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Overview of Mental Health Issues For Law Enforcement Personnel

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- ☐ Goals of discussion
  - ○ Review of issues concerning management of the mentally ill during the course of community police work
  - ○ Suggestions for future, more focused training

- ☐ Background
  - ○ Deinstitutionalization of the mentally ill (MI) has brought an influx of psychiatrically ill patients into the community. Consequently, the police are in the frontline of responding to crises involving individuals suffering from some form of mental illness.
  - ○ The rationale for police intervention with an MI individual is twofold:
    - The power & authority of the police to protect the safety and welfare of the community, and
    - The state's protective interest in caring for citizen's with disabilities who cannot care for themselves, such as those with MI.
  - ○ Police intervention scenarios
    - Police in all states have the power to transport persons for psychiatric evaluation and treatment when there is probable cause to think that they are a danger to themselves or to others because of their mental illness
    - Police are typically the first and often the sole community resource called on to respond to urgent situations with an MI individual.
    - Police function as default "street corner psychiatrists", serving as primary gatekeepers, making a decision in the field as to whether the mental health system or the criminal justice system is the most appropriate setting for transport of an individual in the community.
      - □ When called-upon to intervene with an individual whose apparent mental illness is causing moderately disruptive behavior in the community, some studies have found that responding officers most often intervene by trying to calm the person and perhaps arranging for the individual to be returned home.
      - □ However, more serious behaviors will trigger referral to the mental health system or, if a more serious criminal offense is alleged to have been committed, to the criminal justice system. The decision as to which route to pursue is typically shaped by:
        - ♦ The nature and seriousness of the alleged offense
        - ♦ The impact of the behavior upon others in the community
        - ♦ The availability of mental health evaluation & treatment resources
        - ♦ The time demands placed upon responding officers in accessing mental health evaluation.
      - □ As in the general public, studies of police officers have shown that concerns over the risk of violence rise when dealing with persons suffering a mental illness.
        - ♦ While certain psychiatric illnesses (e.g., untreated manic episode, especially when accompanied by substance use) are associated with an increased risk of violence, police officers can benefit from training to better differentiate which circumstances and presentations pose a greater threat.

- ☐ Programs to promote collaboration of police & mental health services
  - ○ Many communities and police departments have recognized the need to better identify and treat individuals suffering from some form of MI and a number of programs have been developed to promote collaboration between police officers and mental health professionals. Often, these programs are referred to as diversion programs—the intent is to divert psychiatrically ill patients from the criminal justice system into a treatment program. Generally, these initiatives fall into two categories: pre-booking & post-booking programs.

- Pre-booking programs: the diversion occurs before arrest charges are filed
  - □ Police officers are provided with training and access to mental health clinicians and programs, to make direct referrals to the mental health system.
    - ♦ The "Memphis Model" is one of the most visible and well-developed programs in the country
      - ➢ Developed in response to a 1987 police shooting incident involving a psychiatrically ill individual
      - ➢ Broad-based community support/input (e.g., NAMI, university, etc.)
      - ➢ Uses a crisis intervention team composed of specially trained officers—130 of a total force of 1,350 in the Memphis Police Department participate on the team
      - ➢ Community-based treatment facilities agree to accept referrals from the MPD for rapid evaluation/treatment.
    - ♦ Other programs encourage collaboration between police and mental health professionals through:
      - ➢ Use of external consultant
      - ➢ Development of crisis teams which accompany responding officers to calls involving an apparently mentally ill individual.
    - ♦ Studies of diversion programs generally find lower arrest rates and increased utilization of mental health programs as opposed to criminal justice resources.

○ Training issues
- Surveys of police officers generally find that officers feel that their level of training in psychiatric issues is inadequate to support their day-to-day work. Issues of most concern tend to include:
  - □ How to recognize mental illness
  - □ How to deal with psychotic behavior
  - □ How to handle suicide threats
  - □ Maintaining a clear understanding of the civil commitment procedures
  - □ Maintaining a knowledge base of mental health programs and resources within the community

☐ Brief overview of common training needs for police officers

○ How to recognize mental illness
- Serious mental illness is characterized by:
  - □ Disturbances in thinking
    - ♦ Delusions
    - ♦ Illogical, magical thinking
  - □ Disturbances in perception
    - ♦ Auditory (most common) or visual hallucinations
  - □ Disturbances in affect
    - ♦ The person's facial expressions don't make sense
  - □ Disturbances in behavior
- Questions to better identify someone suffering from a mental illness include:
  - □ Listening for references to delusion ideas/beliefs. Paranoid ideation is often accompanied by grandiosity and may pose a threat to others if the individual believes they must protect themselves from a perceived threat.
  - □ Assessing for perceptual disturbances: "How's your hearing? Ever heard things you're not sure other people have heard?"
  - □ Inquire about the individual's psychiatric treatment history: "Have you ever been psychiatrically hospitalized?", "Are you taking any psychiatric medication right now?", "Who is your doctor?"

○ Dealing with psychotic behavior
- The best strategy is to get the person to a safe, controlled setting ASAP.
- De-escalation strategies usually emphasize not matching the individual's own affective intensity.
- Delusional beliefs do not need to be endorsed—it's okay to say, "I'm sorry, ma'am….I know it makes sense to you, but it's difficult for me to understand."

