it becomes a game, a communications game. And then, slowly but surely, hopefully, you win them over and they start listening to me.

Sounds like that happens most of the time.

Yeah, when I run into them most of the time, if they give me a hard time, and I run into them before, then start talking about things I did with them in the past. "Hey, remember when I this and... Where you grow up at?" "Oh, I grew up at..." "Oh, nice place." Sooner or later, I start getting interested in what he has, his background, what, so he has one uncle... "Oh, my uncle on policeman." "Oh, what is his name?" "Oh, I can't remember." Maybe they tell you a name, but you don't know them 'cause that was like a long time ago. So you say "Oh, I think I remember that name." So I said... Now, you've interested them. Once I get that, oh yeah, so I go "So what you want to do now? Where do you want to go? You want to go up here? You taking your medication?" And then, boom, they say "Oh, I go up there." So, now I just won his trust, yeah. So now he feel like he's known me forever, right, so. And he'll give in, so I can take care or whatever. But, I think if a police officer, to me, I can spend time. We not that busy down here. But there is a lot of time, you know, when you don't have a lot of time to deal with them. But then, that's why communication, I'll spend maybe a half an hour trying to get with him, then I can start working the options. And, to me, the biggest thing is talking to these people. You know, especially in town, they go over there and grab him by the shirt, throw him in a white car and take him to Queen's, you know what I mean. 'Cause the deal with, I guess, they busy, they got to deal with these guys every day and stuff like that. So...in Kaneohe, I got a little more time, maybe, to talk to these people. But as far as the state, some place to go, that would really help the police department to at least take 'em there, you know. If it's in town, no, but if they have a place in Kaneohe, outpatient houses, fine, you know. Any place maybe for them to go, to sit down even. They have one or two counselors over there. You know. And then maybe counselors could give them guys the doctor's name, and they could do all the calling too, yeah. 'Cause the person is kind of calmed down, you know, calm like that, what are they going to do? And they can use, they can call maybe the contacts already. Sometimes when we make
the contacts we end up talking to six different people and that takes like forever. Just like one or two hours.

Another example from District 4 demonstrates the lengths to which some officers are willing to go to act in what they think is the best interest of the person with a mental illness:

So, what we'll do is, I'll try to talk to 'em and give them as much options as possible. Places to go and things like that. We'll exhaust that. We'll stay, I'll stay there for, as long as I can, hopefully not too long, to try to work it out with this person. We'll make the cases and stuff like that, refer it to the prosecutors like that, ask this guy if he wants to go somewhere. And if he leaves, most of the time they leave on their own, ok. A couple of days ago we had one at Zippy's where he didn't want to leave at all. This was his initial trespass warning we were going to do that day. He didn't want to leave, told me "No, no, no" for half an hour. He said we got to shoot him, beat him up to get him out. So I take that as a no, yeah? But, I dealt with him many times already and you know he can be real stubborn. But I kept talking to him, talking to him. But he still he kept to his, no, you have to beat me up, kill me, or whatever it is, right? Well, what we did finally was, my last option was, ok, we're going to have to take him in. 'Cause he's not leaving. The businesses, people are coming in eating, and stuff like that, it's, I said, we can't sit here all day 'cause now we got a problem. So what we did is went to a light touch on him. Just show him that we, kinda like, meant business now. And then, soon as we did that, he reacted and, well he's going to go either two ways: he's gonna charge us now, which hopefully, we're not hoping for that, or he's going to succumb to what we're trying to tell him. And then, that's what he did. He stood up and said "Ok. Wait wait wait wait." He know the game now, everything serious, yeah. So, he stood up, we escorted him to the car, asked him where he wanted to go, told us where. Ok. And then we told him the reasons he was trespassing, trespass from there, the reasons why and stuff like that, 'cause he went in there, ate food, and when the manager goes in the back, or the lady goes in the back, they go out the door. So, that was the reason for the trespass. But, a lot of them do pay, though. I would say the majority do pay. But, this one didn't and what we did the options on that, came down to he was going to get arrested if he stayed here, we'll have to take him. As far as a criminal offense, MH1, that option would be how he really reacted to us. I think if he, 'cause he was just verbally threatening us and stuff like that, he made no attempts to us in a physical way, to back up what he was saying. We take into consideration, you know, he has a, he's mentally ill, so whatever he yells and screams at us ain't going to hurt us. So you just kind of throw that out the door, and just let him express himself. And the option was, well ok, we'll make the case, refer him to the prosecutors, or we'll take him where he wants to go. Or if he wants to go to the hospital voluntarily, if he wants to. But you know how long that gonna last. He goes in there "I wanna be seen," right. The policeman has left the hospital they'll "I don't want to be seen" and he's back
on the street. And now we just wait for the next call, the next business to
call.

Officers felt that the conditions or situations which led to arrest were clear, though
had some difficulty in making a distinction between taking someone into custody for the
purpose of arrest or for an MH1. An officer from District 2 described the decision making
process:

In what situations, under what conditions, would you arrest someone who
has a mental illness?

Oh, certainly someone who is a danger to themselves or to others and process
the obvious cases -- when they are lashing out, then that is a simple decision
for us.

OK. If they are violent and you need to protect somebody, them or
somebody else.

Those are easy decisions.

How about if it is an arrestable offense. Are there situations where it
may be an arrestable offense where you choose not to arrest?

Uh...that's a gray area. If it's an arrestable offense...Well, yes, we come
across cases like that, say, it's third party information, where we did not
actually see the event take place. Although it can be an arrestable offense, we
may not arrest, simply because we, it's not quite, we don't have all the
information accessible right then and there. So you don't want to make any
false arrests. So you make a case, and you take whatever information you can
and then we refer the case to the victim/witness kokua [assistance].

How about, is it also fairly clear when you decide to take someone to the
ER, or I guess, you're a long ways from Castle or Queen's...

But we do it, we do it. It's either Queen's or Castle.

Depending on the time of day?

I think it's depending on, there's a, I don't know how they deal with it, but
we always have to go through dispatch and they'll tell us if Castle is takin'
'em that day or if Queen's is takin' 'em that day. I've gone to Queen's before
when they've said they have no room. And I had to go to Castle.

That must take a whole shift.
And that's a pretty frustrating, frustrating on beat partners. Because if you have a case like that on the beginning of your shift, chances are you won't be in the rest of the day. With transporting the person and remaining there, they are in our custody until they finally decide, until the doctor decides, yes, we will admit the person. Until then, you are still takin' up, and then you have your report to do. So, you're done.

That's it. That's the day.

That's the day, and then your beat partners are taking your cases.

So, that is something that would probably be used rarely, under certain circumstances. Does it have to be pretty severe, or...

Again, let's say if there is past history, we do have a few that have gone for mental observation in the past. So, again, if we know who they are, I would more than like call and see if they'll admit the person. Because when I talk with the person, it's uh, they are in a state where they really don't mind going. Usually down and out, maybe they've been out in the street a couple of days and they're ready to get cleaned up and have a good meal, and so they don't have any problems saying, Yeah, I'll go. And, if I know that I've taken them in the past, and I know this person is really depressive, then I'll do it. I don't need, and I didn't have any violence or anything like that.

What goes through your mind when you see somebody, say, disturbing the peace, or you get a call from a merchant that this thing is going on, and you approach the situation. Do you have a degree of options that you go in thinking that about?

You don't know. You never know what is going to happen, but that is pretty accurate in that let's say a merchant does make a complaint. You come to the scene and it could be a person who is mentally ill. We don't know that, let's say we don't know the person. The command presence of the officer usually, in most cases, will calm, or the person will desist, but we don't usually don't have to go much further than that. And our intent at that point is just to satisfy the merchant. Let's say he's bothering, he's in the store front, or something, people are not coming and doing business because they, the person could be a street person, hasn't showered in a few weeks, whatever. And so we just want to service the merchant in getting the person out of there. Really no crime has been committed, unless there is, you know, let's say it was a school situation that's got signs against loitering, you know, but coming in there's no law that's been broken yet. Unless he's damaged something, so, our service is just to get them out of the area and then we don't probe any further unless there's no need.

Do merchants ever say, I want this man arrested?

Oh sure. Oh sure.
And just take this person away?

Oh sure, it's very common. "Arrest him, I want him arrested."

Lock 'em up.

But there's no crime committed. You can't do that.

