Wrongful Convictions and Mental Illness:
A Qualitative Case-Study of James Blackmon

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People with a mental illness ("PWMI") are among society's most vulnerable populations, yet PWMI in America face a heightened risk of wrongful conviction for several reasons. At the onset of an investigation, PWMI are more likely to become suspects. Symptoms of mental illness breed fear and misunderstanding, arousing suspicion of PWMI in the first place. Once approached by police, PWMI are more likely to escalate the initial encounter, leading to arrest and further interrogation. Through the lens of the Reid Technique, police misinterpret symptoms of mental illness as signs of guilt. Police continue using the Reid Technique to extract a confession. Mid-interrogation, PWMI are less likely to invoke Miranda rights. Without counsel, PWMI are more susceptible to minimization and maximization techniques, leading to higher rates of false confessions and ultimately false convictions. These issues are significantly exacerbated for PWMI of color, who experience additional racial bias. From the beginning of an investigation to the end, the justice system seems perversely calculated to target innocent PWMI rather than protect them. The case of James Blackmon demonstrates how an innocent PWMI can be railroaded into a false confession and wrongful conviction. This paper details Blackmon's case, analyzes how each step of an investigation endangers PWMI, and examines possible solutions to protect innocent PWMI.

I Introduction

People with a mental illness ("PWMI"[1]) are among society's most vulnerable populations, yet PWMI are significantly overrepresented in the American criminal justice system.[2] According to the Department of Justice, 37% of state and federal prisoners and 44% of jail inmates have been diagnosed, at some point, with a mental health disorder.[3] This is markedly higher than the occurrence of mental illness in the general population, which hovers around 11%.[4] Studies vary on the extent and origin of the problem, but scholars tend to agree that PWMI are jailed at disproportionately high rates when compared to people without a mental health issue.[5]

Despite the frequency at which PWMI come in contact with the criminal justice system,[6] there are few protections recognizing the inherent vulnerability of this group. As a result, PWMI in America face a significantly heightened risk of wrongful conviction.[7]

Several factors contribute to this phenomenon. At the onset of an investigation, "strange" behavior attributable to mental illness can attract attention, both from the community and the

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[1] For simplicity, this paper will also use PWMI to refer to a single person with a mental illness. PWMI are not a homogenous group, and a vast spectrum of mental disorders exist. But generally, a serious mental illness "refers to three diagnoses: (1) schizo-spectrum diagnoses, such as schizophrenia; (2) bipolar disorder; and (3) major depression." Allison Redlich & Steven Drizin, "Police Interrogation of Youth," in Carol Kessler & Louis Kraus, eds, *The Mental Health Needs of Young Offenders: Forging Paths Toward Reintegration and Rehabilitation* (Cambridge: Cambridge University Press, 2007) 61 at 70, online: <https://www.researchgate.net/publication/289783248_Police_interrogation_of_youth> [*Redlich 1*].

[2] See *ibid*. See also Matt Vogel, Katherine D Stephens & Darby Siebels, "Mental Illness and the Criminal Justice System" (2014) 8:6 Sociol Compass 627, online: <https://www.researchgate.net/profile/Matt-Vogel-2/publication/264806391_Mental_Illness_and_the_Criminal_Justice_System/links/59d78be2458515db19cba310/Mental-Illness-and-the-Criminal-Justice-System.pdf>. Seth Prins, "The Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review" (2015) 65:7 Psychiatr Serv 862, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182175/>. This is not a uniquely American phenomenon, and the overrepresentation of PWMI in correctional facilities has been well-documented around the world. However, the scope of this paper is limited to the American justice system and the risk of wrongful conviction PWMI face in America.

[3] US Department of Justice, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12* by Jennifer Bronson & Marcus Berzofsky, (Bureau of Justice Statistics, Jun 2017) at 1, online: <https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf> [*Bronson & Berzofsky*].

[4] US Department of Justice, *Mental Health Problems of Prison and Jail Inmates,* by Doris James & Lauren Glaze, (Bureau of Statistics Sep 2006) at 3, online: <http://biblioteca.cejamericas.org/bitstream/handle/2015/2829/Mental_Health_Problems_Prison_Jail_Inmates.pdf?sequence=1&isAllowed=y>.

[5] Prevalence estimates of mental illness in jail range anywhere from 3 to 12 times higher than in the general population. Prins, *supra* note 2 at 2.

[6] One systemic review found that roughly one in four PWMI have a history of police arrest. James D Livingston, "Contact Between Police and People with Mental Disorders: A Review of Rates" (2016) 67:8 Psychiatr Serv 850 at 851, online: <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500312>. However, surveys have found that as many as 40% of PWMI have been in jail at some point in their lives. See Donald M Steinwachs, Judith D Kasper & Elizabeth A Skinner, National Alliance for the Mentally Ill, *Final Report: NAMI Family Survey* (1992).

[7] See generally Lauren Rogal, "Protecting Persons with Mental Disabilities from Making False Confessions: The Americans with Disabilities Act as a Safeguard" (2017) 47:1 NM L Rev 64, online: <https://digitalrepository.unm.edu/nmlr/vol47/iss1/4>. Allison Redlich, "Mental Illness, Police Interrogations, and the Potential for False Confession" (2004) 55:1 Psychiatr Serv 19 at 19, online: <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.1.19> [*Redlich 2*].

police. Such behavior singles out a PWMI as suspicious, and thus a potential suspect. Once approached by police, PWMI are more likely to escalate the encounter, leading to arrest and formal interrogation. Mid-interrogation, police may misinterpret symptoms of mental illness as signs of guilt. Convinced by the Reid Technique that a PWMI is guilty, officers continue using the Reid Technique to extract a confession. PWMI are more susceptible to both minimization and maximization techniques yet are less likely to understand their *Miranda* rights and the legal protections to which they are entitled. As a result, PWMI are more likely to proffer false confessions, leading to disproportionately high rates of wrongful conviction.[8]

From the beginning of an investigation to the end, PWMI face a higher risk of wrongful conviction than people without mental health issues. A qualitative case study of James Blackmon demonstrates how an innocent PWMI can be railroaded into a false confession and eventually a wrongful conviction. This paper will detail Blackmon's case (Section II), use Blackmon's case to illustrate how each step of an investigation endangers PWMI (Section III), and examine possible solutions to protect innocent PWMI (Section IV).

II The Case of James Blackmon

Around 6:15AM on September 28, 1979, an unidentified man stabbed Helena Payton in the bathroom of Latham Hall, her dorm at St. Augustine's University.[9] Witnesses described the suspect as a tall and thin black male in his twenties, clean-shaven with a short afro.[10] Additionally, they described his clothes as a "dashiki-style shirt."[11] The police recovered such a shirt in the woods behind the dorm, spattered with blood stains.[12]

The case went cold for four years, until Raleigh police received a confidential tip that a patient at Dorothea Dix Hospital—a local psychiatric hospital—had been talking about murdering several black women, including a woman at St. Augustine's.[13] The source was unsure of the patient's name, but thought it was possibly "Braemer or Brammer or Bramer, or something like [that], starting with the letter 'B.'"[14] No patient named "Brammer" resided at the hospital. Police instead focused on 28-year-old James Blackmon, the only patient at Dorothea Dix who fit the general physical description of the suspect.[15]

Detectives James Holder and Andrew Mundy were assigned to the case, and they began to study Blackmon's medical file and criminal history. They learned Blackmon had been diagnosed with paranoid schizophrenia, manic-depressive psychosis, and various other personality

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[8] See *Rogal*, *supra* note 7. *Redlich 2*, *supra* note 7 at 19.
[9] See Ken Otterbourg, "James Blackmon: Other Exonerations with False Confessions" *The National Registry of Exonerations* (3 Sep 2019), online: <https://www.law.umich.edu/special/exoneration/Pages/casedetail.aspx?caseid=5603> [*Otterbourg*].
[10] *Ibid.*
[11] *Ibid.* A dashiki is a style of West African pullover shirt; dashikis are often loose-fitting and colorful.
[12] *Ibid*.
[13] *Ibid.*
[14] North Carolina Innocence Inquiry Commission, *State v. James Blackmon Brief* (2019) at 228, online: <https://innocencecommission-nc.gov/wp-content/uploads/state-v-blackmon/state-v-blackmon-brief.pdf> [*NCIIC*].
[15] See *ibid*. See also *Otterbourg*, *supra* note 9.

disorders.[16] Medical files described Blackmon as hostile, grandiose, paranoid, and subject to powerful delusions.[17] He had cycled in and out of several psychiatric and correctional facilities and was currently residing at Dorothea Dix.[18]

The detectives formally interviewed Blackmon seven times and spoke to him informally on several other occasions.[19] Throughout the interviews, Blackmon displayed evidence of severe delusions. He believed he had powers, like witchcraft, telepathy (reading minds), and telekinesis (making events happen with his mind).[20] For example, Blackmon claimed he "called" a judge to fall out of his chair, and the judge retaliated by sending him to jail.[21] He also frequently wore a Superman cape during his interviews and claimed to levitate.[22]

Despite clear evidence of mental illness, the police continued their interrogations. Moreover, the detectives took advantage of Blackmon's delusions to extract a confession. They told Blackmon that while he may not remember visiting St. Augustine's, his body may have gone while his mind stayed behind.[23] The detectives also encouraged the delusion that Blackmon's "soul" could get loose of his body, and that this "Bad James" committed crimes without "Good James'" knowledge.[24] The detectives consistently asked what Bad James did at St. Augustine's, referring to Bad James in the third-person so as to distance Good James from any wrong-doing.[25] They insisted they believed Good James and they were Good James' friends.[26] Through this manipulation, the detectives led Blackmon to admitting Bad James had visited St. Augustine's, had cut a girl in the bathroom on the top floor, and had buried the knife afterwards.[27]

The police also took Blackmon to the crime scene at St. Augustine's and led him on a tour of Payton's dorm. They led him through the dorm and inside the bathroom where Payton was stabbed. Blackmon pushed open a stall door, and allegedly (the visit was not recorded) said, "This is where it happened." Detective Holder asked Blackmon "What happened, James? Where were you?" Blackmon did not give any details, merely saying "I was here and she was there." Blackmon then went to a sink and washed his hands, saying "This is what I did."[28] The police relied on these vague confessions to pursue a conviction, despite the fact that Blackmon got many details of the crime wrong. The stabbing occurred at around 6:15 in the morning. When the police asked Blackmon what time his body was at St. Augustine's, he responded, "It's about in the evening, at noon."[29] When the detectives asked how he ended Payton's life, he responded that he either "choked her or gave her some kind of drugs to mess up her forever to kill her or some poison."[30]

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[16] *NCIIC*, *supra* note 14 at 230-231, 280.
[17] See *ibid*.
[18] *Ibid* at 228-33.
[19] *Ibid* at 14-15.
[20] *Ibid* at 280, 378-380, 387, 396.
[21] *Ibid* at 374-375.
[22] See *Otterbourg*, *supra* note 9.
[23] *NCIIC*, *supra* note 14 at 382-83, 396-98.
[24] *Ibid* at 380.
[25] *Ibid* at 416-28.
[26] *Ibid* at 422, 425, 427.
[27] *Ibid* at 417-18.
[28] *Ibid* at 405.
[29] *Ibid* at 386.
[30] *Ibid* at 391.

But Payton was stabbed. Blackmon consistently mentioned having sex with the victim, however there was no indication that Payton was raped.[31] Blackmon routinely flip-flopped and gave contradictory statements on multiple aspects of the case.[32]

Such inconsistent testimony is especially alarming because no physical evidence linked Blackmon to the murder, and an eyewitness could not pick Blackmon out of a lineup.[33] The prosecution relied solely on Blackmon's confessions to pursue a conviction.

Blackmon eventually entered an Alford plea, which allows a defendant to acknowledge that prosecutors have enough evidence to win a conviction but does not admit guilt.[34] After submitting his plea, Blackmon went to jail for more than two decades. In 2012, the North Carolina Prisoner Legal Services submitted Blackmon's case to the North Carolina Innocence Inquiry Commission. In 2013, advances in fingerprint technology allowed latent prints from the bathroom to be retested. The prints did not match Blackmon.[35] Five years later, the Commission voted unanimously that there was sufficient evidence of Blackmon's innocence to merit a judicial review. A three-judge panel met in August 2019 for three days of hearings, culminating in a declaration that Blackmon was innocent. After 36 years in prison, Blackmon was released to stay with family members.[36]

A cascading series of increasingly poor decisions led to Blackmon's wrongful conviction. Unfortunately, his case is not unique. On the contrary, it typifies how PWMI are at a higher risk of false conviction. The next section will use details from Blackmon's case to illustrate how PWMI are vulnerable to wrongful convictions at every step of an investigation.

