Mental Illness: A Tactical Understanding

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News coverage over several recent unfortunate incidents has sparked considerable debate over how police should respond to persons with mental illness. While everyone chimes in on what a tragedy it was and how police should receive more training, seldom can anyone say exactly what was the cause of the tragedy. With all the debate and accusations few are able to identify what should be done. Still remaining unanswered is the question of what causes mental illness and what should society do with persons with mental illness.

While understanding the causes of mental illness is important to many including those suffering from mental illness, for the policing profession the question is: "How do we deal with persons who display the characteristics of mental illness?" With the wealth of people who want to chime in after the incident, in the final analysis police officers must balance the rights of those with mental illness with the rights of society, and doing it while maintaining the individual officer's safety.

Discussions of mental illness are emerging from the medical and psychological fields and are now being brought into mainstream society. In the first few months of 2002 a variety of mental health issues were discussed in popular periodicals. Anxiety was explored in *Time*, as was the world of autism. *Newsweek* unlocked the mystery of schizophrenia for its readers; and the Sunday paper supplement *Parade* explored the world of teenage depression.

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Unfortunately, when police officers discuss mental illness it is for purposes of their individual safety and security. More importantly, officers must be able to quickly and accurately assess a situation where someone's behavior often ranges from bizarre to extremely dangerous. When police officers are dispatched to incidents involving a mental subject they are typically apprehensive and often become frustrated and confused in trying to deal with a subject they seldom understand.

One study on mental illness and violent behavior found that three percent of the violent behavior in the United States is attributable to mental disorders, while other studies have shown that people with mental illness are more likely to be victims of crime rather than perpetrators. Research has demonstrated that violent behavior is due more to the current psychotic symptoms and not the mental illness itself. One study found a strong link between the symptoms of hostility and delusions, and when in combination with substance abuse they pose a higher probability of violent behavior. Yet another study found that three symptoms are often associated with violent behavior. They are: 1) Feeling that others wished them harm; 2) That one's mind was dominated by forces beyond one's control; and 3) That others' thoughts were being put into their minds (Monahan, 1996, 1).

While there may be advances in understanding mental illness, many states are experiencing budget deficits that require drastic actions and in some cases this means closing mental health centers. This creates a lack of hospital space for those who would benefit from the therapeutic setting available and places them into communities that are often unsympathetic to their plight. Those least able to cope with all the challenges of society are placed at its mercy. Additionally, an unsuspecting society may be victimized by someone with a mental illness who is unable to function outside of a secure setting. Without proper treatment (medication and therapy) and supervision the person with mental illness will not be able to assimilate into society and often will either commit criminal acts or becomes victimized.

Mental health professionals, in the last few decades, have become more adept at keeping those with diagnosed mental illness out of state mental health facilities and mainstreaming them into the community with appropriate support and supervision. This not only allows the person to have a meaningful life and to be a positive contribution to society, but also saves taxpayers millions of dollars in caring for them.

In a recent study the United States Department of Education found those enrolled in Special Education classes in

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local school systems have a 57.4 percent graduation rate. Additionally, the study found the drop-out rate for Special Education students is at 28.9 percent of the total number of students enrolled in special education programs (Pantagraph). These students represent a large number of persons who, with help and support, are becoming productive members of society.

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College campuses, as part of the large communities they serve, are finding more persons with mental illnesses as part of their populations as well. Unfortunately, they are finding themselves faced with an increasing number of disruptive students, many suffering from a diagnosable mental illness. "Predictably, a disproportionately large number of disruptive students are seriously emotionally disturbed; their emotional disturbance being either a cause or effect of their disruptive behavior (Amada, 2001, 67). Additionally, many incidents of disruptive students on college campuses involve students who have a variety of mental health issues (Amada, 2001, 97). Amada (2001, 97-99) posits three reasons for this increase: (1) Legislative changes resulting in the release of more emotionally disturbed persons; (2) Advances in the use of psychotropic medications to allow persons to remain within the community and participate fully in resources of the community; and (3) The intentional, but improper use of the college environment to serve as a rich source of experiences for persons with emotional disturbances. The diagnoses of these disruptive students include manic depression, schizophrenia, character disorders particularly antisocial personality disorder, and borderline personality disorder (Amada, 2001, 114).