I mean you could probably find something you could cite him for.

Yes, we can go as far as a trespass, see, and that's an out that they have. Let's say if it is bothersome and the person comes in and does not purchase anything, just stands in front of the store, comes in and walks around in circles. Yes. If we feel that it has been a problem for a store owner, let's say if it is the second or third time that this individual has been there and hasn't bought anything, yes, we could trespass warn the person. That person would be warned that he could not come in to that store. He can still stay outside the store, though, on the walkway, on the sidewalk. We have no control over that. Then it would only be a warning.

As stated above, a number of mitigating factors related to arrest came out in the course of the interviews. Officers in District 1 stated that:

If there's a complaint, we have to act on it. If no one complains, then we don't do anything.

And the way you act on that complaint is kind of what you decide when you get there?

You have to ascertain the situation. Is he mentally ill or is he committing a criminal violation. If you're looking on the mentally ill part, is he just sick or a danger to somebody. If he's a danger to somebody, you got to see if you can try to take him to the hospital. If not, there is nothing you can do. If he can understand what is going on and he still doesn't want to go, there is nothing you can do. Then, on the other side, you have the criminal offenses, if you find something, you can bring him in. That's a waste.

What if you bring him in?

The judge releases him immediately. That doesn't solve the problem for most of us. If he is a regular, we can deal with him. You know, I give him cigarettes and I ask him, "Here, I'll give you cigarettes if you'll clean up all this" and if the complaint is about his mess. I just ask him to clean up his mess. And I just treat him like any other citizen, right. If someone else is littering, I give them an opportunity to clean it up, right. So... it really doesn't bother me.
Oh, but, then so, you know, he’s treated like any other citizen until a point where there’s not compliance or he becomes violent or disorderly and then, like I said, that’s usually where we have to take further action on a mentally ill person. If they become violent or, you know, they’re disorderly or they’re creating some kind of a hazard to themselves or somebody else. Otherwise, you know, we get there and you can tell anybody, I can’t imagine why a doctor could stand there and talk to Theodore and say, "He’s ok; he should be out or he should be in a mental hospital. Somebody should be taking care of him." And there’s just hundreds, maybe even thousands, of people like that downtown, and, uh...

You can classify a lot of things as danger to yourself, I mean... He’s obviously out of his mind, yeah, that’s a danger to yourself. It just depends how you define danger to yourself.

If "you have a criminal offense, if you find something, you can bring him in," but then went on to conclude "[t]hat’s a waste." Most officers felt it was necessary to act if there was a complaint, but not if no complaint was made.

The officers also reinforced the explanation that was given to the researcher during the first week of data collection as to why some officers indicated on the form that no offense occurred, when the instructions were that forms are completed each time a person was committing an offense. The officers in District 1 said: "[h]ow do you trespass I someone...[t]hat doesn’t understand what you tell him...You can’t." While the individual was technically committing an offense, the officers did not feel that there was any intent to violate the law. One officer from District 2 described a different situation in which an arrest would not occur:

Well, a lot of times an arrestable offense, like theft or something, could be a the complainant could elect not to pursue the charges so that would be an arrestable offense that might not end up in an arrest. He gets his stuff back, the guy is kind of unstable, doesn’t want to take him to court so, you don’t have a complainant.

All the officers were acutely aware that arresting someone with a mental illness 1) does not help the individual, 2) puts them in conflict with the booking sergeant, who usually orders
them to take the hospital, and 3) would waste their time at the hospital if the person was not a
danger to self or others.

Both officers from District 2 stated that it was appropriate to arrest someone who was
violent or who committed a criminal offense when there was a complainant. The same
general criteria is used by all the other officers.

The critical distinction they all struggled with concerned whether to take the mentally
ill person to the police cell block or to the hospital on an MH1, once the person was taken
into custody. The choice between the two dispositions came down to whether the person
would meet the involuntary commitment standards.

Basically, until I came to the airport, I would try to avoid it [taking someone
in on an MH1] at all costs, 'cause it is not easy to deal with and the hospital's
really don't...If I understand the laws correctly, and I'm not really sure I do,
basically if a person needs psychiatric help, he can only get it if a: he
volunteers for it, or b: he's of physical harm to another or himself. The
average person who's gone, who's off in la-la land, is not really a physical
threat, usually, ok. And because he's off in la-la land, he doesn't know he
needs help and he's sure as hell not going to volunteer for it. Ok? So, you
have to be able to articulate stuff in such a manner as to justify why we bring
these people in for psych. And there's no place to house them and if they
sign themselves out, they're gone. They're gone. So, there's an awful lot of
red tape involved, and time, and it's wasted manpower, you're off the street,
you can't do your job, you can't cover your beat, 'cause you're trying to get
this person something that basically doesn't exist. There is no care, or slot in
the system, for this person.

They're below this critical level...

Yeah.

The distinction required to meet the involuntary commitment standard is problematic in two
regards: first, is the danger to self or others imminent, and second, would the symptoms still
be present by the time the individual was seen by a psychiatrist or psychiatric resident.

Several officers relayed stories of suspects who, after several hours of waiting in the hospital
emergency room, calmed sufficiently to be released by the hospital:
...you get a case where it takes us a couple of hours to get somebody into Queen's, they've been yelling and screaming and acting like a madman for two hours. By the time you get to the hospital, you know, you know, all that sweat's starting to dry, they're calmin' down, they've already exhausted all their energy, so they go to the hospital and they're like little puppy dogs that didn't do anything wrong. But we had to deal with them for two hours, just, like, you know crazed maniacs. So I love when I bring one in to Queen's and they're screaming and kicking and everything else, just precisely what we dealt with, why we brought this person in. And then they have to deal with it. I just had one like that. I get giggles out of it, because...they finally can, they finally realized what we do, but sometimes they don't. They get mad at us (District 1).

There are two standards at work. The first standard relates to an officer's authority, and, in the officer's eyes, duty, to take someone who is mentally ill to the hospital. The second standard is applied by the hospital staff in determining whether the individual meets the criteria to be held against his or her will for an evaluation. The officers see little value in applying the first standard in the absence of the second. Officers feel like they need to be able to predict what the suspect will be like by the time of the evaluation.

The officer from Kaneohe was the only exception to the view that officers need to try to apply the hospital standard for admission when they make an emergency apprehension. The officer stated that he was bound to take an individual to the hospital if he or she was mentally ill and had committed an offense, "regardless of what they're going to do or not going to do." If the hospital would not accept the person, the officer said the next step was to take him or her to the receiving desk to be treated like every other prisoner. However, the officer admitted "...now I'm kinda stuck" and retreated from the hardline arrest approach. Before "he's going to be treated like the rest of the prisoners," the officer would try to get the person to voluntarily "go or name places, and most of them know places," including home, the doctor, or "that comprehension center." It is very unlikely that the officer would release a suspect who was not mentally ill after the suspect had been taken into custody.
Both the Crisis Response System Program (CRSP) and Project Outreach generally received positive review. The crisis response team deals with individuals who are suicidal.

I usually call, I call the crisis unit where I had someone that was wanting to commit suicide. And that person, don’t know who it was, it was a worker, he talked to the person on the phone while I was there, when I worked in Waipahu. And that seemed to work, and whatever that person did, the worker calmed him down to the point where he, you know, volunteered to go in. And, so, I called.

The officers who had used CRSP were happy to have the support in these critical situations. One officer from Waikiki, however, was frustrated by the crisis team’s approach: after having to physically restrain a suicidal person who had "drank a whole bunch of like a pine-all cleaner," the crisis team "asked him ‘Are you sure you want to hurt yourself?’" This officer, like all of the others interviewed, felt the need for medical and psychiatric intervention was obvious in certain situations. They resented being questioned and overruled by doctors, or in this case, a suicide crisis worker.

The praise for Project Outreach and its sole employee, Sharon Black, was also near universal. The officers expressed gratitude for assistance in obtaining an MH2 so that they would not have to wait at the hospital.