III Problem: Innocent PWMI Face a Heightened Risk of Wrongful Conviction

A. Pre-Indictment: More likely to become a suspect

In the early stages of an investigation, misinterpretation of a PWMI's symptoms may increase the chance he is flagged as a suspect. Symptoms of mental illness often attract attention, leading the community and officers to deem a PWMI as suspicious. Once approached, officers tend to misconstrue symptoms of mental illness as guilt, especially when using the Reid Technique. Such misinterpretation leads to further questioning and eventually formal interrogation, rather than clearing the PWMI and moving on to the next suspect.

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[31] *Ibid* at 406-408.
[32] *State of North Carolina v James Blackmon*, "Special Session Before the North Carolina Innocence Inquiry Commission Transcript" (14 Nov 2018) 1 at 428-29, 442, online: <https://innocencecommission-nc.gov/wp-content/uploads/state-v-blackmon/state-v-blackmon-hearing-transcript.pdf> [*NC Blackmon*].
[33] Associated Press, "False Confession Expert Testifies in NC Innocence Case", *WCTI News* (21 Aug 2019), online: <https://wcti12.com/news/state-news/false-confession-expert-testifies-in-nc-innocence-case>.
[34] Martha Waggoner, "North Carolina Man Exonerated by Panel in 1979 Dorm Slaying", *AP News* (22 Aug 2019), online: <https://apnews.com/93519aca1dfd4b0585e8a0feab93f51c>.
[35] Martha Waggoner, "NC Innocence Case Hinges on Mentally Ill Man's Confession," *AP News* (19 Aug 2019), online: <https://apnews.com/a7c0cce0f4a04bc8b7211e3529a9f8f3>.
[36] *Otterbourg*, *supra* note 9.

a. Attracting attention and suspicion

Due to their mental illness, innocent PWMI may behave in ways that are strange or off-putting to observers.[37] Such behavior attracts attention and suspicion and may create a reputation in the community that a particular PWMI is odd or dangerous. This preconceived idea that a PWMI is frightening and strange may lead a community to suspect that person when a crime occurs, especially if there are no other clear suspects. Generalized fear of a local PWMI narrows into particularized suspicion that he perpetrated a violent crime.

For example, police investigating Sabrina Buie's murder focused their investigation on 19-year-old Henry Lee McCollum because a local teenager thought McCollum was "crazy."[38] Buie, an 11-year-old girl, was murdered in Red Springs, North Carolina in 1983. Local 17-year-old Ethel Furmage informed police that she had heard rumours at school that McCollum's half-brother, Leon Brown, was responsible for the murder. However, she also pointed the police towards McCollum because he "stared at people" and "just [did] not act right."[39]

McCollum and his brother were wrongfully convicted for the murder and spent 30 years in prison before DNA evidence exonerated them.[40] Furmage had no personal knowledge that McCollum was involved in Buie's death, nor had she heard any rumours indicating he committed the crime.[41] No physical evidence or eyewitness testimony tied McCollum to the murdered girl.

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[37] Mental illness varies widely, covering a vast spectrum of symptoms. However, some common symptoms of mental illness include:

1. Confusion, disorientation, and disorganization of thought.
2. Poor working memory and memory gaps.
3. Deficits in executive functioning, problems paying attention, and impaired decision making.
4. Unusual speech patterns or peculiar styles of speech, such as rambling, vaguely trailing off, speaking too quickly or too slow, or racing through thoughts that are not connected.
5. Bizarre or unusual thoughts, delusions, and belief in special powers (such as telepathy). This could include responding to voices or visions, or interacting with people who are not really there.
6. Inappropriate emotional responses to situations, or jumping from one emotional extreme to another.
7. Excessive movement, such as trembling, shaking, and fidgeting.
8. Aggression or hostility. Most individuals with mental illnesses are not violent. However, some mental illnesses, like personality disorders, can manifest in anger and belligerence.

See e.g., National Alliance on Mental Illness, *Know the Warning Signs*, online: <https://www.nami.org/learn-more/know-the-warning-signs>. Mayo Clinic, *Schizotypal Personality Disorder*, online: <https://kcms-prod-mcorg.mayo.edu/diseases-conditions/schizotypal-personality-disorder/symptoms-causes/syc-20353919>[*Mental Illness*]. Judges' Criminal Justice/Mental Health Leadership Initiative, *Judges' Guide to Mental Illnesses in the Courtroom*, online: <https://www.tmcec.com/files/1615/1440/5028/00_-_Spain_BINDER_Special_Populations.pdf>. *Redlich 1*, *supra* note 1 at 70.

[38] *State of North Carolina v Henry Lee McCollum*, "MAR Hearing Transcript" (2 Sep 2014) 1 at 21-23, online: <http://www.ncpolicywatch.com/wp-content/uploads/2015/05/Postconviction-Hearing-State-v.-McCollum-and-Brown.pdf1_.pdf> [*NC McCollum*].

[39] *Ibid* at 21-23. See also Sharon McCloskey, "Begging for a Pardon: Why Some of the Wrongfully Convicted could go Penniless", *NC Policy Watch* (5 Jun 2015), online: <http://www.ncpolicywatch.com/2015/05/06/begging-for-a-pardon-why-some-of-the-wrongfully-convicted-could-go-penniless>.

[40] Joseph Neff, "Innocent, Disabled and Vulnerable A judge protects an exonerated man from his lawyer." *The Marshall Project* (24 Oct 2017), online: <https://www.themarshallproject.org/2017/10/24/innocent-disabled-and-vulnerable>.

[41] *NC McCollum*, *supra* note 38 at 23.

Furmage pointed the police in his direction, and police began investigating him, simply because Furmage thought he was strange.[42]

McCollum, in fact, had severe emotional and intellectual disabilities.[43] Mental illness and intellectual disabilities are not synonymous, and require different legal analyses. Nonetheless, McCollum illustrates how citizens can change the course of an investigation by pointing police towards suspects they consider "odd." A reputation in the community as frightening or crazy can make PWMI a serious suspect in a crime he had nothing to do with.

Furthermore, abnormal actions may independently rouse the suspicion of the police. In 1989, high school student Angela Correa was raped and murdered in Westchester County, New York.[44] One of Correa's classmates, 16-year-old Jeffrey Deskovic, was distraught by the murder. He aroused police suspicion by "weeping openly" at Correa's funeral [45] and attending three out of four sessions of her wake.[46] Deskovic was eventually convicted of the crime and spent 16 years in prison. He was exonerated in 2006.[47]

Although hair and semen samples taken from the scene did not match Deskovic's DNA, detectives continued to believe he was guilty because he seemed "unusually distraught" after Correa's death and was "determined" to help solve the case.[48] However, police failed to take into account (or ignored) the fact that Deskovic had severe psychological problems. He was described as "emotionally handicapped" and "heard voices."[49] Although Deskovic's actions were likely the result of psychological issues, his "unusual" displays of emotion kept suspicion on Deskovic even after physical evidence cleared him of the rape.

Blackmon's case is slightly different than McCollum's or Deskovic's, since investigators were on notice of Blackmon's mental illness (at the time of the investigation, he resided at a psychiatric hospital). However, Blackmon's mental illness manifested as aggression and anger. This created a reputation for violence, and hospital staff and other patients believed Blackmon to be extremely dangerous. According to a confidential source, Blackmon was "real strange, people were afraid of him."[50] This reputation entrenched investigators' suspicions of Blackmon's guilt. Yvette Peebles, Blackmon's girlfriend's sister, further confirmed police suspicions. Peebles told the police she was "very fearful of [Blackmon]."[51] She knew there was "something wrong" with him, so she tried to stay away. The fear stemmed in part from Blackmon's delusions about

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[42] See *ibid*. Edwin Grimsley, "Lessons about Black Youth and Wrongful Convictions: Three Things You Should Know", *Innocence Project* (5 Jan 2015), online: <https://www.innocenceproject.org/lessons-about-black-youth-and-wrongful-convictions-three-things-you-should-know-2>.
[43] *NC McCollum*, *supra* note 38 at 87.
[44] Alan Feuer, "Exonerated. Now What?" *The New York Times* (21 Feb 2014), online: <https://www.nytimes.com/2014/02/23/nyregion/exonerated-now-what.html> [*Feuer*].
[45] *Ibid.*
[46] New York, Westchester County District Attorney's Office *Report on the Conviction of Jeffrey Deskovic*, (2007) at 24, online: <https://www.westchesterda.net/Jeffrey%20Deskovic%20Comm%20Rpt.pdf> [*NY Westchester*].
[47] Feuer, *supra* note 44.
[48] Fernanda Santos, "Playing Down DNA Evidence Contributed to Wrongful Conviction, Review Finds" *The New York Times Times* (3 Jul 2007), online: <https://www.nytimes.com/2007/07/03/nyregion/03dna.html>.
[49] *NY Westchester*, *supra* note 46 at 11, 24-25.
[50] *NCIIC*, *supra* note 14 at 228.
[51] *Ibid* at 313-14.

witchcraft, in part from his tendency to "watch" Peebles, and in part from his generally aggressive demeanor. Peebles said Blackmon could act "like a madman . . . incoherent and everything, and he said he was going to kill just everybody . . . he was just wild."[52] When the police asked her if she thought Blackmon was capable of the St. Augustine murder, she responded, "Knowing him, I would say he's capable of doing it."[53]

Blackmon's mental illness caused him to act in a way that frightened others. While this reputation did not cause the community or police to single Blackmon out as a suspect (as was the case with McCollum and Deskovic), it did confirm that Blackmon was capable of a violent crime, reinforcing investigators' belief in his guilt.

In both McCollum's and Deskovic's case, "odd" behavior was misinterpreted as suspicious or indicative of criminality. Neither were a suspect until their respective intellectual disability and psychological problems drew attention. In Blackmon's case, mental illness created an aggressive reputation in the community, confirming police suspicions that they had found their man. In all three cases, community opinion of the suspect as "crazy" and "dangerous" turned investigators away from legitimate suspects and towards innocent PWMI. Had investigators recognized that their suspects were exhibiting symptoms of mental illness, they may have changed course early enough to catch the real perpetrator.

b. Misinterpreting symptoms of mental illness as signs of guilt

Once police develop suspects, innocent PWMI are less likely to be "cleared" because police interpret signs of mental illness as signs of guilt. Early in an investigation, a PWMI may not even be the main suspect. He may merely be a potential witness, or a person of interest the police want to look into. But during even casual police encounters, PWMI can act in a way police deem unnatural. These unexpected actions can be "misconstrued by officers or deputies as suspicious or illegal activity or uncooperative behavior."[54] Odd behavior deepens police suspicion, shifting the focus of the investigation away from real suspects and towards an innocent PWMI.

Additionally, PWMI are less likely to respond with deference to the police compared to non-mentally ill persons.[55] Most PWMI are not violent, and hostility is by no means a ubiquitous symptom of mental illness. Nonetheless, some mental illnesses, like personality disorders, can manifest in aggression and hostility.[56] As such, PWMI are statistically more likely to react to police questioning in a hostile or uncooperative way compared with non-mentally disordered suspects.[57]

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[52] *Ibid* at 313-316.
[53] *Ibid* at 320.
[54] US Dept of Justice, *Commonly Asked Questions about the Americans with Disabilities Act and Law Enforcement* (2006), online: <https://www.ada.gov/q%26a_law.htm>.
[55] Camille A Nelson, "Frontlines: Policing at the Nexus of Race and Mental Health" (2016) 43:3 Fordham Urb L J 615 at 639-46, online: <https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=2659&context=ulj> [*Nelson*].
[56] See "Mental Illness and Violence" (2011) 27:7 Harv Ment Health Lett 1, online: <http://www.biblioteca.cij.gob.mx/Archivos/Materiales_de_consulta/Drogas_de_Abuso/Articulos/55984270.pdf>. National Institutes of Health, *NIH Curriculum Supplement Series: Information about Mental Illness and the Brain*, National Center for Biotechnology Information, online: <https://www.ncbi.nlm.nih.gov/books/NBK20369>.
[57] See Kenneth Novak & Robin Engel, "Disentangling the Influence of Suspects' Demeanor and Mental Disorder on Arrest" (2005) 28:3 Policing 493, online:<https://doi.org/10.1108/13639510510614573>. Mental Health Commission of Canada, *A Study of How People with Mental Illness Perceive and Interact with the Police*, (2011) at 33, online:

Signs of mental illness, like verbal abuse, belligerence, and disrespect, may not be against the law, but such symptoms defy police behavioral expectations. Uncooperativeness or defiance can provoke an officer to respond more punitively than if a defendant simply complies.[58]

Hostility and uncooperativeness spiral, escalating the situation. When approached on the street for casual questioning, the probability of arrest is 67% greater for suspects exhibiting signs of mental disorder than for those who are not mentally ill.[59] The PWMI who was once merely a person of interest has become a full-blown suspect, if not the primary suspect. Officers proceed to formal interrogation and the Reid Technique.