The Police Dilemma

Why are the police the first point of contact for complaints about people with mental illness? Often the answer to this dilemma, like many other dilemmas in American society, is based on availability more than training or experience. The Police Executive Research Forum (1997) in their work *The Police Response to People With Mental Illness* provides us with several rationales. First, the police are the only form of twenty-four hour emergency response available in many areas. Secondly, the police are the most visible government service available. Finally, the police have the legal authority to detain, arrest, and use force when necessary.

Calls for police assistance in mental health issues come from a variety of people. Family, friends, concerned citizens, a citizen who feels threatened, mental health agencies, hospitals, local merchants, and even victims of mental illness themselves may contact the police to deal with "incidents" they experience because of their illness. Additionally, rather than being the catalyst for the call to the police, persons with mental illness may themselves become victims or witnesses of a crime or accident and request police assistance (PERF, 1997,6).

Police officers interact with persons having a mental illness in a variety of situations. Officers may be called to respond to a problem with a confused, disoriented person who does not know where they are; a shoplifter of wine, beer, or food items; an individual demonstrating bizarre or unusual behavior or being aggressive; assault or violence toward others. Persons with mental illness may also be homeless and are found sleeping in doorways or in all-night restaurants.

Understanding the symptomatic behaviors of persons who are afflicted with a form of mental illness is essential for police officers, but the more immediate concern for police officers is to determine the intent and capabilities of the person and taking those steps to ensure the safety of the officers and others (IACP Training Key #487). Having some familiarity with the symptoms and behaviors of mental illness the officer is in a better position to make appropriate decisions on methods for dealing with the subject. Conversely, by misinterpreting a subject's action or behavior an officer may make incorrect assumptions and create and implement action plans that are inappropriate for the situation.

Common Mental Illness Indicators

In the last decade many studies involving mental illness have helped to paint the picture of what contributes to create mental illness. Many studies have demonstrated that mental illness is not synonymous with either dangerousness or criminality. These studies are helping to debunk and dispel public myths and prejudices about the mentally ill and are therefore of immense general importance (Amada, 2001, 114).

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However, police do not have the luxury of quick diagnosis and vast amounts of medical and psychological expertise when encountering a potential subject suffering from mental illness. Police should NEVER attempt to diagnose someone who is suspected of having a mental illness; however, there are common characteristics among persons with mental illness that would provide officers ample warning when encountering someone on the street.

Police officers confront a variety of circumstances daily, and in any one of those circumstances the person may be suffering from a mental illness. Common situations police officers encounter that may involve someone with a mental illness are persons who compulsively talk, are conscious but not responsive to others around them or to commands, exhibit bizarre behavior or are disturbing others. People may complain of or report others having hallucinations or delusional episodes. Para-

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noid behavior may be followed by aggression or complete withdrawal. Additionally, officers may encounter someone who is complaining of one of the following conditions.

There are three broad types of behavior that officers may observe that may suggest some form of mental illness. First, their degree of reaction to crowds, people, places, or things may make them aggressive or reclusive without sufficient cause.

Second, the appropriateness of their behavior for a given situation may indicate they suffer some form of mental illness. A student who becomes hostile and aggressive towards other students in a slow moving cafeteria line would be one example where their behavior would be inappropriate for the circumstances. Anytime an incident that most people would perceive as minor escalates out of proportion may be indicative of mental illness.

Finally, emotionally disturbed people may also demonstrate extreme rigidity or inflexibility in new and unforeseen circumstance, especially if they also demonstrate aggressive behavior. A student who will not rearrange their residence hall room when they are asked to by a new roommate may be indicative of this rigidity of behavior. If this refusal is accompanied by a violent outburst the responding officers should consider the possibility that the aggressive party is suffering from a form of mental illness.

Hallucinations are very common in persons with mental illness. These hallucinations may involve three different senses. Reporting seeing things, having visual hallucinations, could be an indication they are suffering from an organic brain problem. Auditory hallucinations, or hearing voices or noises, is the most common form of hallucination in mental illness. Tactile (touch) hallucinations are often a benign symptom in many people often seen when you feel something on your leg and nothing is there. While this is most often a benign symptom, it could also be indicative of mental illness when taken to extremes.