... an MH1 is a policeman’s tool, a form that’s saying we as policemen believe this person needs to be psychologically evaluated. Now if Queen’s takes the time to do the eval, which could take them x amount of, you know, a couple of hours to get the psych in there, if the psych decides he’s not going to keep him, that body is still our responsibility if Queen’s is going to kick it back to us. So, you’ve gotten a lot of time off the road. Now, the oral ex parte [MH2], which is basically a judge saying, under this set of circumstances, described to me at such and such a time, by the officers via this operations person Sharon Black, I believe he needs to be off the street. They can’t refuse that. I take him and I just drop him. Here’s your body, here’s your form. Bye. And then they do whatever it is they do (District 5, Airport).
Another testimonial came from the officers in District 6, Waikiki (one female, age 35, Caucasian, six years of experience; one male, age 42, Hawaiian/part Hawaiian, five years of experience):

She helps us, she helps us a lot with these people.

She’s very helpful. She’s been able to get a lot of stuff done for us. In her capacity alone, including the other districts, she’s been able to place a lot of people, you know which is great. When we first heard about her, it was like a big joke, yeah, right. But then, as it went on and we arrested a few people that needed it, we realized, wow, she’s really effective. She’s something we’ve been looking for all this time.

In less severe cases, those not requiring hospitalization, the Project Outreach worker was also able to successful intervene by diverting the mentally ill person away from the police and criminal justice system to medical and psychiatric treatment. The worker has established relationships with a number of care facilities and can often find bed space in crisis situations.

Two criticisms of Project Outreach emerged from the interviews. The most common complaint was that there was only one worker. While all districts have used the service at one time or another, some were reluctant to call as often as they might, recognizing the entire island is too large of an area for one person to cover. The other criticism arose out of a specific encounter in which an officer was called to a private residence. The family wanted their 19-year-old son involuntarily committed and the Outreach worker told the officer to do an MH1. However, the officer did not feel that the person was a danger to self or others, and would be exposed to liability if the person was taken into custody. "She’s not a medical authority...I can tell whether it is a danger, you know, based on those two things we only have to go by: danger to self or others." The officer in this case, as well as his co-workers, wants someone with more expertise to make the call that a person needs to be taken into custody.
Several officers raised the issue of liability in two contexts: not responding to a situation in an adequate manner and having the suspect commit suicide or a violent crime, and exceeding their authority by taking someone into custody when it was not warranted. In the first context, officers in District 6 were careful to document every step they took. They felt the greatest risk involved situations in which the person with a mental illness did not want assistance and the officers did not feel that they had the authority to take the person into custody.

Yeah, [we document] what we’ve done, the person’s demeanor, whatever, to cover ourselves as well. In case this person turns around and kills himself, to document we were there, we tried to assist, tried this. The person wasn’t as obviously ill as we, you know, thought, you know. But still, liability still falls back on you no matter what.

I think that’s one of the questions you asked earlier is how much time you spend. I think the time each individual case is different based upon the severity of the illness. Ok. Whether or not he’s really that ill, or it’s just an emotional problem. But, see, even when it becomes an emotional problem, that depression could lead to something fatal. You don’t know. You don’t know.

Again, the officers were acutely aware of subtle distinctions in the law and felt unqualified to assess when "obviously ill" and "gravely disabled" can turn into "imminent danger to self or others."

In the second context, officers in District 1 were concerned about exposure to civil liability if they took someone against their will to the hospital when no crime had been committed or there was no imminent danger.

[What we need are] [p]eople that are medically qualified that can make that determination that this person is mentally ill and they can set up their own thing by calling an ambulance. I mean, we can’t, we’re spread so thin right now that those people should be able to handle the situation unless the person is disorderly.

Also liability wise, wouldn’t it be nice to have a doctor who takes that liability on himself or herself and says that I’m making the decision, MH1 or
whatever, and not some cop with a high school diploma and six months of training to make that medical decision. Right.

And they may be able to cut off the mental ones and take them to Queen’s and get advice, then they got to take them to the hospital, they may be able to evaluate them on the scene and take them straight to the State Hospital and they call and says "Hey you guys got the bed open?" OK, it’s going to take three hours. Then as soon as that bed gets open they transport the person. It cuts off that middle man.

One officer in District 5 had a similar concern:

...where the people are just out of control...[y]ou have to wrestle, you have to remove them from the environment up there, and once I’ve done that, once me or any other officer has put handcuffs on someone or even laid a hand on them, we’re going to go the whole route. Because if we don’t, we’re leaving ourselves open for suit, liabilities, all kinds of things.

The officers who participated in the interviews were sensitive to, and frustrated with, all the competing interests and pressures they confront when dealing with persons with a mental illness. Overall, the officers seemed genuinely concerned for the health and safety of the mentally ill, though for some officers "compassionate" may be too strong a descriptor.

Officers have little tolerance for the homeless in general, the able-bodied who can and should work.

You know, I would really like to see the people that deserve, now who deserves it? I think if you’re not drunk, you’re not an alcoholic, and willing to make a goal, willing to show these people that, "Hey, look, I just need help for a little while." That’s what welfare was supposed to be, right? These are the people that should get that opportunity. Unfortunately, from what I understand, if you can show that you’re medically addicted to alcohol or drugs, you qualify. You know, that’s our basic problem when it comes to mental health and homeless. Most of these people have an alcohol problem. And we just are not addressing that problem. We’re looking at the other roots and other problems, and we’re not taking care of the root.

Those with disabilities, however, deserved more slack.

Officers recognize and are sensitive to the concerns expressed by the community, residents and merchants alike, about the appearance of the homeless and homeless mentally ill and the disruption they sometimes cause. However, officers also seemed to resent that
pressure and were quick to point out to demanding residents and merchants the rights of persons in public places.

Yeah, or they’re on the neighborhood board, for example. They’ll say ‘You know, I walk through Kapiolani Park and I feel so unsafe ’cause all these people are laying around.’ And I’m like ‘What do you want me to do?’ If we tell these people to get out of Waikiki, we’re violating their civil rights. We go to jail, not the homeless, not these old ladies out there. It’s a give and take thing. If anything, policemen make good politicians. You know, you gotta make one side happy at the same time do something else to make these people happy.

Sometimes I feel I got it rough ’cause I got Kapiolani Park, Diamond Head area up here. There’s a lot more of the more high class, rich people. And the park is full of homeless. And like you said they come to you ‘Officer, can’t you do something?’ I say ‘No ma’am. I can’t. They have every right to be in here.’ They’re lying under a tree, it’s 12 o’clock in the afternoon. You got a regular John Doe lying, sunbathing under a tree. Just because this guy’s homeless and dressed real slummy, whatever, he has a right to be there laying under the tree like everybody else. And they ask you ‘But I’ve been coming here for years, I live here, I pay my taxes.’ I like ‘Ma’am, I’m not going to argue with you.’ If you say elderly people, but they’re more or less the well off ones because the Diamond Head area, Kapiolani Park, all the areas, you know, more of the high class people. And they get on you, want your name and badge number because you didn’t get this person out of here. And it’s like I said, sometimes I got it rough ’cause I got that area, and I try to be as polite as possible, but inside of me I’m like ‘You old hag’ (District 6).

One of the factors that made officers more tolerant of the mentally ill was that "as far as our homeless is concerned, the mentally ill ones, those with emotional problems, aren’t our criminal element" (District 1). Police are fairly clear where their priorities are, and the mentally ill are low on that list.

The most difficult pressures for officers to reconcile come from the criminal justice and mental health systems. There is pressure to protect the public by making appropriate arrests, but none of the officers felt that police cell block was where those with a mental illness should be. To some degree, the officer did not want to book a person with a mental illness because they did not think the person was culpable. To a greater degree, however, the
officers did not want to enrage the booking officer. Officers also did not think the judicial arm of the criminal justice system was responsive to their efforts: "The judge releases him immediately. That doesn’t solve the problem for most of us." Overall, the officers who were interviewed did not feel that the criminal justice system provided options for dealing with persons who have a mental illness who violate the law.