Once a PWMI is brought in for questioning, investigators may misinterpret symptoms as signs of guilt. This kind of underdiagnosis is often inadvertent, and not always malicious. Even a well-intentioned officer may mistake mental illness for guilt if unfamiliar with common symptoms. This is especially true if the officer relies on the highly popular Reid Technique.[60]

Widely considered to be the Bible of American interrogation tactics, the Reid Technique urges investigators to look for verbal and non-verbal "behavior symptoms" like body language, facial expression, and tone of voice.[61] According to the Reid Technique Manual, guilty people are often anxious, evasive, agitated, worried, and nervous throughout the duration of the interview.[62]

These feelings, and the underlying feeling of guilt, can manifest through "acting aggressive, having a bitter attitude, appearing to be in a shocked condition, experiencing mental blocks, being evasive, having and extremely dry mouth, continually sighing or yawning, refusing to look the examiner in the eye, and moving about."[63] The Reid Technique posits that by recognizing these behavioral cues, investigators can either confirm innocence or detect deception and guilt.[64]

However, as detailed below, many of these "behavior symptoms" are highly likely to appear in PWMI, either as a symptom of mental illness or as a side effect of medication.[65] Indeed,

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<https://www.mentalhealthcommission.ca/sites/default/files/Law_How_People_with_Mental_Illness_Perceive_Interact_Police_Study_ENG_1_0_1.pdf>.

[58] Linda Teplin, "Keeping the Peace: Police Discretion and Mentally Ill Persons" (2000) Nat'l Inst Justice J 9 at 12, online: <https://www.ncjrs.gov/pdffiles1/jr000244c.pdf>. See also Linda Teplin, "Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill" (1984) 39:7 Am Psychol 794, online: <https://psycnet.apa.org/doi/10.1037/0003-066X.39.7.794>.

[59] See *ibid.*

[60] See *Redlich 2*, *supra* note 7 at 20.

[61] See Fred Inbau *et al*, *Essentials of the Reid Technique Criminal Interrogation and Confessions*, 2nd ed (Burlington: Jones & Bartlett Learning, 2015) at chapter 7 [*Inbau 1*].

[62] *Ibid* at 106-107, 172.

[63] John E Reid & Richard O Arther, "Behavior Symptoms of Lie-Detector Subjects" (1953) 44:1 J Crim L Crimin & Pol Sc 104 at 105, online: <https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=4113&context=jclc>.

[64] See *ibid*. "During an interview the investigator should closely evaluate the suspect's behavioral responses to interview questions. The suspect's posture, eye contact, facial expressions, word choice, and response delivery may each reveal symptoms of truthfulness or deception." *Inbau 1*, *supra* note 61 at 4.

[65] *Redlich 1*, *supra* note 1 at 63-64.

Blackmon displayed many of these behavioral cues during his interrogation, which could have easily been misconstrued by Holder and Mundy as guilt.

Worrying, nervousness, and restlessness are three hallmarks of schizophrenia,[66] and paranoia is a common indicator of personality disorders.[67] The Chief of the Psychiatric Unit at Attica Correctional Facility, where Blackmon was held in 1974, reported that Blackmon "cannot take any pressures whatsoever."[68] He also acted "very suspicious and very paranoid towards the examiners."[69] To an untrained officer, this behavior could easily be misinterpreted as fear one has been caught.

As previously mentioned, many PWMI are non-violent and harbour no aggressive tendencies. Nonetheless, some mental illnesses can manifest in the form of belligerence and hostility.[70] For example, one doctor surmised that Blackmon "responds to a stressful situation by becoming angry and dominating."[71] The doctor continued that Blackmon's mood was

> …very changeable, and he can go very quickly from being friendly and cooperative to being angry and threatening . . . He has a very low tolerance for stress and frustration, and usually reacts by becoming angry and intimidating . . . He's extremely hostile-dependent, and gets angry when others don't meet his needs.[72]

Such hostility, in both Blackmon and other innocent PWMI, could easily be perceived as guilt.

Another common symptom of mood disorders and schizophrenia is "flat affect," which is the "reduced expression of emotions via facial expression or voice tone."[73] This may cause PWMI to appear disinterested in proceedings and detached from the result.[74] Police may misinterpret this lack of emotion as a sign the suspect has "given up," or resigned themselves to the fact they have been caught. In reality, it is a common sign of mental illness.[75]

Yet another indicator of mental illness is poor working memory and memory gaps.[76] A PWMI may not remember his whereabouts or activities on certain days or may give inconsistent statements on their past. For example, Blackmon did not remember when he was released from

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[66] See Heinz Hafner & Kurt Maurer, "Early Detection of Schizophrenia: Current Evidence and Future Perspectives" (2006) 5:3 World Psychiatry 130, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1636122>.
[67] See Amy Vyas & Madiha Khan, "Paranoid Personality Disorder" (2016) 11:1 Am J Psychiatry Resid J 9, online: <https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp-rj.2016.110103>.
[68] *NCIIC*, *supra* note 14 at 254-55.
[69] *Ibid* at 255.
[70] See *supra* note 56.
[71] *NCIIC*, *supra* note 14 at 240.
[72] *Ibid* at 300-302.
[73] Kimberly Holland, "What is Flat Affect?" *Healthline* (4 Aug 2017), online: <https://www.healthline.com/health/flat-affect>. *Schizophrenia*, National Institute of Mental Health, online: <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> [*NIMH*]. Raquel Gur *et al*, "Flat Affect in Schizophrenia: Relation to Emotion Processing and Neurocognitive Measures" (2006) 32:2 Schizophr Bull 279 at 279, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632232>.
[74] See *Mental Illness*, *supra* note 37. See *ibid* note 73.
[75] *Ibid*.
[76] *Ibid*.

prison in New York [77] or when he first went to Dorothea Dix.[78] To an investigator, the inability to remember such details indicates a lie, especially if the suspected PWMI cannot remember his alibi.

In his initial psychiatric assessment at Dorothea Dix, Blackmon experienced "flight of ideas" and was generally uncooperative.[79] He displayed similar behavior in his interrogations, rambling and jumping from one idea to another.[80] This kind of disorganized speech—including derailment, disconnected thoughts, and incoherence—is a common symptom of mental illness.[81] Confusion and general disorientation are also common, as well as a refusal to speak, trouble focusing, and trouble paying attention.[82] PWMI may also experience odd speaking patterns, such as stuttering, speaking too quickly, or speaking too slow.[83] Furthermore, PWMI may experience inappropriate emotional responses to situations, or jump from one emotional extreme to another.[84] Any of these erratic behaviors could easily be misinterpreted as guilt, or attempting to evade the question.

The shifty-eyed suspect is synonymous with guilt, and the Reid Technique urges investigators to look for a lack of eye contact.[85] However, such a trait is also a common symptom of mental illness.[86] For example, a psychological examiner at Dorothea Dix noted that Blackmon tended to avoid eye contact at the beginning of interviews but could warm up with encouragement.[87] Investigators may misinterpret this common trait as evasive or indicative of guilt.

Lastly, under the Reid Technique, fidgeting—i.e. excessive leg movement, blinking, foot wiggling, hand wringing, finger tapping, picking fingernails, or fumbling with objects—is often perceived as a physical manifestation of lying.[88] However, many PWMI suffer from symptoms that cause them to tremble and shake uncontrollably, or move around excessively. In fact, schizophrenia is often characterized by "movement disorders," such as agitated body movement.[89] In his initial psychiatric assessment at Dorothea Dix, Blackmon constantly paced the room and fidgeted.[90] This inability to sit still and focus could be perceived as nerves or guilt, when in fact it is a common symptom experienced by many PWMI.[91]

As demonstrated by Blackmon, the Reid Technique's behavior symptoms show alarming overlap with common symptoms of mental illness. Even if police are acting in good faith, relying on the technique risks confusing mental illness with guilt. Such a tactic creates a heightened risk

[77] *NCIIC*, *supra* note 14 at 454-56.
[78] *Ibid* at 376.
[79] *Ibid* at 295.
[80] *Ibid* at 409-411.
[81] See *Mental Illness*, *supra* note 37. See also *Redlich 1*, *supra* note 1 at 70. *NIMH*, *supra* note 73.
[82] See *Mental Illness*, *supra* note 37. See *NIMH*, *supra* note 73.
[83] See *Mental Illness*, *supra* note 37.
[84] *Ibid*.
[85] *Inbau 1*, *supra* note 61 at 82-84.
[86] See *Mental Illness*, *supra* note 37.
[87] *NCIIC*, *supra* note 14 at 244, 283.
[88] *Inbau 1*, *supra* note 61 at 82-83.
[89] See *Mental Illness*, *supra* note 37.
[90] *NCIIC*, *supra* note 14 at 295.
[91] See *Mental Illness*, *supra* note 37.

that police will move forward with the investigation and attempt to extract a confession, rather than releasing an innocent PWMI and searching for other suspects.

B. Mid-Investigation/Interrogation: More likely to make a false confession

Once a formal interrogation is underway, PWMI face a heightened risk of making a false confession. Mental illness is a well-recognized risk factor for false confessions,[92] and among the known pool of exonerees who have falsely confessed, PWMI are disproportionately represented.[93] Two factors likely contribute to this trend. First, PWMI are less likely to understand their legal rights under *Miranda*. Second, symptoms of mental illness make PWMI more susceptible to the Reid Technique.

a. Less likely to understand Miranda rights

Miranda v Arizona forms the cornerstone of American due process law, creating crucial protections against coercive police interrogations.[94] However, *Miranda*'s legal safeguards afford little protection for PWMI.

First, PWMI may not understand *Miranda* rights well enough to invoke them. *Miranda* rights are complex legal tools that require a suspect to weigh long-term consequences. Hallmarks of mental illness include confusion, disorganization of thought, deficits in executive functioning and attention, and impaired decision making.[95] These symptoms make it more likely that a PWMI simply does not understand the rights being read to him, or how he will be disadvantaged should he waive them. One study found that 41% of individuals with a psychotic disorder were impaired in their understanding of their legal rights.[96] The same study found that 24% of individuals with affective disorders (i.e., depression, bipolar disorder, anxiety) were similarly impaired.[97] If a PWMI does not understand his rights, it is highly unlikely he will invoke them for protection.

Furthermore, to invoke *Miranda* protections a PWMI must realize he is being questioned in the first place. Blackmon never considered that he was a suspect because the officers held

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[92] *Redlich 2*, *supra* note 7 at 19. *Rogal*, *supra* note 7 at 70. Lisa E Hasel & Saul M Kassin, "False Confessions" in Brian L Cutler, ed, *Conviction of the Innocent: Lessons from Psychological Research* (American Psychological Association, 2012) 53 at 62, online: <https://www.researchgate.net/publication/326529372_False_Confessions> [*Hasel & Kassin*].

[93] Sheri L Johnson, John H Blume & Amelia C Hritz, "Convictions of Innocent People with Intellectual Disability" (2019) 82:3 Alb L Rev 1031 at 1043, online: <http://www.albanylawreview.org/Articles/Vol82_3/1031-Convictions-of-Innocent-People-with-Intellectual-Disability.pdf> [*Johnson*]. Samuel R Gross *et al*, "Exonerations in the United States 1989 through 2003" (2005) 95:2 J Crim L & Criminology 523 at 545, online: <https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=7186&context=jclc> [*Gross et al*].

[94] See *Miranda v Arizona*, [1966] 384 US 436. Prior to an interrogation in police custody, a defendant is required to be warned that (1) he has the right to remain silent, (2) that anything he says can be used against him in a court of law, (3) he has the right to an attorney, and (4) if he cannot afford an attorney, one can be appointed for him.

[95] *Redlich 2*, *supra* note 7 at 20.

[96] See Jodi Viljoen, "An Examination of the Relationship Between Competency to Stand Trial, Competency to Waive Interrogation Rights, and Psychopathology" (2002) 26:5 Law & Hum Behav 481 at 493, online: <https://www.researchgate.net/publication/11051727_An_Examination_of_the_Relationship_Between_Competency_to_Stand_Trial_Competency_to_Waive_Interrogation_Rights_and_Psychopathology>.

[97] *Ibid* at 493.

themselves out as his friends. He trusted them and believed they were helping him.[98] He voluntarily came to the station several times, often on his own volition.[99] The officers never told Blackmon his *Miranda* rights until after he confessed, and the court found that the officers did not violate the law because Blackmon was never "in custody."[100] The detectives should have realized that Blackmon did not comprehend the investigation that was going on, and he did not understand the gravity of the situation. This failure to recognize Blackmon's incapacity goes back to misinterpreting his symptoms and underscores the importance of recognizing mental illness early in the investigation.