○ Suicide assessment
- Whenever there is reason to suspect that an individual may be a danger to himself/herself, the best course of action is to provide transport to the local ER for further assessment

- Signs of depression and suicide risk:
  - □ Change in personality-becoming sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
  - □ Change in behavior-can't concentrate on school, work, routine tasks
  - □ Change in sleep pattern-oversleeping or insomnia, sometimes with early waking
  - □ Change in eating habits-loss of appetite and weight, or overeating
  - □ Loss of interest in friends, sex, hobbies, activities previously enjoyed
  - □ Worry about money, illness (real or imaginary)
  - □ Fear of losing control, "going crazy," harming self or others
  - □ Feelings of overwhelming guilt, shame, self-hatred
  - □ No hope for the future-"It will never get better, I will always feel this way."
  - □ Drug or alcohol abuse
  - □ Recent loss of a loved one through death, divorce, separation, broken relationship; or loss of job, money, status, self-confidence, self-esteem
  - □ Loss of religious faith
  - □ Agitation, hyperactivity, restlessness may indicate masked depression
- Don't be afraid to ask: "Do you sometimes feel so bad you think of suicide?"
  - □ Just about everyone has considered suicide, however fleetingly, at one time or another. There is no danger of "giving someone the idea." In fact, it can be a great relief if you bring the question of suicide into the open, and discuss it freely, without showing shock or disapproval. Raising the question of suicide shows you are taking the person seriously and responding to the potential of his/her distress.
  - □ Ask questions like: *Have you thought about how you'd do it? Do you have the means? Have you decided when you'll do it? Have you ever tried suicide before? What happened then?*
  - □ If the person has a defined plan, the means are easily available, the method is a lethal one, and the time is set, the risk of suicide is very high. Your response will be geared to the urgency of the situation as you see it. Therefore, it is vital not to underestimate the danger by not asking for details.
- Common misconceptions about suicide:
  - □ *"People who talk about suicide won't really do it."*
    - ♦ Almost everyone who commits suicide has given some clue or warning. Do not ignore suicide threats. Statements like "You'll be sorry when I'm dead," or "I can't see any way out"-no matter how casually or jokingly said-may indicate serious suicidal feelings.
  - □ *"Anyone who tries to kill themselves must be crazy."*
    - ♦ Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed, or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.
  - □ *"If a person is determined to kill themselves, nothing is going to stop them."*
    - ♦ Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.
  - □ *"People who commit suicide are people who were unwilling to seek help."*
    - ♦ Studies of suicide victims have shown that more than half had sought medical help within six months before their deaths.
  - □ *"Talking about suicide may give someone the idea."*
    - ♦ You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true-bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.
- Persons who may be at high risk for suicide:
  - □ Persons who are severely depressed and feel hopeless
  - □ Persons who have a past history of suicide attempts
  - □ Persons who have made concrete plans or preparations for suicide
- Basic suicide assessment questions: ask these questions-in the same order-to find out if the person is seriously considering suicide:
  - □ *"Have you been feeling sad or unhappy?"*
    - ♦ A "yes" response will confirm that the person has been feeling some depression.

- □ *"Do you ever feel hopeless? Does it seem as if things can never get better?"*
  - ♦ Feelings of hopelessness are often associated with suicidal thoughts.
- □ *"Are you having thoughts of wanting to end your life?"*
  - ♦ A "yes" indicates an active desire to die. This is a more serious situation.
- □ *"Do you have any actual plans to kill yourself?"*
  - ♦ If the answer is "yes," ask about their specific plans. What method have they chosen? Hanging? Jumping? Pills? A gun? Have they actually obtained the rope? What building do they plan to jump from? Although these questions may sound grotesque, they may save a life. The danger is greatest when the plans are clear and specific, when they have made actual preparations, and when the method they have chosen is clearly lethal.
- □ *"Is there anything that would hold you back, such as your family or your religious convictions?"*
  - ♦ If the person says that people would be better off without them, and if they have no deterrents, suicide is much more likely.
- □ *"Have you ever made a suicide attempt in the past?"*
  - ♦ Previous suicide attempts indicate that future attempts are more likely. Even if a previous attempt did not seem serious, the next attempt may be fatal. All suicide attempts should be taken seriously. However, suicidal "gestures" can be more dangerous than they seem, since many people do kill themselves.
- □ *"Would you be willing to talk to someone or seek help if you felt desperate? With whom would you talk?"*
  - ♦ If the person who feels suicidal is cooperative and has a clear plan to reach out for help, the danger is less than if they are stubborn, secretive, hostile, and unwilling to ask for help.

○ Civil commitment procedures

- In Illinois, the criteria for involuntary psychiatric hospitalization include:
  - □ A person with mental illness and who because of his or her illness is reasonably expected to inflict serious physical harm upon himself or herself or another in the near future which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed; or
  - □ A person with mental illness and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or outside help.
- The power to detain someone for evaluation comes from the petition. The Illinois mental health code has the following provision regarding completion of petitions:
  - □ *A peace officer may take a person into custody and transport him to a mental health facility when the peace officer has reasonable grounds to believe that the person is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm. Upon arrival at the facility, the peace officer may complete the petition under Section 3-601. If the petition is not completed by the peace officer transporting the person, the transporting officer's name, badge number, and employer shall be included in the petition as a potential witness as provided in Section 3-601 of this Chapter.* (405 ILCS 5/3-606).

☐ Discussion of local mental health resources

- ○ Outpatient mental health programs
- ○ Chemical dependency programs
- ○ Inpatient psychiatric programs

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Good Luck!

Dr. John Jochem is a clinical psychologist with many years experience working with adults, adolescents, couples and families. Should you have any questions about this presentation, or wish to learn more about the range of services available through Dr. Jochem's practice, Hawthorn Counseling Group, feel free to call Dr. Jochem at ***(847) 680-0755*** *or contact him via email at* ***jjochem@aol.com*** *.*