We had one just the other day. We’re called two days in a row, on two different occasions, that he was dropping his pants and masturbating, or whatever it is, on the beach. So we get there, he’s gone. The lifeguard, nobody wants to do anything. "Oh, we don’t want to go to court. You know, he does this all the time." So we find him and he’s mentally ill, you know. He’s on the church grounds, and he’s yelling...So we talk to him, calms down, and talk to him, it’s like he understands you. One moment he’s perfectly fine, like you and I, and another he’s kind of off the wall. It’s kind of like, hey now. Ok, we’ll give him a break. I said "We want to take him in." And somebody already said "Well, we took him to the VA already." He’s a Vietnam vet and he’s 60 some years old, you know. All that they did was, I guess was talk, in the end they let him go. So what can you do at that point, right. The next day, we get a call first thing in the morning, he’s out there again. I get there, he’s totally nude, you know. Get him a beach towel, somebody gives him a pair of shorts, a top, so on and so forth. At that point I said "You know, we can’t just let him go again." ‘Cause it happened like twice the day before but we couldn’t find him the second time and then the next morning. So, like I said, and he was loud, disorderly, he was all yelling at me and so forth. You know, it’s like, we could arrest him for disorderly but what good is it going to do. I ran his record, his rap, and he’s been arrested for disorderly so many times, like what good is that going to do.

Police officers feel the solutions to the problems presented by mentally ill persons lie in the mental health system; the problem is gaining access. For a great number of mentally persons, access to the mental health system comes via the police and the courts.

Even still, you need a slot for these people to fit into. I’m still, I’m only talking about people that have forced me into making an arrest. When you’re dealing with the mentally ill homeless, or at least for me, well, most of us down here, you’re not going to arrest them unless you have to. There’s just too many problems.

And most of the time it doesn’t reach the level where you need that evaluation because you pretty well know the outcome of that.
Unless they’ve really done something violent. Now we do have a person, _, who got, who was off his meds. He’s fine if he stays on his meds, if he’s not on his meds he’s very violent. He actually punched a woman, a female employee inside the airport and messed her up. Now, of course, obviously, he was arrested on the criminal charges and if I understand it correctly, I don’t know if we have a copy of the paperwork, we were able to get a ‘stay away’ order for him. That person is not allowed in the airport area. Basically, ’cause that woman works here and she’s scared to death of him. And he is. When he’s off his meds, he’s really hard to control. He’s violent. It takes a couple of guys to deal with him. Now what do you do with a person in that situation? I mean, we knew that eventually that was going to happen. But we couldn’t do anything about it. He hadn’t committed any offense. Until he did, and then I was still surprised that they got the stay away order. That was fantastic.

Yeah. That’s a great idea.

But, I’m sure he’s a problem someplace else now. All it means is this, I’ve eliminated him from this beat at the airport. I don’t know where he stays now. We have another one, __, that they got an order on. He can’t come back to the airport either. I don’t know how much of his problem is mental, or just a smart-ass homeless. But his thing was sexual innuendos and pat the girls on the ass and all kinds of things like that. So he’s just, he could just very well be cocky. That is so funny because I know he didn’t know who I was, I was down at the Ilikai recently on some other business, out of uniform, in civilian clothes, and I look entirely different out of uniform, and he came up to me and it’s like ten o’clock in the morning, and he comes up to me and says ‘Oh missy, I can wash your car.’ ’Cause that’s his thing, he carries a thing and he wants to wash your car. He’s being all, ‘Oh, you’re so pretty, can I wash your car for you?’ ‘Get away from me __,’ you know. ‘I’m going, bye’ (District 5).

Hospital emergency rooms have very limited space for emergency evaluations. Under the provisions of the emergency examination and hospitalization statute (HRS § 334-59(e)), the patient must be released within 48 hours of admission, unless the patient agrees to voluntary hospitalization. If the patient is under criminal charges, he or she will be returned to the custody of a law enforcement officer. If the attending physician believes the patient requires further evaluation or hospitalization, the court can order the patient detained for a period not to exceed 90 days (HRS § 334-60.6). Ninety-day evaluations are conducted at the Hawaii State Hospital.
As of December 18, 1994, 119 of the 182 beds in the Hawaii State Hospital in Kaneohe were filled by forensic patients, while a majority of the 63 civilly committed patients were originally forensic admissions (Schultz-Ross 1995). Of the 119 penal code commitments, 60 involved an examination pursuant to HRS § 704-404, where a defendant has filed a notice to the court with the intent of relying on a defense of mental disease, disorder, or defect, or where there is reason to doubt the defendant's fitness to proceed with a trial; 18 involved defendants who were found unfit to proceed (HRS § 704-406); 11 involved defendants who were acquitted on the grounds of physical or mental disease, disorder, or defect (HRS § 704-411); and 30 involved other commitment statuses, including MH-9s (transfer from a correctional facility), civil commitment in lieu of prosecution, and 72-hour evaluations. Of the 119 penal code patients, 54 percent were charged with a felony (A, B, or C), and 46 percent were charged with a misdemeanor, petty misdemeanor, or violation (Hawaii State Hospital 1995).

However, the route to the State Hospital is essentially closed to police: the State Hospital is at capacity and suffering from staff shortages and failure to ensure constitutional protection for patients. On January 11, 1995, United States District Judge David Ezra found the State of Hawaii in contempt of court for failing to honor a 1991 settlement agreement with the United States Department of Justice for improvements at the State Hospital (Kobayashi 1995).

Access to the mental health system is also restricted by strict emergency hospitalization standards. It is important to note, however, that the standards are strict by precedent, not by statute. State law allows for involuntary commitment if the person "is gravely disabled, or is obviously ill" (HRS § 334-59(d)). However, the Family Court of the First Circuit of the State of Hawaii has decided that the only standard that is constitutional, in
light of *Suzuki v. Quisenberry*, 411 F.Supp. 1113, is imminent danger to self or others, a much higher standard.

Finally, police must be aware of the department's formal and informal guidance on the use of discretion, and the liability associated with exceeding that authority by either wrongful arrest or failure to act. One officer seemed to capture the difficult balance between competing interests best when he said "We're between a rock and a hard place."

The final chapter draws conclusions based on the preceding qualitative and quantitative analyses. In addition, Chapter 6 presents a series of recommendations for dealing with persons who have a mental illness in the community.
CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

It is fair to note that one aspect of police discretion not measured by this study is an officer's decision to participate in data collection. In this regard, it is almost certain that the study underestimates the degree to which police are involved with persons who have a mental illness. The four officers in District 1, in response to a question about why there were fewer incidents reported on Friday or Saturday night, stated:

I think that in all honesty in regards to your forms that probably Friday and Saturday nights is our busy nights and cops are tired and nobody wants to fill out forms. I'll be honest with you. I think a lot of forms were just plain weren't done because of you know, I was here late last yesterday filling out forms and, no offense, but I didn't sit down and write out any of those reports for you. I, not to spite you or anything, like 'Who is that guy and his forms,' but we're just too busy. You know, and if you didn't see a lot on weekends is because the guys are tired and overworked and the last thing they want to do is fill out another form. Even though it's not that difficult, that was a pretty easy form, it took less than a couple of minutes, but you just do not want to do it. You want to go home. So that is probably why you did not see a lot of forms on the weekend, not because we did not deal with these guys on the weekends.

I could have written 10 or 15 of these a day . . .

Depending on your caseload, like, you are reactive or you can be proactive.

Well, the airport, that all you have to do is write those things.

They don't do cases, you know.

You could be going to a case and you recognize a homeless person, you know, maybe sleeping on a bench or something, but you're going on to something else, you're not going to have time to stop and deal with it.

Right.
You see, that is a big problem of the airport guys. Every area has their problems, their goals of that their commanders are trying to reach, and I think airport besides the drug thing, you know, coming in on airplanes, that is mostly done by plainclothes, uniform cops at the airport their biggest thing besides parking which is taken care of another agency anyhow, is the homeless. And their commanders, from the politicians on down, they don’t want the homeless at the airport greeting our visitors, right? So that is a, that is probably, that is an agenda there. So that is probably why you see a lot more paperwork in that area. Because that is one of their big things. Where, you know, we’ve got such a drug problem in Chinatown that we’ve got theft and burglaries and robberies, and all kinds of, you know, gambling and anything you can think of we’ve got downtown that homeless, mentally ill people is not at the top, you know, of the list.

The police officers made two important points concerning the completion of the incident forms. First, officers were sometimes too busy to complete forms. Second, officers were sometimes too busy to deal with persons who have a mental illness.

In 1993, District 1 had the second highest number of reported offenses of the seven police districts for forcible rape, robbery, aggravated assault, larceny-theft, simple assault, and vandalism (in 1993, District 3, which had the highest number of reported offenses, included Waianae. In 1994, the Waianae coast area became a separate district.). Nearly half the county’s reported drug offenses and the highest incidence of reported prostitution offenses occurred in District 1 (Honolulu Police Department 1993). While there is no reason to assume that there are fewer mentally ill persons in District 1 than at the airport, persons with a mental illness are less likely to stand out and come to the attention of police officers in District 1 than at the airport.