Due to these limitations, *Miranda* is inadequate to protect PWMI from wrongful convictions. For the protections to function, a suspect must be able to comprehend one's rights and be aware that one is under investigation in the first place.

b. Susceptibility to Reid Technique: Minimization and Maximization

If a suspect fails to invoke his *Miranda* rights, he may still suppress the statement if he can show the confession was coerced. However, in *Colorado v Connelly*, the Supreme Court ruled that a suspect's mental condition alone is insufficient to find coercion.[101] Rather, the defendant must demonstrate that the police used "coercive techniques."[102] The Supreme Court has a narrow definition of "coercive techniques," and the Reid Technique is not considered coercive under this limited framework.[103]

This approach fails to take into account the reality of mental illness, and how common symptoms may manifest in the interrogation environment. Under the Reid Technique, police interrogators are taught to assume guilt and manipulate the suspect's emotions and expectations.[104] The approach relies on minimization techniques "such as feigning sympathy, offering a moral justification for the crime, or shifting blame" to create a false sense of security, and maximization techniques "such as presenting false evidence" to scare or browbeat the suspect into confessing.[105] PWMI are more susceptible to both strategies.[106]

As previously mentioned, common symptoms of mental illness include proneness to confusion, disorganization of thought, deficits in executive functioning and attention, and impaired decision making.[107] These symptoms make PWMI more susceptible to minimization for a few reasons.

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[98] *NCIIC*, *supra* note 14 at 444-445. This theme is further developed in the Minimization Section.
[99] *Ibid* at 436-37.
[100] *Ibid* at 591.
[101] See *Colorado v Connelly*, [1986] 449 US 157.
[102] *Ibid.*
[103] *Redlich 2*, *supra* note 7 at 19-20.
[104] *Ibid* at 20.
[105] *Ibid* at 20.
[106] *Ibid* at 20. *Hasel & Kassin*, *supra* note 92 at 54-55, 62. *Rogal*, *supra* note 7, at 70. Gisli H Gudjonsson, *The Psychology of Interrogations and Confessions: A Handbook* (Chichester: John Wiley & Sons, Ltd, 2003) at 218-224, 316-318 [*Gudjonsson*].
[107] *Redlich 2*, *supra* note 7 at 19-20. See *Mental Illness*, *supra* note 37.

First, PWMI who have deficits in social skills, struggle with a distorted sense of reality, and are prone to delusions may more readily believe—compared to persons without a mental illness—that an officer questioning them is a friend.[108] Where non-mentally disordered defendants tend to be on guard and wary of police, faulty reality monitoring can lead a PWMI to think a sympathetic officer is genuinely on his side, an ally who "has been there."[109] Misinterpreting or misunderstanding the context of an interrogation can lead a PWMI to comply when an officer asks for an incriminating statement, since the PWMI wrongly perceives the officer to be working in his best interest.[110]

This is precisely what occurred in Blackmon's case, where police purposefully cultivated a friendship in order to extract a confession. The detectives complimented Blackmon, telling him was "a very intelligent man" despite his second-grade education.[111] They gave him snacks and cigarettes, to the point where Blackmon began visiting the station when he needed food.[112] They drove him from Dorothea Dix to his grandmother's house and back.[113] When asked open-ended questions, Blackmon tended to ramble about his religious delusions and special abilities.[114] The detectives reassured Blackmon that they believed his delusions and even asked Blackmon to elaborate.[115]

Blackmon began to see the detectives as his confidants, "nice people" who helped him when he was struggling.[116] The detective once asked Blackmon why he came down to the police station so often, and he responded, "You all can help me, you know?" The officer clarified, "Am I making you come down here?" Blackmon responded, "No. You just asked me to come down out of the kindness of your heart, man, and I do it out the kindness of mine."[117] The officers told him they liked him, and asked him several times whether the officers were his friends.[118] Blackmon always responded they were.[119] He liked his prosecutor so much he brought her candy, and he trusted the detectives enough to ask them for money to buy his girlfriend a doll.[120] Due to symptoms of his illness, Blackmon genuinely believed the police were his allies; he did not understand their adversarial role in the justice process. By holding themselves out as friends in this fashion, police can gain a PWMI's trust, then use that trust to convince a PWMI like Blackmon that confessing is in his best interest.[121]

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[108] *Redlich 2*, *ibid* note 7 at 20.
[109] *Ibid* at 20.
[110] *Ibid* at 20. *Rogal*, *supra* note 7 at 70 (detailing a PWMI in Detroit who falsely confessed to a murder in order to help the police "smoke out" the real perpetrator; the police both permitted and encouraged this delusion in order to obtain a confession). Richard A Leo, "False Confessions: Causes, Consequences, and Implications" (2009) 37:3 J Am Acad Psychiatry & L 332 at 336-37, online: <http://jaapl.org/content/jaapl/37/3/332.full.pdf> [*Leo*].
[111] *NCIIC*, *supra* note 14 at 370.
[112] *Ibid* at 440-41.
[113] *Ibid* at 447-48.
[114] *Ibid* at 380, 417, 432, 468.
[115] *Ibid* at 370, 374-75, 378.
[116] *Ibid* at 437. *NC Blackmon*, *supra* note 32 at 422-23, 438.
[117] *NCIIC*, *supra* note 14 at 444-445.
[118] *Ibid* at 474.
[119] *Ibid* at 364, 429.
[120] *Ibid* at 443-444.
[121] *Rogal*, *supra* note 7 at 70. *Redlich 2*, *supra* note 7 at 20. *NC Blackmon*, *supra* note 32 at 423-24, 438-39.

For many of the same reasons, a PWMI who struggles with distorted perceptions and delusional beliefs, as well as memory deficits that lead him to distrust his own sense of reality, may be more inclined to believe an officer who downplays the seriousness of a crime, or minimizes involvement in a crime.[122] In Blackmon's case, the officers encouraged a confession by repeatedly distancing Blackmon from the crime and downplaying his culpability.

Blackmon initially denied all responsibility, claiming the only time he "really" hurt someone was when he set fire to a house in New York.[123] He also denied several specific aspects of the case, claiming that he had never owned a knife like the one used in the murder [124] or a dashiki like the one found in the woods.[125] But most importantly, he claimed he had never been to St. Augustine's University and he did not know where the campus was located.[126]

The detectives ignored Blackmon's claims and encouraged the delusion that Blackmon's "body" had been to St. Augustine's even if his "mind" was somewhere else.[127] They told him, "Your body, separate from your mind, reformed into another James Blackmon over on the top floor of the dorm."[128] The detectives convinced Blackmon that his body could commit wrongdoing while his mind stayed behind. Blackmon agreed, and claimed it happened before.[129] By encouraging Blackmon's mind-body distinction, the detectives reassured Blackmon that they did not hold *him* responsible for the murder at St. Augustine's.

Closely linked to this delusion was the idea that Blackmon's "soul" could get loose of his body and commit crimes without his knowledge.[130] Early on, the detectives impressed upon Blackmon that "Bad James" could commit crimes independently of "Good James." The idea of dissociation immediately resonated with Blackmon, and he tied Bad James to his religious fantasies.[131] The detectives fed the Bad James delusion frequently, and dissociation became a staple of the interrogations.[132]

The detectives purposefully capitalized on Blackmon's mental illness—namely his delusions and his dissociative symptoms—to extract a confession. At one point, Blackmon asked the detectives point-blank, "Hey, do you think that my spirit body can go somewhere and do somebody some wrong or hurt somebody?" One of the detectives responded, "I do, James." Blackmon confirmed he shared the belief.[133] Both detectives were careful to ask what "Bad James" did at St. Augustine's, while simultaneously reassuring Blackmon they were not talking about the "Good James" currently in the police station.[134] They explicitly distinguished the two on more than one occasion, and insisted they were only interested in Bad James' actions, "not this [current]

[122] *Redlich 2*, *ibid* at 19-20. *Rogal*, *ibid* at 70.
[123] *NCIIC*, *supra* note 14 at 452.
[124] *Ibid* at 415-16.
[125] *Ibid* at 413-414.
[126] *Ibid* at 381.
[127] *Ibid* at 382-83, 396-98.
[128] *Ibid* at 403.
[129] *Ibid* at 380-83.
[130] *Ibid* at 380.
[131] *Ibid* at 399-402.
[132] *Ibid* at 399-402, 413-14, 417-19, 426-27, 431-33.
[133] *Ibid* at 400-401.
[134] *Ibid* at 413-414, 416-28.

James Blackmon."[135] By using dissociation to distance Blackmon from the crime, the detectives coaxed Blackmon into agreeing that Bad James hurt a woman at St. Augustine's.[136]

Post-confession, the detectives told Blackmon he must take responsibility for Bad James, "because you are actually one and the same."[137] Blackmon verbally agreed, but he clearly did not understand the consequences of his confession. He was confused when the officers told him he would be punished for Bad James' actions. Blackmon agreed "old James" must go to jail but clarified that the "new James" should not get any time.[138] When the detectives told Blackmon he would to go before a judge and jury, he continued to think the detectives were talking about Bad James.[139] Because of his mental illness, and its dissociative symptoms, Blackmon genuinely did not understand that he had implicated *himself* in a crime. To him, the distinction between Bad James and Good James was so complete that he could not fathom why he was being punished for a confession about Bad James.

Blackmon's symptoms are far from unique. Dissociation plays a key role in several kinds of mental illness, including schizophrenia and borderline personality disorder.[140] Symptoms of dissociation include significant memory loss, out-of-body experiences (such as feeling as though you are watching a movie of yourself), a sense of detachment from your emotions and a lack of a sense of self-identity.[141] Through the mind-body distinction and the Good James-Bad James distinction, the police intentionally promoted these symptoms. They built their entire interrogation strategy around Blackmon's illness and proneness to delusion, emphasizing that Blackmon had no control over what Bad James did to Payton.[142] By minimizing Blackmon's involvement, detectives wrongly led him to believe he would not be in trouble if he confessed. Blackmon believed them and provided the requested confession.

In doing so, Blackmon demonstrates how a disconnect from reality can lead a PWMI to fall for minimization techniques and falsely confess, especially if the PWMI already suffers from memory loss and dissociation. By constantly downplaying Blackmon's responsibility for the crime, officers made it appear as if he could go home if he agreed with them. As discussed in more detail below, erroneously believing that there are no consequences to a confession almost certainly contributes to higher rates of false confessions from PWMI.[143]

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[135] *Ibid* at 422, 425, 427.
[136] *Ibid* at 389.
[137] *Ibid* at 480.
[138] *Ibid* at 481.
[139] See *ibid* at 482.
[140] See Ondrej Pec, Petr Bob & Jiri Raboch, "Dissociation in Schizophrenia and Borderline Personality Disorder" (2014) 10 Neuropsychiatr Dis Treat 487 at 487-490, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3964156>.
[141] See *Dissociative Disorders*, National Alliance on Mental Illness, online: <https://www.nami.org/learn-more/mental-health-conditions/dissociative-disorders>.
[142] *NC Blackmon*, *supra* note 32 at 423-24.
[143] Allison Redlich, Alicia Summers & Steven Hoover, "Self-Reported False Confessions and False Guilty Pleas among Offenders with Mental Illness" (2010) 34:1 Law & Hum Behav 79 at 80, online: <https://doi.apa.org/doiLanding?doi=10.1007%2Fs10979-009-9194-8> [*Redlich 3*].

