The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

Police Use of the Taser With People With Mental Illness in Crisis

Police officers have become first responders to individuals with mental illness who are experiencing a crisis. Much recent attention has been given to the overrepresentation of people with severe and persistent mental disorders in U.S. jails and prisons. More tragic still are the incidents in which law enforcement officers either kill a person with mental illness or are killed during an encounter. The Treatment Advocacy Center reports on its Web site that 52 mentally ill individuals were killed in 2003 by law enforcement officers and that seven officers were killed by persons with mental illness.

Law enforcement experts speculate that fatal encounters with individuals with mental illness have increased over the past few decades as a result of promulgation of what they call the "21 foot rule" and an impression that people with mental illness commonly carry knives for self-defense. Police are trained that a person with a knife can traverse 21 feet and deliver a fatal strike before an officer can draw and accurately deploy his or her weapon.

The Summit County, Ohio, mental health community began planning with advocates and the Akron Police Department for implementation of a crisis intervention team (CIT) in June 2000. The CIT model, which was first used in Memphis, provides intensive training about mental illness and the treatment system to patrol officers who volunteer for this additional training. Particular emphasis is given to verbal deescalation skills. Trained officers are on duty at all times and respond to calls that are believed to involve individuals in a mental illness crisis.

In planning the program, the training director of the Akron Police Department, Michael Woody, identified the need for CIT officers to have a less lethal weapon available when words alone were not adequate. The police department decided to provide CIT officers with the M-26 advanced Taser, an electroshock device that is a less lethal weapon when deployed in situations when a regular service revolver may not be necessary. The M-26 Taser delivers a 50 kV (3 mA) electrical charge by means of shooting two darts connected to the device by a 21-foot tether. Before adopting the Taser, the police department's training director consulted the local chapter of the National Alliance on Mental Illness (NAMI). Given the choice between guns and Tasers, the advocates at NAMI urged the department to deploy Tasers.

We examined the early experience of the Akron Police Department with the Taser. CIT officers documented use in 35 incidents during the first 18 months. No incident resulted in serious harm to the individuals in crisis or officers. Twenty-seven of the 35 individuals were judged to have a mental illness. Although 21 were known to the public mental health system, only two were engaged in outpatient treatment and adhering to treatment. Individuals were judged to be acutely psychotic in eight incidents, and in 16 incidents individuals expressed suicidal ideation and one was also homicidal. Ten possessed weapons, most often a knife. Sixteen of the crises were judged to be potentially life threatening.

Police use of the Taser has become a source of recent controversy. Concerns have been raised about its safety, and some people believe that it may be used too casually as a means of intimidation or control. The Akron Police Department provided Tasers only to specially trained CIT officers, believing that these officers were more likely to encounter situations in which the Taser might be needed and that these officers were most likely to use verbal deescalation skills before using force. The police department has in fact used the Taser sparingly. The 35 cases reported here occurred over an 18-month period in which there were 541 CIT responses. The frequency of use has increased only modestly over time, with a total of 150 uses in the first 51 months of deployment. We did not find any cases of clearly inappropriate or abusive use of the Taser in the sample of 35 incidents.

Given the problem of deaths and serious injuries resulting from encounters between the police and people with mental disorders, deployment of less lethal weapons, such as the Taser, may be part of a solution to a significant public health problem. However, because of recent controversy about the safety of this weapon and efforts to reduce the use of seclusion and restraint in mental health settings, deployments of the Taser is likely to be controversial, and opinions of mental health advocates are likely to be divided.

More systematic risk-benefit studies of the Taser are clearly needed. Perhaps this tool can be used most prudently in communities with effective partnerships between the law enforcement and mental health treatment systems.

Mark R. Munetz, M.D.
Antonia Fitzgerald, M.D.
Lt. Michael Woody (Retired)

Dr. Munetz is chief clinical officer of the Summit County Alcohol, Drug Addiction and Mental Health Services Board, 100 West Cedar Street, Suite 300, Akron, Ohio 44307 (e-mail, mmunetz@neoucom.edu). He is also professor of psychiatry at Northeastern Ohio Universities College of Medicine. Dr. Fitzgerald is staff psychiatrist at St. Elizabeth Health Center in Youngstown, Ohio. Lt. Woody is law enforcement liaison with the Ohio Criminal Justice Coordinating Center of Excellence at the Northeastern Ohio Universities College of Medicine.