In addition to hallucinations, delusions, or believing something is true that is not, is another very common symptom demonstrated by persons with mental illness. They may believe they are Jesus Christ, or the king of England. Unfortunately, for most people their beliefs are their reality and dispelling that belief may be impossible without professional mental health assistance.

Everyone from time to time may believe someone in their life is out to get them, but consistent beliefs that everyone is out to get you, or being paranoid, is another indicator of a potential mental illness. The longer this thinking continues or the more illogical the belief is (e.g., everybody in the department hates me and is out to get me) the more likely some underlying mental illness is the cause of their beliefs rather than someone actually attempting to get them.

Mood swings are very common and most people have good days and bad days; neither normally lasts for very long. If prolonged fluctuations to either extreme (very happy or very sad) are noted it could be due to mental illness. The person who demonstrates prolonged depression, especially if also accompanied by manic behavior, or accelerated thinking and speaking (hyperactivity), may be suffering from a form of mental illness.

Other indicators of mental illness officers may observe are a loss of memory, confusion, anxiety, or incoherent speech or thoughts. Anytime there is a marked change in the behaviors or actions of a person without other obvious cause (e.g., a death in the family, divorce, lack of sleep, head trauma, etc.) mental illness could be at the base of the problem. Other indicators may include: unusual or bizarre mannerisms, hostility toward and distrust of others, withdrawn behavior, lack of cooperation, one-sided conversations, or a tendency to argue.

At this point a word of caution needs to be reinforced. Police officers should never try, or believe they are able, to diagnose someone's mental state. Additionally, just because someone demonstrates one or more of the previously described symptoms does not mean they are suffering from a mental illness. Conversely, just because you have not been informed of or observed these behaviors does not mean they are free from mental illness. The indicators above should be used as a guide to help interpret someone's behavior and thereby have a greater understanding of why someone is exhibiting a specific behavior. Always base your actions upon the subject's behavior and not what you, or someone else, believe to be their mental stability. Always practice good officer safety skills and never let your guard down.

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When encountering anyone exhibiting these behaviors officers should be especially cautious if, in addition to the behaviors, the person has been consuming alcohol or other drugs, which may intensify the experiences the person is having. The person may feel someone wishes them harm, or that another is dominating their mind, or they may believe others are putting thoughts into their minds. Any of these conditions, especially combined with other symptoms outlined above, may indicate an extremely dangerous subject the officer is encountering.

The Police Response

Police officers responding to calls for service must ALWAYS maintain a high level of alertness and always be vigilant for signs of impending danger of attack. Police reactions to persons with mental illness must be based upon behaviors exhibited by the person and not on their perceived mental illness. Being familiar with the common indicators of mental illness may alert the officer to alternative actions they may take, but officers must always base their response to the actions of the person, not their perceived mental status (IACP #487, 1997, 39). Mental illness does not preclude, or enhance, a subject from having the capability to kill or seriously injure officers or innocent bystanders.

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The annual report of Law Enforcement Officers Killed and Assaulted (2000) by the Federal Bureau of Investigation reports that in the period from 1991 through 2000, eight police officers were killed in circumstances involving mentally deranged assailants. In seven of the lethal assaults firearms were used, and one involved an edged weapon. Additionally, during the first year of the new millennium 781 officers were assaulted in incidents involving a mentally deranged subject. Five-hundred eighty-one of the assaults involved the assailant's hands and feet; 31 with firearms; 60 involved knives or cutting instruments; and 109 involved other dangerous weapons.

The FBI has not yet released a final report for 2001, but their preliminary report shows that two of the sixty-nine police officers slain in the United States were involved in situations involving mentally deranged subjects.

Unless a weapon has been used, or other crime of violence has occurred, officers should normally respond to a person with a known or suspected mental illness in a low profile manner. Emergency equipment (e.g., lights and sirens) can negatively impact a person with mental illness and create an increased hazard. Additional officers should be present in the event an escalation of aggression occurs; however, only one officer should speak to the person to avoid confusion.