Perhaps most importantly, mood disorders and schizophrenia are often characterized by "deficits in risk assessment and reward processing."[144] In general, this means PWMI struggle to weigh the costs and benefits of a decision.[145] In the criminal justice context, this means PWMI struggle to understand and properly weigh the long-term consequences of confessing.[146]

To a PWMI, a confession seems to be a rational trade-off in the short-term. Give the officers what they want (a confession) and the officers will give you what you want (the freedom to leave).[147] In one study of incarcerated PWMI who self-reported as false confessors, the majority (65%) "claimed to falsely take responsibility because they wanted to end questioning, get of jail, or go home."[148] A "common feature" among these false confessors was that the PWMI was either "told or incorrectly believed they could go home after admitting guilt."[149] For a PWMI with impaired decision-making ability, a confession seems a small price to pay to terminate a stressful interrogation and go home.[150]

This inability to process consequences may have contributed to Blackmon's false confession. One psychiatric assessment found that Blackmon's weaknesses included difficulty completing structured tasks, lack of insight into realistic goals, and difficulty completing problem-solving tasks.[151] Such symptoms made it difficult for Blackmon, and other PWMI with similar symptoms, to grasp the true consequences of a confession.[152]

These three factors likely work in tandem to drive PWMI towards false confessions. Where the general public is more likely to see through police deception, PWMI may believe an officer who identifies as a friend or claims there are minimal consequences to confessing. Based on these false notions, and an inability to weigh the consequences of a confession, PWMI are more inclined to believe that a false confession will end an interrogation, and that this benefit outweighs any long-term costs.[153]

As for maximization techniques, three common indicators of mental illness include memory gaps, distorted perceptions of events, and breakdowns in reality monitoring.[154] These symptoms often lead to heightened suggestibility and the "inability to distinguish fact from

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[144] Ricardo Caceda *et al*, "Toward an Understanding of Decision Making in Severe Mental Illness" (2014) 26:3 J Neuropsychiatry Clin Neurosci 196 at 207, online: <https://neuro.psychiatryonline.org/doi/full/10.1176/appi.neuropsych.12110268>.
[145] *Ibid* at 207.
[146] Saul M Kassin *et al*, "Police-Induced Confessions: Risk Factors and Recommendations" (2010) 34:3 Law & Hum Behav 3 at 12, 14, online: <https://web.williams.edu/Psychology/Faculty/Kassin/files/White%20Paper%20-%20LHB%20(2010).pdf> [*Kassin 1*].
[147] See *ibid* at 14. *Redlich 3*, *supra* note 143 at 87.
[148] *Redlich 3*, *ibid* at 87.
[149] *Ibid.*
[150] *Kassin 1*, *supra* note 146 at 21. Leo, *supra* note 110 at 336. Saul Kassin & Gisli Gudjonsson, "The Psychology of Confessions: A Review of the Literature and Issues" (2004) 5:2 Psychol Sci Public Interest 33 at 53, online: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.858.8042&rep=rep1&type=pdf> [*Kassin 2*].
[151] *NCIIC*, *supra* note 14 at 305.
[152] *Kassin 1*, *supra* note 146 at 21. *Redlich 3*, *supra* note 143 at 87. *Redlich 2*, *supra* note 7 at 20.
[153] *Redlich 3*, *ibid* at 87. *Redlich 2*, *ibid*.
[154] *Redlich 2*, *ibid*. *Mental Illness*, *supra* note 37.

fantasy."[155] Maximization techniques are particularly effective on PWMI with these symptoms, as they are more easily influenced than non-mentally disordered suspects, making it easier for officers to convince them of guilt that does not truly exist.[156]

For example, detectives slowly persuaded Blackmon to change his story by feeding him information and stating accusations as facts. As mentioned in the previous section, Blackmon was initially staunch in his declaration of innocence. Over and over, Blackmon repeated that he "never did nothing to really hurt nobody."[157] He even told detectives, "I never killed nobody in my life."[158] When they asked, "What's the only thing the bad James has really done, then?" Blackmon responded, "Commit adultery, steal, stick-up, beat people up, that's it."[159]

However, through detailed imagery and stressing visualization, the police were able to change Blackmon's statements.[160] The detectives repeatedly told Blackmon to imagine himself at St. Augustine's, to picture his body going up the stairway, walking around the top floor, and finding women.[161] Blackmon initially said, "I can't picture it, and I can't see her." [162] The detective ignored him and pressed on, asking, "What's happened to the girl. She gets hurt. What happens to her?"[163] The detectives described disturbing and visceral scenes, asking about blood and telling him that a girl was "screaming for help."[164] They told Blackmon, rather than asked him, "Something happened. Something you had no control over . . . Your body was there. You were re-formed . . . And, you know, somebody got hurt . . . What's happened to the girl. She gets hurt. What happens to her?"[165] Rather than letting Blackmon describe the events himself, the police carefully walked him through the confession.[166] They told him, "James Blackmon, the old James Blackmon and the girl were in the stall together, and the girl started screaming because she did not want James Blackmon to leave . . . What did James Blackmon do with the knife?"[167] Only after detectives painted the scene in his mind did Blackmon finally give a straightforward confession, saying that Bad James cut her and killed her.[168] The detectives' vivid imagery firmly planted the image of the murder in Blackmon's mind, and he became unable to distinguish it from his own memories.

By presenting accusations as facts and feeding Blackmon detailed mental images, the detectives slowly caused Blackmon to accept their version of events. Unable to separate his own memory from the scenes the police told him to visualize, Blackmon eventually agreed with their

[155] *Kassin 2*, *supra* note 150 at 49. *Redlich 2*, *ibid* at 20.
[156] *Redlich 2*, *ibid*. *Rogal*, *supra* note 7 at 70. *Gudjonsson*, *supra* note 106 at 194-195, 218-224, 316-318. *Hasel & Kassin*, *supra* note 92 at 54-55.
[157] *NCIIC*, *supra* note 14 at 451-52.
[158] *Ibid* at 451.
[159] *Ibid*.
[160] *Ibid* at 383.
[161] *Ibid* at 397-98.
[162] *Ibid* at 401.
[163] *Ibid*.
[164] *Ibid.*
[165] *Ibid* at 399-402.
[166] *Ibid* at 416-418.
[167] *Ibid* at 416.
[168] *Ibid*.

version of events. He internalized the accusations, accepted them as his own memory, and even began to regurgitate them back to the officers.

Such receptiveness highlights the danger of maximization techniques for PWMI. A PWMI like Blackmon who distrusts his own memories, and struggles to distinguish reality from delusion, presents a heightened risk of a false confession.[169] After being told a story several times, he may struggle to remember whether a fact actually happened or was just told to him by the police.[170] In Blackmon's case, a distorted sense of reality made it "quite easy" for detectives to flip his statements.[171]

Blackmon is not alone in this respect; he merely exemplifies how PWMI are less able to withstand the psychological pressures of the Reid technique. Although data is limited, the research that has taken place indicates that PWMI falsely confess at higher rates than non-mentally disordered suspects. One 2005 study found that out of all exonerees from 1989 through 2003, 11% falsely confessed to their crime.[172] But out of the ten exonerees who appeared to suffer from mental illness, seven had falsely confessed.[173] A later study examining exonerations through 2019 similarly found that 12% of non-mentally ill exonerees falsely confessed, but well over half of PWMI who were wrongfully convicted made a false confession.[174]

A different kind of study surveyed 1,249 PWMI currently involved in the American criminal justice system, and found that 22% claimed to have falsely confessed to the police, while 37% claimed to have falsely pleaded guilty.[175] These figures were notably higher than the percentage of non-mentally ill offenders who self-reported as false confessors in a comparable European study.[176] Although such research is far from conclusive, what little data has been

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[169] *Gudjonsson*, *supra* note 106 at 218-224. *Hasel & Kassin*, *supra* note 92 at 54-55. *Kassin 1*, *supra* note 146 at 15.
[170] *Rogal*, *supra* note 7 at 70.
[171] Josh Shaffer, "Murder Convict Wore Superman Cape, Compared Himself to Dracula, During Confession," *The News & Observer* (20 Aug 2019), online: <https://www.newsobserver.com/news/local/crime/article234174577.html>. Allison Redlich, "In re: the State of North Carolina vs James Blackmon, case # 83CRS84695" (7 Nov 2018) at 19, online: <https://innocencecommission-nc.gov/wp-content/uploads/state-v-blackmon/handouts-provided-to-the-commission-during-the-hearing.pdf> [*Redlich 4*]. "Detectives also asked Blackmon to engage in a lot of speculation about how the crime may have occurred, how he got into or left the building, etc. In my expert opinion, these requests to speculate and imagine are dangerous when used with innocent suspects in that they can lead to false confessions. When used with innocent suspects who are susceptible to suggestion and easily confused, the risk increases."
[172] *Gross et al*, *supra* note 93 at 545.
[173] *Ibid* at 545.
[174] See *Johnson*, *supra* note 93 at 113. The NRE reported in February 2019 that out of roughly 2,400 known wrongful convictions, 146 exonerees had a reported mental or intellectual disability. Although the NRE did not distinguish between the two, Sheri Johnson "reviewed case information provided by the NRE and parsed out the intellectual disability and mental illness variable." She concluded that out of the 146 defendants with a reported mental impairment, 45 lacked evidence of intellectual or learning disabilities. Of these defendants, 29, or 64%, falsely confessed. Proportionally, this is far greater than the number of non-mentally ill defendants who falsely confessed (12%). For a more detailed breakdown of this statistic, see Alexis E Carl, "Dead Wrong: Capital Punishment, Wrongful Convictions, and Serious Mental Illness" (2020) 1:3 Wrongful Conviction L Rev 336 at 344, online: <https://wclawr.org/index.php/wclr/article/view/16/57>.
[175] *Redlich 3*, *supra* note 143 at 91.
[176] *Ibid* at 91.

collected indicates that PWMI like Blackmon proffer false confessions at a markedly higher rate than non-mentally disordered defendants.

A false confession is merely the capstone of an investigation that is heavily weighted against a PWMI from the start. Symptoms of mental illness breed fear and misunderstanding, arousing suspicion of a PWMI in the first place. Those same symptoms, misinterpreted through the lens of the Reid Technique, seem to confirm guilt during an interrogation. Mental illness decreases the likelihood of understanding and invoking *Miranda* and increases the likelihood of a false confession under minimization/maximization techniques. The whole approach seems perversely calculated to target innocent PWMI rather than protect them. Some states and cities have recognized this problem and have worked towards a solution to better protect innocent PWMI.

IV Potential Solution: Training Officers to Recognize Mental Illness

North Carolina responded to the broader problem of wrongful convictions by establishing the North Carolina Innocence Inquiry Commission. Started in 2006, the Commission examines cases of factual innocence, like Blackmon's.[177] Blackmon was the 12th exoneration, and the Commission will surely continue to exonerate innocent PWMI. Such an institution on the back-end of wrongful convictions is vital to rectify past misconduct. However, improvements are also needed on the front-end to avoid wrongful convictions of PWMI in the first place.

Many of the problems discussed in Section III share a common root cause: officers' inability to identify mental illness. If an officer is able to recognize symptoms of mental illness when he or she first approaches a PWMI on the street, that officer can avoid escalating the situation into an arrest. Or, if officers bring a mentally disordered suspect to the station for questioning but then later recognize symptoms of mental illness, those officers know not to rely on the Reid Technique's behavior symptoms to determine guilt. They are also aware that any "confession" they obtain under minimization or maximization could be false, and the true perpetrator may very well remain at large. Underdiagnosis causes ripple effects throughout an investigation, and those ripples culminate in wrongful convictions. To avoid snowballing harms in the first place, officers must become more familiar with the common signs of mental illness.

In theory, officers should already be on alert that PWMI are a special class. The Reid Manual nominally recognizes the danger of misinterpreting symptoms as signs of guilt and warns investigators to be "highly skeptical of the behavior symptoms of a person with a psychiatric history."[178] When suspects have delusions or hallucinations, "obviously little weight should be placed on that subject's behavior symptoms."[179]

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[177] See Robert Mosteller, "NC Innocence Inquiry Commission's First Decade: Impressive Success and Lessons Learned" (2016) 94:6 NC L Rev 1725, online: <https://scholarship.law.unc.edu/cgi/viewcontent.cgi?article=4875&context=nclr>.

[178] *Inbau 1*, *supra* note 61 at 92.

[179] *Ibid* at 93.

However, the manual immediately reassures officers that through the process of patient questioning, a professional interrogator can "bring [...] to light the delusion" and separate legitimate confessions from false confessions.[180] Similarly, the Manual's companion book *Criminal Interrogation and Confessions* reassures officers that suspects with mental illness "are not skilled or confident liars and will often reveal the truth through the interviewing process."[181]

These kinds of warnings assume that mental illness is so obvious, officers will recognize it when they see it. Cases like James Blackmon demonstrate this is not a safe assumption.