More important to the study, however, is the distribution of the various dispositions and the factors which inform police decision making. In this regard, there is good evidence the study is accurate. First, the quantitative data are verified by the qualitative data. Police acknowledge that they use arrest as a last resort; informal dispositions are preferable to formal.
Yeah, well the other day the guy was beefin' with another guy that lived on the street and all of his clothes was ripped off except for like the waistband of his pants and so was like tattered portions of his pant leg, but he was like completely naked almost. He was just freakin' out. But it was a cocaine thing — he'd been doing cocaine for days. But, so now how do you define that? Is he mentally ill or what? I talked to him and got him to calm down, and I went to the substation and raided Sharon Black's homeless clothing supply and I got a whole bunch of clothes and I went back and he put the clothes on and we talked, smoked a cigarette, and he calmed down and he was cool. But, how do you know, whether, and then he told me he'd been smoking coke, but a lot of times just looking at a guy that, how he's acting, he's just off the wall. But that's a situation where we calmed him down and didn't have to MH1 him. But we could of and he's probably there a year, yeah, that's what I mean. So, I don't know. It's a tough call. But like you said, we want to fix the problem. Well, we're just peacekeepers, right? Go there, keep the peace. You know, calm down, keep everything cool.

Everything's as fast as, the fastest thing that you can do, you know.

I don't see where we do anything that's hardly long term because we just make the arrest, bring 'em in, and it's up to them to...

With our caseload, we don't have any time to do anything long term, that's...

You got to work with these people so we know them when we get the call. Then you can say, alright, I see you haven't been taking your medication first two or three days, you're starting to slip a little. And then you can sit there and take the time, run this person to the hospital, even though we don't do that cause it's really not our job to help, but, we don't have the time to do that. So, we end up getting the person when they've already snapped, and then we deal with the situation (District 1).

The results are also consistent with the findings by Teplin (1984b). Teplin's research design is similar to this study. Teplin found 71.8 percent of the suspects were handled informally (versus 72.3 percent of the suspects the Honolulu study handled informally or where no action was taken), 16.5 percent arrested (versus 14.9 percent in this study), and 11.8 percent hospitalized (versus 9.5 percent in this study combining MH1/MH2, voluntary transport, and arrest to the hospital emergency room).

Of the two theoretical orientations used to explain police behavior in encounters with persons who have a mental illness, labeling appears most useful. As stated in Hypothesis I,
a police officer's knowledge that a mentally ill person had a criminal history was an important explanatory variable in the multivariate logistic regression model of arrest. There are two explanations why this knowledge is an important factor: 1) officers are more likely to invoke criminal sanctions where those sanctions have been used previously, perhaps in part because they get less resistance from the booking officer, and in part because that sanction may have resolved the problem(s) in the past; and 2) officers may have no choice, as in a case where there is an outstanding bench warrant. The latter explanation, however, goes beyond a labeling perspective.

While knowledge that a person has a history of mental illness is significantly related to non-arrest options, as stated in Hypothesis 2, the relationship is not strong enough for the "Known History of Mental Illness" variable to be significant in the multivariate logistic regression models of informal sanctions or no action. In this study, officers believed that all the persons they encountered had a mental illness; in situations where they were certain, they did not want to arrest.

The greatest support for a labeling perspective is found in the multivariate logistic regression model for "no action." The explanatory variable "Known on Sight" is an important predictor of which suspects will be ignored. Suspects for whom police have established certain expectations regarding their behavior, Teplin's (1984b) "neighborhood characters" (p. 170), "nondisruptive regulars," and "unobtrusive 'mentals'" (p. 172), are more likely to be tolerated. As stated in Chapter 1, however, a labeling perspective is not useful in explaining police decision making in situations where a suspect's criminal or mental health history is not known.

Unfortunately, attribution theory is also not particularly useful in explaining police decision making. Three of four hypotheses used to test attribution theory were rejected as the
result of bivariate analyses. One of the hypotheses (number 6) did have an unexpected corollary, however, in that adults with a serious mental illness who lived in a house or apartment/condominium were the ones who most often were taken to the hospital emergency room on an MH1 or MH2 (oral *ex parte*); this finding is consistent with an attribution perspective. The only attribution significantly related to arrest concerned a suspect’s demeanor, specifically aggressive, violent, or uncooperative behaviors. From the data collected with the incident forms and the interviews with officers, it is apparent that officers are more influenced by factors other than an individual’s social characteristics.

Research on police discretion has generally focused on situational and attitudinal factors to explain variations in police behavior. What is lacking is a theoretical model which describes police decision making by integrating institutional- and individual-level characteristics: legal constraints, departmental policies, organizational pressures, years and types of experiences, as well as situational and attitudinal factors. The factors affecting police discretion are complex, coming from a wide range of sources at both micro and macro levels.

One way to connect the micro and macro levels involved in trying to explaining police decision making may be found in organizational theory. Organizational theory typically provides a framework in which micro interactions can be used to build up to macro level organizations. This research strongly suggests that the decision making process is influenced by channels of communication, both vertical and horizontal, the actors which control those channels, the threats and controls which constitute power within the police department’s formal and informal networks, and the incentives and rewards for complying with internal norms. Organizational theory may provide the means to evaluate personal, attitudinal, and situational factors within the context of legal and policy matters; future research on police decision making should examine this approach.
The different roles police are called upon to play in the course of their duties are evident in this study of police discretion. Police are most commonly thought of as enforcers of the criminal law, society's "or else": society's agent to achieve whatever end is intended, including the potential for coercive means (Bittner 1990). However, the police spend relatively little of their time in criminal law enforcement. A greater amount of police resources is expended in regulatory control, such as traffic control, and the greatest amount in activities generally described as peacekeeping. The results of this study support this distribution of resources: most of the police encounters with persons who have a mental illness did not involve the invocation of criminal law or regulatory control, but rather situations in which they had to deal with a public nuisance and their actions constituted an effort to "fix the situation."

On the one hand, police do not have a great deal of control over their activities: our society expects the police to respond whenever they are called. They are always on duty, are constantly being evaluated on how quickly they respond to 911 calls, and their behavior is scrutinized. The expectations confronting the police and the volume of work are overwhelming: in 1993, there were 56,681 reported Index Crimes¹ in the City and County of Honolulu, of which only 13.4 percent were cleared either by arrest or exceptional means (i.e., the suspect is known but cannot be arrested, charged, or prosecuted) (Department of the Attorney General 1994).

On the other hand, police have a great deal of discretion in the exercise of their duties. Some of this discretion is conferred statutorily, some by police policy, and some by common practice. Granting police a certain amount of discretion clearly serves a number of purposes for a wide range of interests: the police can modify their workload and accommodate their capacity to arrest, hold, and process offenders; the courts are not more
overwhelmed with hearings, trials, and probation; the jail (for both pretrial detainees and convicted offenders) and prisons are not even more inundated; etc.

There is a certain amount of ambivalence on the part of society in general concerning how police use this discretion. We do not want the police to give tickets to everyone who violates an ordinance or commits what constitutes a petty misdemeanor, unless that person cuts us off on the freeway or our neighbor plays music too loud at night. We expect the police to respond instantly to our calls while patrolling constantly to prevent us from becoming victims. And we want our Constitutional rights protected but we want dirty, smelly, disheveled homeless persons swept from our sight. We want results, but do not provide the police with the tools to do the job.

It is clear from both the data collection forms and interviews with officers that society’s ambivalence about the police role in social control is not lost on the police department. In general, police are frustrated by the demands of society and the options at their disposal for meeting those demands. The police have accepted their role as "streetcorner psychiatrists" (Teplin 1984b); but when it comes to finding reasonable solutions for dealing with a person with a serious mental illness, the police are at a loss.

Virtually every one of the dispositional options available to the police for dealing with persons with a serious mental illness is inadequate. Officers are most likely to try to diffuse a situation, to try and "fix" what is wrong and ensure that it does not escalate by responding informally, usually with varying degrees of implied or explicit coercion. While that may solve the immediate problem, most officers realize that the solution is temporary: sooner or later, usually sooner, the suspect will return to the baggage claim area to sleep, or stand with papers spilling out of his grocery cart on the sidewalk. The larger problem, that a severely
disabled person is trying to meet basic food, clothing, and shelter needs with minimal success, has not been addressed.