Streets to Shelter in Chennai, India

The Banyan, a shelter for homeless women with mental illness in Chennai, India, was set up in an effort to restore hope and dignity to ignored and marginalized women. Chennai is one of the four largest cities in India, with an estimated population in excess of seven million. The Banyan serves as a sanctuary for these women and strives to make a difference through providing treatment and rehabilitation and helping residents reunite with their families. Over the past decade it has reached out to more than 1,500 women and has helped more than 850 find their way home. At any given time the program shelters more than 550 women.

The program was conceived by two young women who encountered a mentally ill woman on the street. Half naked, alone, unable to care for herself, and in desperate need of attention, she was denied help by health institutions. Similar encounters left the idealistic duo disillusioned, and they decided to do something themselves. The Banyan began in 1993 as a three-bedroom shelter for women with mental illness who had wandered from their homes and ended up living on the street.

Founded on the belief that every person is entitled to a life of dignity, the Banyan was registered as a trust later that year. Social marketing of the cause and lobbying to increase society's responsibility for people in need became important objectives. Efforts to involve all sections of society in a movement to ensure the rights of individuals with mental illness gained momentum. Media outlets and celebrities were enlisted to make the campaign highly visible.

With the rapid increase in the number of women seeking the services, it became imperative that the Banyan had a building of its own. Land was donated by the government, and after two years of fund raising, the dream became a reality. In 2001, a facility with 24,000 square feet of fully equipped, comfortable space was opened. Designed in two blocks—transit care and vocational training—the new facility includes consulting rooms, sick bays, an auditorium, medical and psychiatric isolation facilities, a geriatric ward, and a recreational therapy unit. Women are housed in the transit care home on admission and gradually moved to the vocational block, which operates in nearby building because of lack of space. The Banyan employs a staff of 106, which includes 35 health care assistants, 12 professionals (medical and psychiatric social workers, clinical psychologists, and occupational therapists) and three trained nurses. The medical team comprises three psychiatrists, a general physician, and a dermatologist.

The program uses a three-step approach. For crisis intervention, a rescue team provides immediate outreach when a report is received about a mentally ill woman on the street. Women are also brought to the facility by concerned volunteers or police. In the second step, women receive treatment and holistic care. Treatment is a mix of pharmacotherapy, alternative therapies, and positive reinforcement. The healing energies of dance, music, and art are harnessed. On average, women spend from three to six months in the program.

The third step is rehabilitation. The rehabilitation process includes ongoing pharmacotherapy, psychological sessions, group activities, assessment and training in activities of daily living, and vocational training. Psychological sessions include psychoeducation and cognitive-behavioral therapy. Groups are designed to facilitate freedom and ownership of the program; participants are encouraged to share their grievances and voice their opinions about the shelter environment and suggest ways to improve it. Teaching and practical training on aspects of daily living, such as personal hygiene, cooking, and domestic tasks, are provided. Vocational training works toward helping women gain employment and financial independence. Tailoring, weaving, handicrafts, printing, and further education are examples of some of the activities pursued.

After successful rehabilitation, the Banyan program provides a lifelong supply of free medication to ensure residents' continued health. The Banyan helps residents find and contact their family members. Women who live outside the city are linked to local psychiatric services or other nongovernmental organizations for ongoing assessment and distribution of medication.

The Banyan has set up a group home near the shelter. The unstaffed home currently houses nine women for whom integration with families has not worked for various reasons. The residents are gainfully employed and take care of their own day-to-day needs.

As the Banyan staff dealt with the immediate problem of destitute women with mental illness, they became aware of the unlimited need for mental health services. In response, the Banyan introduced free outpatient psychiatric consultation for former residents and for the public—women, men, and children. To decrease stigma, they also organize events, such as street theater and dance, to raise awareness about mental illness in areas where superstition and ostracism of people with mental illness are serious problems. Program staff have also worked with the courts to establish a legal aid clinic to ensure that the rights of individuals with mental illness are recognized and attended to.

To help strengthen the mental health system, the Banyan program created a network of advocacy organizations across India. The Banyan also advises partner organizations that replicate the model of care. Resources to operate the Banyan come from individual donations, corporations, and fund raising. Not long ago, mental illness and homelessness were problems that few people in India acknowledged. Today the local population is aware of these problems and of the need to provide solutions.

Dharangini Dinakaran, M.R.C.Psych.

Dr. Dinakaran is a psychiatrist currently working in London. Send correspondence to her at dharangini@yahoo.com. More information is available on the Banyan's Web site at www.thebanyan.org.