Without proper training, the Reid Technique's warning rings hollow. Practical experience does not create sufficient familiarity to recognize mental illness in a suspect.[182] Unless states and cities invest in deliberate, specialized training to recognize mental illness, even well-intentioned officers risk confusing symptoms with signs of guilt.[183]

A. Implementing Crisis Intervention Team (CIT) Training

To that end, one way to address underdiagnosis is mandating that a certain number of training hours be dedicated to mental health recognition and management. Many states and cities have adopted this approach through the Crisis Intervention Team (CIT) model. The Memphis Police Department originally developed the CIT program in 1988 in response to an officer fatally shooting a PWMI.[184] The department collaborated with the University of Tennessee, the University of Memphis, and the National Alliance on Mental Illness to create a specialized training curriculum that would both familiarize officers with the symptoms of mental illness and provide de-escalation training, with the overall goal of redirecting PWMI towards treatment services instead of the judicial system.[185] The model was quickly adopted by other localities and can now be found in over a thousand police departments across the country.[186]

These programs have been found to have "a positive effect on officers' attitudes, beliefs, and knowledge relevant to interactions with [PWMI]."[187] This includes a reduction in negative stereotypes and stigma surrounding mental illness in officers who receive mental health training.[188]

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[180] *Ibid* at 94.
[181] Fred Inbau *et al*, *Criminal Interrogation and Confessions*, 4th ed (Gaithersburg, MD: Aspen Publishers, 2001) at 431-32 [*Inbau 2*].
[182] See H Richard Lamb, Linda E Weinberger & Walter J DeCuir Jr, "The Police and Mental Health" (2002) 53:10 Psychiatr Serv 1266 at 1267, online: <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.53.10.1266> [*Lamb*].
[183] See *Ibid*.
[184] Amy C Watson & Anjali Fulambarker, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners" (2013) 8:2 Best Pract Mental Health 71 at 72, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/pdf/nihms500811.pdf> [*Watson 1*].
[185] Michael T Compton *et al*, "A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs" (2008) 36:1 J Am Acad Psychiatry & L 47 at 52, online: <https://pdfs.semanticscholar.org/7174/f4b1c49d645ea52b151eff00bb6040d4bf1c.pdf> [*Compton 1*].
[186] *Ibid* at 48. See also Matthew Epperson *et al*, "Envisioning the Next Generation of Behavioral Health and Criminal Justice Interventions" (2014) 37:5 Int'l JL & Psychiatry 427 at 433, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142111/#S2title> [*Epperson*].
[187] *Compton 1*, *supra* note 185 at 52-53.
[188] Michael T Compton *et al*, "Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia" (2006) 57:8 Psychiatr Serv 1199 at 1201-02, online: <https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.8.1199> [*Compton 2*].

Furthermore, "CIT-trained officers have reported feeling better prepared in handling calls involving individuals with mental illness."[189]

In some cities, this shift in attitude has translated to measurably positive outcomes for both officers and PWMI.[190] In Chicago, officers who received CIT training were significantly more likely to refer individuals to mental health services.[191] In Memphis, officers who received training were less likely to use force when responding to a mental health call, and officer injuries were down 80% when responding to such calls.[192]

These programs, and CIT programs in general, show great promise. Widespread implementation of similar policies could greatly improve officer recognition of mental illness when officers encounter PWMI in the community.[193]

a. Factors maximizing success

Importantly, some research indicates that CITs are no silver bullet.[194] One meta-study found that CITs have no overall effect on arrests of PWMI or officer safety.[195] Interestingly, the article warns that these results "do not suggest that CIT programs should be discontinued."[196] Rather, the results indicate that all programs are not created equal, and in many programs, there

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[189] *Compton 1*, *supra* note 185 at 52-53.
[190] *Watson 1*, *supra* note 184 at 74-75.
[191] See Amy C Watson, Victor C Ottati, Jeff Draine & Melissa Morabito, "CIT in Context: The Impact of Mental Health Resource Availability and District Saturation on Call Dispositions" (2011) 34:4 Int'l JL & Psychiatry 287 at 292, online: <https://indigo.uic.edu/articles/journal_contribution/CIT_in_Context_The_Impact_of_Mental_Health_Resource_Availability_and_District_Saturation_on_Call_Dispositions/10763180> [*Watson 2*].
[192] See *Crisis Intervention Team (CIT) Programs*, National Alliance on Mental Illness, online: <https://www.nami.org/get-involved/law-enforcement-and-mental-health>. See Randolph Dupont, Sam Cochran & A Bush, *Reducing Criminalization among Individuals with Mental Illness, Presented at the US Department of Justice and Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Conference on Forensics and Mental Illness,* (Washington, DC: Jul 1999). See Randolph Dupont & Sam Cochran, "Police Response to Mental Health Emergencies – Barriers to Change" (2000) 28:3 J Am Acad Psychiatry & L 338, online: <https://www.ojp.gov/ncjrs/virtual-library/abstracts/police-response-mental-health-emergencies-barriers-change>.
[193] Michael T Compton *et al*, "The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills" (2014) 65:4 Psychiatr Serv 517 at 521, online: <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300107> [*Compton 3*]. See also Susan M Godschalx, "Effect of a Mental Health Educational Program Upon Police Officers" (1984) 7:2 Research in Nursing & Health 111, online: <https://onlinelibrary.wiley.com/doi/abs/10.1002/nur.4770070207>. Lars Hansson & Urban Markstrom, "The Effectiveness of Anti-Stigma Intervention in a Basic Police Officer Training Programme: A Controlled Study" (2014) 14 BMC Psychiatry 1 at 5, online: <https://link.springer.com/content/pdf/10.1186/1471-244X-14-55.pdf> .
[194] See Michael S Rogers, Dale E McNiel & Renée L Binder, "Effectiveness of Police Crisis Intervention Training Programs" (2019) 47:4 J Am Acad Psychiatry & L, online: http://jaapl.org/content/jaapl/early/2019/09/24/JAAPL.003863-19.full.pdf.
[195] See Sema Taheri, "Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis" (2016) 27:1 Crim Justice Policy Rev 76 at 92, online: <http://www.gocit.org/uploads/3/0/5/5/30557023/sept_19_event_meta-analysis_crisis_intervention_training_for_police.pdf>.
[196] *Ibid* at 76.

are improvements to be made. Certain tactics appear to work better than others, and a few factors, examined below, seem to maximize a CIT program's chance at success.

Many police departments only train a few specialized officers to deal with mental health crises, arguing that they do not have the time or budget to train everyone.[197] Some cities do not even assign CIT training, instead relying on officers who self-select into the program voluntarily.[198]

However, one three-city study found that 92% of officers reported at least one encounter with a PWMI within the past month, and 84% reported having more than one encounter.[199] On average, officers reported six encounters with PWMI during the previous month.[200] Nationwide, approximately 7-10% percent of all police encounters involve people affected by mental illness.[201] Departments cannot guarantee that a handful of specialists are the first officers on the scene in these situations. Every officer must be equipped to recognize mental illness and interact with PWMI lest the situation escalate before a "specialist" arrives.

Likewise, a few trained specialists cannot be expected to catch every single PWMI that comes through the department doors. If departments hope to avoid wrongful convictions of PWMI, then the detectives doing day-to-day investigations must be trained to recognize mental illness themselves. The officers tasked with pursuing convictions and given the discretion to focus on one suspect over another must be able to identify PWMI like Blackmon.

In the majority of states that have implemented CIT programs, the required training is 8 hours or less.[202] To ensure officers fully understand, recognize, and appreciate the symptoms of mental illnesses, states and cities must ensure that departments undergo the full CIT curriculum, which includes approximately 40 hours of training.[203] This burden is not unreasonable. For

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[197] See Megan Pauly, "How Police Officers Are (or Aren't) Trained in Mental Health," *The Atlantic* (11 Oct 2013), online: <https://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485> [*Pauly*].

[198] See Michael T Compton, "Police Officers' Volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) Training: Evidence for a Beneficial Self-Selection Effect" (2017) 35:5-6 Behav Sci & L 470, online: <https://cit-utah.com/resources/Documents/CIT%20Training%20Self-selecting%20Proves%20Better%20Outcomes.pdf> [*Compton 4*].

[199] Randy Borum, "Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness" (1999) 16 Behav Sci & L 393 at 401, online: <https://scholarcommons.usf.edu/cgi/viewcontent.cgi?article=1567&context=mhlp_facpub>.

[200] *Ibid* at 397.

[201] See Doris A Fuller, H Richard Lamb, Michael Biasotti & John Snook, *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (The Treatment Advocacy Center, 2015) at 5, online: <https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>.
Jennifer Wood, Amy Watson & Anjali Fulambarker, "The 'Gray Zone' of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago" (2016) 20:1 Police Q 81 at 82, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5342894>.

[202] See *Pauly*, *supra* note 197.

[203] See Ernie Stevens & Joe Smarro, "Why Crisis Intervention Team Training Should be the Standard" (13 Dec 2019), National Alliance on Mental Illness, online: <https://www.nami.org/Blogs/NAMI-Blog/December-2019/Why-Crisis-Intervention-Team-Training-Should-Be-the-Standard>. The standard CIT program - developed by the Memphis Police Department Memphis Police Department, the University of Tennessee, the University of Memphis, and the National Alliance on Mental Illness - is a 40-hour curriculum consisting of the following topics: "Active listening and

example, in Florida, officers undergo 40 hours of mental health training during the police academy.[204] Investing in training up front will ensure officers do not waste time down the line interrogating innocent PWMI.

Learning theorists have found that punishment is not the most effective method of changing behavior.[205] If CIT training is only required *after* an officer mishandles a situation involving a PWMI, the officer is more likely to fixate on the chore of CIT training rather than examining the behavior that led to the punishment.[206] Moreover, if officers see CIT training as punishment, they are more likely to develop negative feelings towards PWMI because they blame the PWMI for their punishment.[207] Bearing this in mind, an effective CIT program must focus on training officers before they encounter a PWMI. For example, Florida's approach of training officers while they are at the police academy is more effective than framing CIT training as punishment for a mistake.

Studies show that race-based implicit bias training fades.[208] In the same way, mental health training may fade over time. Police departments must ensure that mental health awareness is integrated into the department's continued training requirement. For example, Florida requires every officer to complete 40 hours of continued education or training every four years.[209] Florida already has various requirements built into these 40 hours, such as a mandatory "Use-of-Force" training.[210] CIT training and mental health awareness could be seamlessly incorporated into pre-existing requirements, decreasing the risk that mental illness awareness fades over time.

Officers should recognize that their unconscious biases against PWMI [211] intersect with biases against women [212] and people of color.[213] Without discussing these intersectional biases, officers may not recognize PWMI in a female suspect or suspect of color.[214] CIT training should not be considered comprehensive unless it specifically covers mental illness in minority populations and all genders.

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de-escalation; Legal considerations; Mental illness basics; Various conditions including bipolar disorder, schizophrenia, depression, anxiety, PTSD, etc.; Suicide detection & prevention; police officer suicide; suicide by cop; Excited delirium; Local resources; Jail diversion [and] Role plays."

[204] See *Pauly*, *supra* note 197.

[205] See David Cherrington, "Crime and Punishment: Does Punishment Work?" (2007) 22:2 The Hayes Report on Loss Prevention 1 at 2-3, online: <https://scholarsarchive.byu.edu/cgi/viewcontent.cgi?article=1953&context=facpub>.

[206] See *ibid.*

[207] See *ibid.*

[208] See Calvin K Lai *et al*, "Reducing Implicit Racial Preferences: II. Intervention Effectiveness across Time" (2016) 145:8 J Exp Psychol Gen 1001, online: <https://psycnet.apa.org/doiLanding?doi=10.1037%2Fxge0000179>.

[209] See Florida Criminal Justice Standards & Training Commission, *Florida Officer Mandatory Retraining Requirements* (2014), online: <https://www.fdle.state.fl.us/CJSTC/Documents/Officer-Requirements/Mandatory-Retraining-Update-12-2014.aspx>.

[210] See *ibid*.

[211] See *infra* note 222.

[212] See generally Alisha Ali, Paula J Caplan & Rachel Fagnant, "Gender Stereotypes in Diagnostic Criteria," in Joan C Chrisler & Donald R McCreaty (eds), *Handbook of Gender Research in Psychology Volume 2: Gender Research in Social and Applied Psychology* (New York: Spring Science Business Media, LLC, 2010) 91, online: <http://xyonline.net/sites/xyonline.net/files/2020-07/Chrisler%2C%20Handbook%20of%20Gender%20Research%20in%20Psychology%20Vol%202%20%282010%29.pdf>.

[213] See *infra* note 247.

[214] The complicated issue of racial bias and mental health is more fully explored in the Challenges Section.

Implementing a CIT program that accounts for all these variables could significantly boost awareness of mental illness within a police force, as well as train officers how to distinguish common symptoms of illness from signs of a guilty conscience.[215] The ability to recognize a PWMI early in the investigative process lowers the risk downstream that mental illness is misinterpreted as guilt, which in turn lowers the risk that an officer coerces a PWMI into a false confession. Accordingly, CIT training appears to be a valuable tool for any state or city seeking to avoid wrongful convictions of PWMI.

B. Challenges and Limitations of CIT Programs

That being said, states and cities that choose to adopt CIT programs must also recognize their inherent limitations. Comprehensive training may decrease the risk that symptoms are *accidentally* mistaken for guilt. But CIT programs cannot protect innocent PWMI from officers who recognize mental illness but choose to pursue a conviction anyway. In this sense, even the most successful CIT program is constrained by its reliance on officer discretion.