The police in this study consider arrest to be a last resort, reserved only for those who are too violent and disruptive to be left alone (though the arrest data does not wholly support this). From the viewpoint of protecting society and the suspect, arrest is an effective option. As in Worden's (1989) analysis, police were the most consistent in interpreting a situation which called for arrest (i.e., of all the multivariate models in this study, the one which predicted arrest was the most successful). Again, however, the solution is temporary because the source of the problem, the suspect's mental illness, has not been addressed. Arrest in nonviolent situations, or issuing citations, are generally considered futile.

The only dispositional option which addresses the root cause of the violation involves hospitalization, through a courtesy transport, MH1, or MH2 (oral \textit{ex parte}). However, the police recognize that this option is of limited utility: unless admission is voluntary, it is very difficult to meet the involuntary hospitalization criteria. So while the police have the authority to take into custody and transport to the hospital a person with an apparent mental illness who has committed an offense, the person will be released back to the streets unless the stringent criteria are met. It is frustrating for police to try to initiate medical care for a suspect, wait for hours for an exam, only to have the suspect released.

Police are not formally trained to recognize, assess, and treat mental illness; the knowledge and skills they do have are mostly acquired through on-the-job experience. Police do not consider themselves competent diagnosticians, but generally do not hold emergency room psychiatric residents in very high regard either. When the police encounter a seriously disruptive person who has a mental illness and decide to initiate an MH1, they sincerely believe that person meets the involuntary commitment criteria. However, by the time the
suspect is evaluated by a psychiatric resident, several hours have usually passed and the suspect is often less agitated. The psychiatric resident does not witness "imminent" danger and the suspect is not held.

Many police would like to compel the hospitals to admit persons who have a serious mental illness. Given the liability associated with detaining someone against their will, this is unlikely to happen. It is equally unlikely that statutory changes will be made to either broaden police powers in this regard or to lessen the criteria for involuntary commitment. There are other possible solutions, some of which are discussed below.

B. Recommendations

It would be presumptuous to make recommendations concerning police handling of persons with a mental illness if no changes were needed. There are two findings in particular from this study which support changes in current practices. The first finding is that during the one-month study period, police spent 90 hours dealing with persons with a mental illness. Even if the time police spent making arrests, which is the exclusive domain of the police, is subtracted from that total, 66 hours were spent informally treating and transporting mentally ill persons. Moreover, if the officers had chosen to take action in the 30 incidents where they did nothing, another 18 hours of police time could have been spent (30 times 36 minutes, the average amount of time spent). These figures, as stated above, are not a complete accounting of all police-mentally ill civilian encounters and underestimate the total amount of time officers of the Honolulu Police Department spend dealing with mentally ill persons.

Two questions are raised by these figures. First, is this a legitimate function for the police and is this an appropriate investment of police resources? Since the study focuses on
those persons with a mental illness who are doing something for which they could be cited or
arrested, the immediate answer would seem to be yes. However, there is a certain amount of
agreement, at least in the police department and the literature on police discretion in dealing
with the mentally ill that people who violate the law as a direct result of their mental illness
should not be treated the same as those who are not mentally ill. Most of the police-citizen
encounters in this study could have been handled by someone other than a patrol officer. It is
also possible that the eight arrests for contempt could have been avoided, since, in all
probability, the contempt orders were filed for missing a court appearance: it is difficult for
many seriously mentally ill persons to organize their lives to the point where they can keep
track of, and make, court appearances.

Another aspect of the amount of time police spend with persons who have a mental
illness concerns training. None of the police officers interviewed had specialized training
dealing with this population, yet the majority of their involvement requires them to act as
"frontline mental health workers." Police officers expressed frustration at this lack of
training.

The second finding which supports changing the status quo is related to police
frustration: in addition to the lack of training, police are concerned about being put in a
position where nothing they do is effective. Police want to catch criminals and lock them up;
they want to make neighborhoods safe by involving citizens in crime prevention activities and
through community-oriented policing; and they want to help people solve problems, whether
it's a dispute between two people or assisting a stranded motorist. All of those situations have
closure and have a positive result for all concerned. When the police are called to deal with a
person who has a severe mental illness who is disrobing in front of a store, they know they
cannot help in a manner which will be in the best interest of everyone involved. They can get
the person dressed and away from the store, but they cannot help the person who is
decompensating from not having the medication which keeps him or her relatively stable.
They also cannot usually prevent the incident from reoccurring.

There are any number of solutions to dealing with the problems associated with the
police handling of persons with a mental illness in the community. They vary in levels of
sophistication, which roughly translates to commitment, which can be based either on a sense
of social justice or organizational efficiency, and financial resources; the latter usually follows
the former. Three existing models are discussed below (all described in Finn and Sullivan
1989), as well as more limited approaches.

The Los Angeles Police Department faced many of the problems described by officers
in Honolulu: officers were not trained to deal with mentally ill persons, had limited
dispositional options, preferred to divert mentally ill persons involved in minor criminal
offenses into the health care system, had to wait long hours for hospital evaluations, and
frequently had people in custody turned away by the hospitals for lack of space. These
problems were magnified by a series of violent crimes involving persons with a mental
illness. As a result, the chief of police brought together top-level criminal justice and mental
health officials to make recommendations.

The police department established a mental health emergency command post,
upgrading its one-person mental evaluation detail to include nine additional, specially trained
detectives and a secretary. The unit is responsible for:

1. providing immediate telephone consultation in handling mental illness
to any officer in the Los Angeles Police Department;
2. evaluating the condition of suspected mentally ill individuals brought
to the unit's office in downtown Los Angeles; and
3. going on-site, when necessary, to assist police with crisis situations
involving the mentally ill and, when appropriate, to take over the
cases (Finn and Sullivan 1989, p. 5).
In addition, all Los Angeles police officers received instruction at roll calls, continuing education classes, and in field activities to contact the Mental Evaluation Unit before taking into custody someone suspected of having a mental illness. In 1989, the unit received 550-600 calls a month.

The Los Angeles County Department of Mental Health had difficulty fulfilling their part of the program: psychiatric emergency facilities had a chronic shortage of beds. The department implemented several changes in an effort to accommodate emergency admission and to reduce the amount of time officers had to wait. All 24-hour psychiatric emergency service units are required to call a centralized number each morning to report the number of available beds and anticipated vacancies during the next 24 hours. The department's administration could then tell a facility where they could transfer a patient when they reached capacity. In addition, the department encouraged facilities to carefully screen admissions, discharge patients as quickly as appropriate, and to be creative in improvising space.

Interagency cooperation was also the critical component in the approach taken by Washtenaw County, Michigan. The county developed a Policy Team, consisting of major county public service agencies, and an Operational Team, consisting of mid-level agency managers. The Policy Team members were all in a position to make immediate policy decisions regarding the mentally ill. The Operational Team members worked on specific implementation problems. Ten years after this approach was developed (1978), the two teams were meeting every two to three months to address new issues.

The core of the system is a 24-hour telephone hotline supported by a civilian mental health outreach unit. When a sheriff’s deputy encounters a person the deputy suspects has a mental illness, he or she contacts the mental health center assigned to that geographic area
with a description of the general appearance, condition, and behavior of the suspect. Four
courses of action may result:

1. If the subject may not be involuntarily committed under state law but
   might benefit from mental health services, the clinician recommends
   appropriate referral to the deputy by phone.

2. If the clinician judges over the telephone that the person is
   committable, he or she telephones the psychiatric facility nearest the
   scene to arrange for an evaluation. The sheriff’s deputy transports the
   subject to the facility.

3. If the person’s condition at the scene is volatile, or if the clinician and
   deputy sheriff disagree over the phone about whether the person
   should be committed, the mental health center dispatches a two-person
   outreach team to the scene to provide crisis intervention and determine
   the need for hospitalization.

4. Finally, in extreme cases (as when a person is making persistent
   attempts at suicide), deputies may transport the individual directly to
   the center for crisis intervention and assessment (Finn and Sullivan
   1989, p. 6).

The strength of the Washtenaw County approach is the effective communication and
decision making of the Policy Team, combined with the quick implementation of policy
changes by the Operational Team.

The third program highlighted by Finn and Sullivan (1989) involves a cooperative
effort between the Birmingham, Alabama police department and civilian in-house social
workers, Community Services Officers (CSOs). In 1989, six CSOs operated out of police
headquarters, assisting officers between 8 a.m. and 11 p.m., seven days a week. After hours,
CSOs were on-call.

When a police officer came in contact with a mentally ill person, a CSO was called
and usually took over the scene, allowing the officer to return his or her beat. The CSO
would then work with the individual’s family to obtain assistance through a hospital or mental
health center, when possible, or the CSO could contact a case manager or health center
directly. In cases where the mentally ill person was violent, the CSO accompanied the officer
to the hospital emergency room. Once the mentally ill person was restrained by the hospital,
the officer could leave the CSO as the police department's representative for completing paperwork and other official proceedings. If hospitalization was required, the CSO was involved in making arrangements.

All three programs have identified three elements which are essential for the success of any program designed to assist the police deal with persons with a mental illness, and to divert those persons from the criminal justice system, whenever possible: a formal agreement of cooperation between all the participants, a detailed description within the agreement of the specific responsibilities and activities each party will undertake, the participation of every agency and facility that provides emergency services to the mentally ill, and every agency which participates receiving some benefit. Typically, law enforcement benefits in three ways: there is more time for law enforcement, trained staff can reduce danger to the officers, and increased job satisfaction for the officers. The social service system benefits from unnecessarily evaluating, treating, and transferring inappropriate referrals, while the clients of the system benefit from greater continuity of care resulting from referral to facilities which have treated them before. Local government officials also benefit by demonstrating to their constituents concern about a serious community problem, by reducing the possibility of lawsuits for failing to provide adequate services, and by reducing jail overcrowding by diverting the mentally ill to treatment (Finn and Sullivan 1989).

Expenses were not substantial for the three sites. Both Birmingham and Washtenaw County utilized federal funds, while Los Angeles accomplished most of the changes by reassigning staff. Formal evaluations of these programs have not been done or, at least, published. Before implementation of its program, Los Angeles police spent an average of four hours per incident involving persons with a mental illness; after implementation, two and
two-tenths hours. In 1975, Birmingham police handled 900 disturbance calls, mostly involving persons with a mental illness; in 1985, the two CSOs handled all 1,000 such calls.

The American Bar Association (ABA) has developed seven guidelines for the emergency detention of persons with a mental illness by law enforcement officers (Parry 1986). The guidelines call for a better understanding of mental health services by law enforcement officers and increased cooperation and coordination between law enforcement and mental health agencies.

The first guideline suggests that officers seek assistance from screening agencies or a specified mental health screening officer. The purpose of this contact is to help the officer determine if the suspect is appropriate for involuntary civil commitment and to make the screening agency the point of entry into the mental health system.

The second guideline urges that when law enforcement officers take a person into custody, that it be done in a manner to reduce stress and embarrassment to the person with a mental illness, and that the least amount of force necessary is used. Officers are also encouraged to protect the property of the suspect as much as possible.

In many instances, persons with a mental illness do not comprehend what is happening to them when they are taken into custody. The third ABA guideline recommends that officers present the information concerning the reasons for custody, where the person is being taken, and what will happen in a manner that is intelligible to the person.

The fourth guideline is one that Honolulu officers suggest: once an officer has conferred with the mental health screening officer or agency and has taken the person with a mental illness to a mental health facility, the facility should accept the person for evaluation. Such a "no decline" policy allows the officer to leave after completing the necessary paperwork.
Another concern expressed by Honolulu police officers is addressed in the fifth guideline. If the mentally ill person is not admitted to the mental health facility on a voluntary or involuntary basis, the person should not be simply released back to the street. The mental health screening officer or the mental health facility staff should arrange for the person to be returned to home or to another place in the community where they can receive appropriate treatment.

Prompt notification in the early stages of involuntary civil commitment is called for under guideline number six. It is difficult, but important, to balance the individual's right to privacy and the confidentiality of his or her treatment records with the legitimate needs of other people to know the whereabouts, condition, and circumstances of the mentally ill person.

The last guideline recommends that law enforcement officers be provided with adequate training. The training should include

...the nature and manifestations of mental disorders; appropriate techniques for communicating with and handling mentally disordered persons; laws (including the scope of potential liability), policies, and procedures established for responding to requests involving mentally disordered persons, obtaining necessary services for them, and taking mentally disordered persons into custody; policies and procedures for transporting mentally disordered persons to and from mental health and social service facilities; the scope and quality of resources available to assist mentally disordered persons, including those provided by mental health screening officers and screening agencies; and the procedures for contacting an appropriate screening agency and the duties and powers of mental health screening officers (Parry 1986, p. 447-448).

Programs and guidelines such as those described above have implications for the City and County of Honolulu. At the very least, Honolulu should adopt three approaches to dealing with the problems associated with police involvement with persons who have a mental illness. The first approach involves training. The current training program for new recruits is eight and one-half months in duration. During that period, police cadets should receive
training in recognizing and handling the mentally ill. In order to adequately accomplish training, the department must have clearly defined policies and procedures that provide guidance for the humane handling of persons with a mental illness and channelling them through the most appropriate system. More structured and extensive in-service training should be provided.

Second, the police department should also convene a working group, or groups, similar to those in Washtenaw County, Michigan. Both the police and the mental health services community need to make a commitment to provide adequate treatment for persons with mental illness. Police would benefit if they could negotiate a "no-decline" agreement with the hospitals. A centralized clearinghouse for information concerning the availability of bed space and other services would assist both the police and hospitals in making appropriate referrals.

Third, the Honolulu Police Department should institutionalize and expand Project Outreach. An interview with the coordinator of Project Outreach reinforced the need to make the program a permanent part of the department:

The program needs to get some stability, some permanency, because without permanency, you know, it's like you're driving and driving and driving and driving and you come to a stop because you just don't know how much you can do. And you just keep doing everything you can, but yet there's always that subconscious, when is it going to fall.

The program, now in its third year, has accomplished much of what the programs described above have. In the first year, Project Outreach handled about 20 to 30 cases per month; last year, 40 to 50 cases. The program has demonstrated that it has "proven itself as a valuable tool" by reducing the amount of time police officers spend away from their beat.

In addition to lending permanency to Project Outreach, the Honolulu Police Department should expand the program. Current staffing by one person is inadequate to
provide services to all eight districts. Many police officers expressed a desire to utilize Project Outreach; for those farthest from downtown Honolulu, it was not always practical to call, given the amount of time it took to respond; for others, the knowledge that there was only one person made them reluctant to call. An expanded staff could accomplish two important goals. First, more outreach workers could be more effective in preventing persons with a mental illness from coming into contact with the police. An outreach worker with a specific caseload could make sure his or her clients made court appearances, took medication (even if the outreach worker delivered the medication on a daily basis), assisted with food, clothing, and shelter, and served as an advocate in dealing with the criminal justice and mental health systems. Second, more outreach workers could be used to staff a program similar to that in Washtenaw County or Birmingham. Most of the eight police districts could benefit from having an outreach worker assigned to their substation. The outreach worker could serve as a reference to patrol officers dealing with a difficult person, take over specific cases, especially at hospital emergency rooms, and provide in-house training. Once the outreach worker got to know the "regulars" in a district, he or she could function more proactively than reactively.

The vision expressed by the coordinator of Project Outreach is similar in many respects. Project Outreach could serve as a central point for a number of department-based service programs, with specialists in domestic violence, juveniles, the elderly, and the mentally ill. The advantages of Project Outreach over some programs piloted by the department are 1) the program has a view to both the legal and social systems; and 2) most importantly, operates 24 hours a day, seven days a week.

Like many efforts to assist the poor and the handicapped, Project Outreach exists in a political environment which is not particularly sensitive to the needs of people who do not
vote. The dual forces of shrinking budgets and public frustration over what is perceived as people taking advantage of "the system" have placed prevention programs in jeopardy.