Such is the case with James Blackmon. Mundy and Holder knew beyond a shadow of a doubt that Blackmon had serious mental health problems, yet they continued to manipulate him into proffering a confession.[216] The detectives knew that Blackmon's mental illness had led to numerous involuntary commitments to state psychiatric hospitals.[217] They knew that he suffered serious delusions.[218] Blackmon admitted to committing murders in the same breath he took responsibility for "devastating" hurricanes, earthquakes, and catastrophes.[219] He admitted to sneaking out of the dorm while it was still dark, but rationalized the decision because he saw himself as Dracula.[220] The officers not only knew that Blackmon suffered from dissociation, they capitalized on and encouraged dissociation by talking about "Bad James" and "Good James."[221]

Despite deafening alarm bells signaling mental illness, Holder and Mundy never considered the possibility of innocence, or even diversion. The problem for these officers was not that they failed to recognize mental illness. They knew about Blackmon's mental illness and did not care. It is unlikely CIT training would have changed the outcome of this case. Indeed, the detectives were so confident that they were not engaged in wrongdoing that they memorialized Blackmon's interviews. They made amply clear on the record that Blackmon came to the station of his own accord and spoke to them voluntarily. These choices suggest the detectives believed they were doing nothing wrong when they recognized mental illness but continued to extort a confession anyway. Their decision was likely influenced by a convergence of biases.

a. Stigma against PWMI

To internally justify their decision, the detectives *must* have concluded that Blackmon warranted incarceration, despite his obvious mental illness. To Mundy and Holder, any person that

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[215] See *Compton 1*, *supra* note 185. *Compton 2*, *supra* note 188.
[216] *NC Blackmon*, *supra* note 32 at 423-24.
[217] *NCIIC*, *supra* note 14 at 228-33.
[218] *NC Blackmon*, *supra* note 32 at 423-24.
[219] *NCIIC*, *supra* note 14 at 451-52.
[220] *Ibid* at 410.
[221] *Ibid* at 422, 425, 427.

dangerous—mentally disordered or not—needed to be jailed. The detectives overlooked signs of Blackmon's disability (and in turn, his innocence), and instead focused on his perceived aggression and capacity for violence.

This association between mental illness and crime, and the ensuing rationalization that Blackmon *belonged* in jail, is one facet of a broader social stigma working against PWMI. PWMI like Blackmon are seen, both by the police and the public, as inherently dangerous, unstable, and prone to acts of violence.[222] This deeply-rooted stigma does not stem from malice per se, but from fear of the different and difficulty empathizing with PWMI.[223] One study in 1964 confirmed that the level of social rejection for a PWMI was not based on his or her medical diagnosis, but rather "how visibly the [PWMI's] behavior deviated from customary role-expectations."[224] In other words, if a PWMI's actions still aligned with social standards, he or she was far less likely to be rejected, regardless of the pathology of their illness. Only when behavior *significantly deviated* from the norm did social rejection occur.[225]

On some level, this rejection is understandable. PWMI like Blackmon act in ways that are rational to themselves but can be frightening to others. As Richard Neutra explains, it is difficult, if not impossible, "to share the feelings of someone who does not who does not talk about the same subject at the end of a sentence as he did at the beginning, who sees and responds to things we do not see, whose mood, reason and very identity may change from moment to moment."[226]

Even so, the pervasive stigma of PWMI as inherently dangerous and inherently criminal is

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[222] One 2013 public survey found that 46% of Americans believed PWMI were "by far, more dangerous than the general population." Colleen Barry *et al*, "After Newtown — Public Opinion on Gun Policy and Mental Illness" (2013) 368:12 N Engl J Med 1077 at 1080, online: <https://www.nejm.org/doi/full/10.1056/nejmp1300512>. Similar results have been replicated by a variety of sources. See Treatment Advocacy Center, *Stigma and Serious Mental Illness* (2016), online: <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/stigma-and-smi.pdf>.

[223] See generally Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York, NY: Pantheon Books, 1965). Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York, NY: The Free Press, 1994) at 4, 17, 51. The association between criminality and PWMI has been extensively studied and can be traced back centuries. Briefly, the 17th-century European medical community believed that health (mental as well as physical) resulted from a balance between man and the natural world. Madness did not strike arbitrarily but was seen as a divine punishment imposed upon those who transgressed the laws of nature. PWMI were therefore equivalent to criminals since any person afflicted with a mental illness must have deliberately chosen to violate God's law. PWMI became linked to immorality and vice, and this stigma traveled with European colonists to America. The Industrial Revolution only deepened the association between PWMI and criminality. PWMI were kept in public almshouses along with other "dependents" like the elderly, sick, poor, and physically and developmentally disabled. These same almshouses also served as prisons for vagabonds, prostitutes, and criminals. PWMI became inextricably linked to both society's unwanted "dependents" as well as its "deviants." This double association meant that PWMI were not only seen as part of society's dangerous, criminal faction, but also as part of the dependent sector draining the community. The combination cultivated an overarching, pervasive fear of PWMI and the threat they posed to "regular" society, one that lingers today.

[224] Derek Phillips, "Rejection of the Mentally Ill: The Influence of Behavior and Sex" (1964) 29:5 Am Soc Rev 679 at 686-687. See also Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health 1961* (Boston, 1961) at xxix.

[225] See *Ibid.*

[226] Morton Birnbaum, "The Right to Treatment: Some Comments on Its Development" in Frank J Ayd, ed, *Medical, Moral, and Legal Issues in Mental Health Care* (Baltimore, MD: Williams & Wilkins Col., 1974) at 97.

unfounded. PWMI are far more likely to be victims of violence than instigators.[227] Yet fear continues to subtly influence decisions, such as the detectives' choice to convict Blackmon. Before they had even met Blackmon, unconscious stigma against PWMI led Holder and Mundy to view Blackmon in a negative, criminally tinged light.

The detectives' background research on Blackmon merely corroborated this unconscious bias. Before interrogating Blackmon, the detectives read prison reports describing Blackmon as extremely hostile and assaultive, and requiring an inordinate amount of time and energy to keep from harming others.[228] They obtained similar reports from Dorothea Dix, which detailed Blackmon's history of threats and physical altercations.[229] The detectives also had access to criminal records detailing petty crimes such as trespass and narcotics possession, as well as violent crimes like armed robbery and assault.[230] Most importantly, the detectives knew Blackmon had a history of violence towards women. The second time Blackmon was referred to Dix, he had forcibly kissed a librarian, exposed himself, and tried to force her into a bathroom.[231]

This detailed mental picture of Blackmon as a violent criminal, one with a past of hurting women, only bolstered the underlying stigma that Holder and Mundy already harboured against Blackmon as a PWMI. This prejudice and preconceived notion of guilt overwhelmed any signs of innocence Blackmon displayed during his interviews.

b. Stigma against PWMI of color

The detectives' predilection to see Blackmon as a criminal was further exacerbated by his identity as a PWMI of color.[232] Even though people of color are statistically more likely to be involved with the criminal justice system, police are less likely to recognize mental illness in black

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[227] See Marie Rueve & Randon Welton, "Violence and Mental Illness" (2008) 5:5 Psychiatry (Edgmont) 34, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686644>. See also Jay Singh *et al*, "Structured Assessment of Violence Risk in Schizophrenia and Other Psychiatric Disorders: A Systematic Review of the Validity, Reliability, and Item Content of 10 Available Instruments" (2011) 37:5 Schizophr Bull 899, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160213>.

[228] *NCIIC*, *supra* note 14 at 244, 280-83.

[229] *Ibid* at 244-46.

[230] *Ibid* at 232-33.

[231] *Ibid* at 299.

[232] For the purposes of this paper, I limit my examination to racial bias in the context of police officers recognizing mental illness in potential suspects. However, racial bias has profound and insidious implications for the entire field of healthcare. Racial and ethnic minorities have less access to mental health services than white people, are less likely to receive needed care, and are more likely to receive poor-quality care when they are treated. This backdrop informs the discussion of minorities receiving (or not receiving) healthcare in a criminal justice context. See generally Alan Nelson, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (2002) 94:8 J Nat'l Med Assoc 666, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/pdf/jnma00325-0024.pdf>. See also Lonnie Snowden, "Bias in Mental Health Assessment and Intervention: Theory and Evidence" (2003) 93:2 Am J Public Health 239, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447723> [*Snowden*]. See also Office of the U.S. Surgeon General, *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001), online: <https://www.ncbi.nlm.nih.gov/pubmed/20669516>.

suspects.[233] As a black male, Blackmon's odds of pretrial diversion to a mental health facility were 44% lower than white suspects charged with similar offenses.[234] This phenomenon is mirrored in juvenile criminal justice systems. Black youths with mental health problems "are treated more harshly for equivalent offenses to which their white cohorts are either released from or unofficially treated through the mental health system."[235] Overall, white prisoners are significantly more likely than black prisoners to have *ever* been told they had a mental disorder.[236]

Further evidence of racialized underdiagnosis can be seen in mental health treatment once incarcerated. White prisoners exhibiting symptoms of mental illness are more likely than black prisoners to receive treatment, while black prisoners exhibiting identical symptoms are 2.52 times more likely to be punished and sent to solitary confinement.[237]

As a whole, the criminal justice apparatus fails to accurately diagnosis black PWMI. Interestingly, in a clinical setting, black men are over diagnosed with schizophrenia.[238] This begs the question: Why are black men over diagnosed in a clinical setting, yet underdiagnosed in the criminal justice setting?

The answer may lie at the complicated nexus of ignorance, bias against PWMI, and bias against people of color. Clinical psychiatrists are trained to look for mental illness, so they tend to find it.[239] Police officers, on the other hand, are unfamiliar with mental illness and its symptoms, but trained to look for guilt.[240] As discussed in Section III, when police use the Reid Technique to conduct this search, they risk mistaking mental illness for criminality.

This risk of underdiagnosis is dangerously heightened for suspects of color. Through implicit bias, police officers unconsciously associate people of color with criminality.[241] This

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[233] Leah Pope, "Racial Disparities in Mental Health and Criminal Justice" (24 Jul 2019) National Alliance on Mental Illness (blog), online: <https://www.nami.org/Blogs/NAMI-Blog/July-2019/Racial-Disparities-in-Mental-Health-and-Criminal-J>.

[234] Traci Schlesinger, "Racial Disparities in Pretrial Diversion: An Analysis of Outcomes Among Men Charged with Felonies and Processed in State Courts" (2013) 3:3 Race and Justice 210 at 223, online: <https://journals.sagepub.com/doi/full/10.1177/2153368713483320>.

[235] Todd Martin & Henry Grubb, "Race Bias in Diagnosis and Treatment of Juvenile Offenders: Findings and Suggestions" (1990) 20:4 J Contemp Psychother 259 at 269 [*Martin & Grubb*].

[236] *Bronson & Berzofsky*, *supra* note 3 at 4.

[237] See Fatos Kaba *et al*, "Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service" (2015) 105:9 Am J Public Health 1911 at 1911, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539829> [*Kaba*].

[238] See Robert Schwartz & David Blankenship, "Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature" (2014) 4:4 World J Psychiatry 133 at 138, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585>. Schwartz found that even after controlling for other significant demographic and clinical characteristics, African Americans were over three times more likely to be diagnosed with Schizophrenia than whites. He posits that unconscious clinician bias may contribute to the misdiagnosis. Furthermore, an overdiagnosis of schizophrenia may stem from an underdiagnosis of Major Depressive Disorder and Bipolar Disorder in African Americans.

[239] See *Lamb*, *supra* note 182.

[240] See *ibid.*

[241] See *Nelson*, *supra* note 55. See Jon Hurwitz & Mark Peffley, "Public Perceptions of Race and Crime: The Role of Racial Stereotypes" (1997) 41:2 AJPS 375, online: <https://www.researchgate.net/profile/Mark_Peffley/publication/271674754_Public_Perceptions_of_Race_and_Crime_The_Role_of_Racial_Stereotypes/links/5833370d08aef19cb81cac38/Public-Perceptions-of-Race-and-Crime-

social tendency to perceive minorities as criminal or untruthful is abhorrent, but well-documented.[242] Race has "always played a central role in constructing a presumption of criminality."[243] Even without considering mental illness, implicit bias studies have shown that individuals harbor a "strong associations between Black and Guilty."[244] Studies repeatedly reveal that people "evaluate ambiguous actions performed by non-Whites as suspicious and criminal while identical actions performed by Whites go unnoticed."[245]

Put simply, racial bias causes police to overlook the mental illness aspect of a black PWMI's identity, and instead focus primarily on the PWMI's race.[246] Then, because officers inherently link "black" with criminality, officers tend to attribute guilty behaviors in black PWMI to membership in a "guilty" social group rather than to mental illness.[247] Symptoms that would be recognized in a white PWMI are written off as "normal" behavior in a black PWMI due to his cultural background.[248] White suspects displaying signs of mental illness are more likely to be seen as sick, and appropriately diverted. A black suspect with identical problems remains undiagnosed because displays of aggression or criminality are "characteristic of his culture."[249] Such behavior warrants punishment rather than treatment.[250]

This insidious bias has devastating consequences for all black PWMI, including Blackmon. Officers misinterpret signs of illness as signs of guilt. An unconscious association between minorities and criminality exacerbates this issue, leading officers to underdiagnose black PWMI far more than white PWMI. This means black, mentally ill, innocent suspects face multiple levels of prejudice and ignorance. Dual biases make it even more unlikely that the police will recognize a black PWMI's innocence and release him. Instead, like James Blackmon, the police are more likely to proceed to the interrogation stage and extract a false confession.