The community needs to come together to decide how to address the increasing problem of homelessness and substance abuse, problems which are magnified in the mentally ill population. Persons with a mental illness who live with family are much less likely to come to the attention of the police and much more likely to receive support. Many of the homeless mentally ill are gravely disabled: malnourished, ill, and/or injured. Frequently, the problems are compounded by self-medication with alcohol and/or illegal drugs. Currently, our society seems to be saying we do not want to criminalize these behaviors for persons with a mental illness, and we are willing to provide treatment for those who can be legally coerced through involuntary civil commitment. But short of those two extremes, there are few efforts to provide community-based services; in fact, public funds for shelters and community health centers are being reduced.

As of January 1995, there are two different efforts to address some of the problems described in this research. First, the State Attorney General is looking for a test case to challenge the Ninth Circuit Court's ruling in Suzuki v. Quisenberry regarding the obviously ill and gravely disabled. People who claim to be advocates for the mentally ill are divided on this issue. Some would like to see the pendulum swing a little away from individual civil liberties towards (involuntary) medical and psychiatric care. Still others are concerned about any diminution in civil rights and equal protection.

The second effort involves a proposal by the City Council of the City and County of Honolulu to make it illegal for anyone to sleep outdoors on any public sidewalk, street, park, mall, parking structure, or any public place under the control of the city between the hours of 8:00 p.m. and 6:00 a.m. The proposal classifies the offense as a petty misdemeanor,
punishable with a maximum fine of $1,000 and 30 days in jail. Advocates for the homeless and the homeless mentally ill complain that the proposal does not address the problem of inadequate living space and would likely be challenged in court (Omandam 1995).

Without community-based services, it is reasonable to assume mentally ill persons who decompensate in public, or who otherwise, by virtue of their mental illness, run afoul of the law, will end up in jail or in the gaping crack between the criminal justice and mental health systems. The police have no choice but to respond to public disorder. Without appropriate alternatives, the police will continue to serve as frontline mental health workers.
1. Index Crimes is a designation of the Federal Bureau of Investigation's Uniform Crime Reporting Program and includes the offenses of homicide, forcible rape, robbery, aggravated assault, burglary, larceny-theft, motor vehicle theft, and arson.
APPENDIX A

INCIDENT CODING FORM

Instructions: Complete this form for each incident in which a person with a suspected mental illness commits an offense for which he/she could be cited or taken into custody. The incident need not result in a citation or an arrest for this form to be completed.

**HRS Section Number/Offense**

<table>
<thead>
<tr>
<th>Location</th>
<th>Beat of Offense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Residence</td>
<td>7. Scenic Pt.</td>
</tr>
<tr>
<td>3. Hotel</td>
<td>9. Restaurant</td>
</tr>
<tr>
<td>4. Street</td>
<td>10. Bar</td>
</tr>
<tr>
<td>5. Non-Beach Park</td>
<td>11. Store</td>
</tr>
<tr>
<td>6. Beach Park</td>
<td>12. Bank, etc.</td>
</tr>
</tbody>
</table>

**Date/Time/Day Occurred From:**

<table>
<thead>
<tr>
<th>Source of Call</th>
<th>Date/Time/Day Occurred to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self Referred</td>
<td>5. Mental Health Facility</td>
</tr>
<tr>
<td>2. Family</td>
<td>8. Store, Restaurant, Business</td>
</tr>
<tr>
<td>3. Neighbor/Friend</td>
<td>(incl. Hawaii State Hospital)</td>
</tr>
<tr>
<td>4. Medical Hospital</td>
<td>9. Other</td>
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<tr>
<td>6. Police Patrol</td>
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**Disposition:**

<table>
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<th>(circle one)</th>
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<tbody>
<tr>
<td>1. Arrest-Police Cell Block</td>
<td>5. Call Support Agency</td>
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<tr>
<td>2. Arrest-Hospital ER</td>
<td>6. Informal</td>
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<tr>
<td>3. Voluntary Transport-ER</td>
<td>7. No Action</td>
</tr>
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<td>4. MH1/Ex Parte</td>
<td>8. Other</td>
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**Reason for Disposition:**

**Age:**

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<td>1. Hawaiian</td>
<td>5. Chinese</td>
</tr>
<tr>
<td>2. White</td>
<td>9. Tongan</td>
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<tr>
<td>3. Filipino</td>
<td>13. Unknown</td>
</tr>
<tr>
<td>5. Chinese</td>
<td>14. Other</td>
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</tbody>
</table>

**Know on Sight?**

| 1. Yes | 2. No |

**Known Criminal History?**

| 1. Yes | 2. No |

**Known History of Mental Illness?**

| 1. Yes | 2. No |

**Residence Type**


**Employment**

| 1. Full-time | 2. Part-time | 3. Unemployed |

**Circle all that pertain to suspect:**

1. Assaultive/Violent Behavior
2. Loud/Obnoxious Behavior
3. Bizarre Behavior
4. Crying/Tearful
5. Confused
6. Uncooperative
7. Passive
8. Intoxicated (drugs or alcohol)
9. Scared
10. Incoherent
11. Cooperative
12. Physical Injuries to Self
13. Embarrassed/Ashamed
14. Depressed
15. Agitated
16. Untidy
17. Non-Communicative

**Years in Police Department:**
APPENDIX B
INTERVIEW QUESTIONS

Cover Page

Date:
Time:
District:
Beat(s):
Officer Age:
Officer Sex:
Officer Race/Ethnicity:
Number of Years in the Police Department:

Questions

A. Perceptions of the Problem

1. In your district (beat) do you encounter many people who you believe have a mental illness?

2. How do you tell if someone has a mental illness?

3. How do you distinguish between someone who has a mental illness and somehow who is not mentally ill but is homeless?

4. What proportion of the homeless do you think have a mental illness?

5. How do you distinguish between someone who is under the influence of alcohol or other drugs and someone who is mentally ill? How about mentally ill and under the influence?

6. What kind of training have you received to recognize and deal with persons who have a mental illness?

7. In what type of situation do you most often encounter persons with a mental illness? [Example]

8. Is there a typical profile for a mentally ill person who comes to your attention?
B. Encounters and Responses

1. Can you tell me about the last time you encountered someone who has a mental illness in the course of your work?

2. Under what conditions or circumstances would you arrest a person with a mental illness? (What would cause you to arrest such a person vs. other dispositions?)

3. Are there situations where a person commits an arrestable offense when you would not arrest them?

4. Are there conditions or circumstances where you would place someone under arrest and take them to the hospital ER, either for evaluation or some other intervention?

5. When would you do a voluntary -- or courtesy -- (which is it called?) transport to a hospital?

6. Do you ever do voluntary transports to other locations (e.g. home, outpatient clinic, etc.)?

7. Under what conditions would you request an oral ex parte -- MH1? How do you get an MH1?

8. Do you ever have occasion to call a support agency to help (e.g. CRSP, Sharon Black, a public or private service provider)? When might you do this?

9. It seems that officers handle many situations informally -- that is, talking with the person, IC (interview). Under what conditions or circumstances would you choose to do this rather than some other action?

10. Are there situations or circumstances where someone who has a mental illness comes to your official attention (that is, that person called, or someone else called about the person, or you see them doing something for which they could be counselled, cited, or even arrested) and you choose to ignore it?

11. During the course of this study, I noticed that very few citations were issued. Why do you think that was?

12. Other than those already mentioned, do you have other options when dealing with mentally ill persons?

C. Policies and Constraints

1. What HPD policies govern your actions or influence your choices?
2. In addition to policies, are there directives or other pressures to do one thing or another (including pressure from the business community because of visibility/tourism)?

3. What do you see as the role of the police when it comes to persons with a mental illness in the community?

4. Is there anything the city/county, state, or private sector could do to make your life any easier?
## APPENDIX C

### VARIABLE LIST

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<tr>
<th>Variable Name</th>
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<td>DISTRICT</td>
<td>District</td>
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<td>OFFENSE</td>
<td>HRS Section Number/Offense</td>
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<td>Beat of Offense</td>
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<td>LOCATION</td>
<td>Location of Offense</td>
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<td>MONTH1</td>
<td>Month Occurred From</td>
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<td>Year Occurred From</td>
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<td>Suspect Race/Ethnicity</td>
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<td>Bizarre Behavior</td>
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<td>Crying/Tearful</td>
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<td>Incoherent</td>
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<td>Officer Years in Police Department</td>
<td>1-28</td>
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Note: The variable list does not include transformations.
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Bittner, Egon.


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<td>1995</td>
<td>Castle Medical Center</td>
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