The-Role-of-Racial-Stereotypes.pdf>. See also Nazgol Ghandnoosh, *Race and Punishment: Racial Perceptions of Crime and Support for Punitive Policies,* The Sentencing Project (2014), online: <https://www.sentencingproject.org/wp-content/uploads/2015/11/Race-and-Punishment.pdf>.

[242] See Kaba, *supra* note 237. See Ghandnoosh, *supra* note 241. See Hurwitz & Peffley, *supra* note 241.

[243] Angela Davis, *Are Prisons Obsolete?*, (New York: Seven Stories Press, 2003) at 28-33, online: <https://decolonisesociology.files.wordpress.com/2019/03/angela-davis-are_prisons_obsolete.pdf>.

[244] *Nelson*, *supra* note 55 at 635.

[245] *Ibid* at 634.

[246] See *Snowden*, *supra* note 232.

[247] *Martin & Grubb*, *supra* note 235 at 261. To explain racialized underdiagnosis in the criminal justice context, Martin and Grubb posit, "The major-culture in this nation upholds the primacy of the individual . . . The Black cultural perspective concerning the place of the member in his group is quite different. The member is understood to be *secondary to the group*." In other words, when a white PWMI exhibits symptoms of mental illness, observers consider that individual to be operating *separate* from his social group. Aggression in a white PWMI is perceived to be an aberration and classified as a mental illness. Conversely, when a black PWMI exhibits identical symptoms, observers consider him to be exhibiting behaviors *characteristic* of his culture. Symptoms that send up red flags for white PWMI are ignored in black PWMI because such behaviors are considered customary for that social group. See also Hava Villaverde, "Racism in the Insanity Defense" (1995) 50 U Miami L Rev 209 at 215-16, online: <https://repository.law.miami.edu/cgi/viewcontent.cgi?article=1797&context=umlr>. See *Kaba*, *supra* note 207.

[248] See *Mental Health Disparities: Diverse Populations*, American Psychiatric Association, online: <https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts>.

[249] *Martin & Grubb*, *supra* note 235 at 269.

[250] See *ibid*. See also Kimberly Kahn, Melissa Thompson & Jean McMahon, "Privileged Protection? Effects of Suspect Race and Mental Illness Status on Public Perceptions of Police Use of Force" (2017) 13 J Exp Criminol 171, online: <https://link.springer.com/article/10.1007/s11292-016-9280-0#citeas>.

Based at least in part on these dovetailing prejudices, the detectives concluded Blackmon was either malingering the degree of his illness or outright faking it.[251] Rather than someone who needed help, police viewed him as a dangerous murderer who gave a legally valid confession.[252]

CIT training has the potential to decrease *inadvertent* underdiagnosis. But it will not prevent a case like Blackmon's, where officers on notice of a diagnosed mental health disorder choose to ignore all signs of illness in pursuit of a conviction. And CIT training almost certainly will not prevent officers from actively capitalizing on an illness to extract a confession, as detectives did to Blackmon. In this sense, Blackmon's case highlights the fallibility of relying on officer discretion to protect PWMI and underscores a significant shortcoming of the CIT model.

c. Supplementing CIT Programs with Mandatory Legal Safeguards

To the extent that underdiagnosis can be attributed to good faith ignorance, CIT programs are a viable solution. But even in cities with robust mental health training, there will invariably be officers who identify mental illness in a suspect but, in their discretion, decide that the suspect is guilty and warrants incarceration anyway.[253] No amount of training could completely negate the decades, if not centuries, of stigma that worked against Blackmon in 1983. These biases continue to work against all PWMI today, especially PWMI of color. Therefore, any state or city that seeks to implement a CIT program should be aware of this shortcoming and consider supplementing its mental health training with automatic legal safeguards that kick in once a PWMI is identified.

One potential blueprint for such safeguards can be found in the United Kingdom. There, Code C of the Police and Criminal Evidence Act 1984 (Code C) requires an officer who "has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable" to treat the person as mentally vulnerable.[254]

Once vulnerability is identified, Code C places two requirements on the custodial officers. First, "[t]he custody officer must make sure a person receives appropriate clinical attention as soon as reasonably practicable if the person appears to be suffering from a mental disorder."[255] This requirement "applies even if the detainee makes no request for clinical attention and whether or not they have already received clinical attention elsewhere."[256]

Second, if a detainee is "mentally disordered or otherwise mentally vulnerable, the custody officer must, as soon as practicable," inform an "appropriate adult" of the grounds for detention

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[251] *NCIIC*, *supra* note 14 at 436.
[252] *Ibid* at 529-530.
[253] *Mental Health and Fair Trial* (London: JUSTICE, 2017) (David Latham) at 27-28, online: <https://files.justice.org.uk/wp-content/uploads/2017/11/06170615/JUSTICE-Mental-Health-and-Fair-Trial-Report-2.pdf> [*Latham*].
[254] *Revised Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers, Police and Criminal Evidence Act 1984 Code C* (May 2014) at para 1.4, Annex E, [PACE] online: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/364707/PaceCodeC2014.pdf> [*PACE*].
[255] *Ibid* Annex E.
[256] *Ibid* at para 9.5A.

and the person's whereabouts and ask the adult to come to the police station to see the detainee.[257] Distinct from an attorney, the main responsibilities of an AA are:

1. To support, advise and assist the detained person, particularly while they are being questioned;
2. To observe whether the police are acting properly, fairly and with respect for the rights of the detained person. And to tell the PWMI if they are not;
3. To assist with communication between the detained person and the police;
4. To ensure that the detained person understands their rights and that the AA plays a role in protecting their rights.[258]

An appropriate adult is either (1) a relative, guardian, or other person responsible for care; (2) someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police; (3) or, failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police.[259]

Subject to a few exceptions, "[a] mentally disordered or otherwise mentally vulnerable person must not be interviewed or asked to provide or sign a written statement in the absence of the appropriate adult."[260] Importantly, "[u]nlike legal advice, this 'backstop' safeguard cannot be waived by . . . vulnerable adults."[261]

Proponents of the AA system claim that AAs, though not legal representatives, provide critical support to PWMIs during interrogations. An AA can help a PWMI understand various "aspects of the situation, including why they were in custody, how long they would be there, the questions that were being asked of them, and what their rights were."[262] AAs also provide emotional support through the stressful and often overwhelmingly negative experience of custody, and a much-needed feeling that someone is "on [the PWMI's] side."[263]

Such a program could compensate for some of the gaps identified in CIT training. Automatically requiring an AA's presence upon identification of mental illness, rather than requiring a PWMI to request help or an officer to recommend it, would avoid the issues associated with *Miranda* invocation as well as reliance upon officer discretion. Furthermore, making an AA's presence unwaivable, rather than an optional right that PWMI can be talked out of invoking, could prevent officers from manipulating PWMI through minimization techniques, as detectives did to Blackmon.

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[257] *Ibid* Annex E.
[258] Chris Bath *et al*, *There to Help: Ensuring Provision of Appropriate Adults for Mentally Vulnerable Adults Detained or Interviewed by Police* (2015) National Appropriate Adult Network at 7, online: <http://www.appropriateadult.org.uk/images/pdf/2015_theretohelp.pdf> [*Bath*].
[259] *PACE*, *supra* note 254 at para 1.7.
[260] *Ibid*, Annex E.
[261] *About Appropriate Adults*, National Appropriate Adult Network, online: <https://appropriateadult.org.uk/information/what-is-an-appropriate-adult>.
[262] Tricia Jessiman & Ailsa Cameron, "The Role of the Appropriate Adult in Supporting Vulnerable Adults in Custody: Comparing the Perspectives of Service Users and Service Providers" (2017) 45 Br J Learn Disabil 246 at 248-50, online: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/bld.12201> [*Jessiman & Cameron*].
[263] *Ibid* at 248-250.

This is especially true if American states and cities were to take the AA provision one step further than the UK and impose a statutory requirement on departments to find an AA for all vulnerable adults.[264] Statutorily guaranteeing an AA's presence for all identified PWMI, even PWMI whom interrogating officers believe to be guilty, could prevent a situation like Blackmon's. Even if an officer firmly believed his tactics were justified by a PWMI's guilt, the presence of an AA could ensure that the officer does not take advantage of extreme delusions or faulty reality monitoring to draw out a confession, as detectives did to Blackmon. Indeed, one study found that although AAs contributed little to police interviews in terms of verbal interactions, "their mere presence during the police interview [had] three important effects."[265] First, in the case of vulnerable adults, the presence of an AAN increased the likelihood that a legal representative will be present. Second, an AA was associated with less interrogative pressure in interview. Third, in the presence of an AA, the legal representative tended to take on a more active role.[266]

Based on these findings, one cannot help but wonder: how may James Blackmon's interviews had gone differently had an AA accompanied him into the interrogation room? The AA system is not perfect, and American communities would need to workshop significant issues raised by UK stakeholders.[267] Nevertheless, an automatic AA requirement in all cases involving mental illness could compensate for some of the aforementioned shortcomings of CIT programs, and ensure that meaningful legal protections follow identification of a PWMI in the justice system.

V Conclusion

James Blackmon's case is tragic, yet emblematic of many PWMI's experience with the justice system. Familiarity with mental illness could decrease the odds that such miscarriages of justice are repeated. Therefore, it is promising that over a thousand police departments have adopted the CIT model of mental health training.[268] States and cities that have not yet addressed the issue must consider the need for a comparable program. Until they do, PWMI in their communities face a heightened risk of wrongful conviction.

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[264] One of the greatest criticisms of the UK's current AA provision is that there is no statutory duty to provide an AA for vulnerable adult suspects. This is in contrast to Section 38 of the *Crime and Disorder Act* 1998, which places a statutory duty on local authorities to "ensure the provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers." No such duty exists for vulnerable adult suspects. If no family member or friend is readily available to act as AA, police can call upon a patchwork network of social workers, clinicians, or locally organized AA chapters comprised of volunteers, to serve as an AA. But these resources are limited, and without a clear legal obligation requiring departments to ensure an AA is found, the actual provision of AAs varies widely among UK municipalities. Many advocates have called on the UK government to amend PACE 1984 to "establish an explicit statutory duty on police officers to secure an AA for all mentally vulnerable adults; and to bring greater consistency to the approach of courts on the admissibility of evidence obtained in the absence of an AA." *Bath*, *supra* note 258 at 8, 11. *Latham*, *supra* note 253 at 36.

[265] See Sarah Medford, Gisli H Gudjonsson & John Pearse, "The Efficacy of the Appropriate Adult Safeguard During Police Interviewing" (2010), 8:2 Leg & Crim Psych 253, online: <https://bpspsychub.onlinelibrary.wiley.com/doi/abs/10.1348/135532503322363022>.

[266] See *ibid*.

[267] Specifically, critics of the AA requirement point out that the role is ambiguously defined, no uniform standards exist governing the qualifications of AAs, and police officers often have trouble procuring AAs for vulnerable adults, leading to wait times of several hours. See *Jessiman & Cameron*, *supra* note 262. See *Latham*, *supra* note 253. See *Bath*, *supra* note 258.

[268] See *Epperson*, *supra* note 186.

However, states and cities that choose to adopt CIT programs must also recognize their limitations. An increase in awareness alone is insufficient to protect PWMI. Mandatory procedural safeguards, ones that do not rely on officer discretion, are also necessary to counterbalance prejudice and stigma in individual actors. To adopt one and not the other leaves PWMI like Blackmon vulnerable to officers who continue to pursue a conviction in the face of clear mental illness (and indeed, may even choose to capitalize on that mental illness to obtain a false confession). In tandem, an increased awareness of mental illness, and mandatory legal safeguards for those identified, could rectify some of the harms identified in this paper, and make James Blackmon's fate far less common in the future.