When possible officers should gather as much information as possible about the person from friends, family, neighbors, other officers, the department's records, or prior experience the officer had with the subject. Information regarding medications, alcohol and drug use history, nature of psychological condition, support structure and other information that provides background information about the person or his condition should be collected.

Officers should never assume the person with mental illness does not pose a threat. Officers should always have adequate backup when dealing with a person having or suspected of having a mental illness. The presence of additional officers may eliminate the need for a physical confrontation with the subject, thereby preventing injury to both officers and civilians alike. Officers should always maintain their reactionary gap from the person. Weapon retention techniques must be practiced in all cases, and dealing with someone who is suspected of having a mental illness is not the time to let down your guard. All persons, regardless of their mental state, possess the ability to inflict great bodily harm or death on police officers.

Officers should attempt to calm the situation and the environment around the scene. Persons with mental illness are easily distracted by sounds, noises, and crowds around them. While family members may be of assistance, in cases where they are contributing to the problem they too should be asked to leave the area. The more chaotic an environment, the more likely the person will lose control and pose a serious threat to themselves or others.

The availability of weapons and whether or not the person is a threat to himself or others is another immediate

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Guidelines for interacting with persons with mental illness

You Should:	You Should Not:
1. Remember that a person with mental illness has the same rights to fair treatment and police protection as anyone else.	1. Arrest the person for behavioral manifestations of mental illness that are not criminal in nature.
2. Continually assess the situation for danger.	2. Join behavior related to the person's mental illness (e.g., agreeing with delusions).
3. Maintain adequate space between you and the subject.	3. Stare at the subject. This may be perceived as a threat.
4. Remain calm.	4. Confuse the subject. One person should do the talking. If a direction or command is given, follow through.
5. Be helpful. In most cases people with mental illnesses will respond to questions concerning their basic needs (e.g., safety). Ask, "What would make you feel safer/calmer?" etc.	5. Touch the subject. While in some cases touching may be helpful to those who are upset, persons with mental illness may react violently to this action.
6. Give firm, clear directions. The subject is probably already confused and may have trouble making even the simplest decision. If possible, only one officer should talk to the subject.	6. Give multiple choices. This only adds to the confusion.
7. Respond to apparent feelings rather than content (e.g., "You look/sound scared.")	7. Whisper, joke or laugh. This increases the subject's suspiciousness and increases the potential for violence.
8. Respond to delusions and hallucinations by talking about the person's feelings rather than what they are saying.	8. Deceive the subject.

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concern officers should consider. Weapons or access to weapons pose a serious risk for both the subject and the officers responding to the call. Officers must not only be aware of a common weapons (guns, knives, clubs) but also for items that can be used as a weapon such as a chair, kitchen tools, pens and pencils, screwdrivers, hammers, insect spray, and similar objects. Responding officers must be alert for any item, no matter how simple or common, that can be used against them. The immediate area should be quickly scanned for these items, as should the area within the immediate proximity of the subject. (See Guidelines for interacting with persons with mental illness page 37.)

Suicidal persons pose a severe threat to themselves and others.

Suicidal persons pose a severe threat to themselves and others. If a person feels they have nothing to live for they will not respond to fear of punishment for their actions. Suicidal persons may not have the ability to commit the act themselves, and will want to commit suicide by committing some act which will force a police officer to kill them. Suicide-by-cop is a very real concern that officers must remember may be the ultimate goal of the suspect with mental illness.

Officers should make mental notes of the amount of control the person demonstrates, especially the amount of control over emotions such as rage, anger, fright, or agitation. Any signs of losing control (wide eyes, rambling thoughts and speech, clutching themselves or other objects to maintain control or begging to be left alone, or offering frantic assurances that they are all right) should be carefully watched for. Should any of these behaviors be observed officers should be extremely alert to a pending attack. Therefore, officers should maintain their awareness of personal safety and assume a defensive position in all dealings with persons who have mental illness. Begin building rapport by speaking to the person in a calm and relaxed manner. Maintain a professional presence by taking charge of the situation, while not becoming overbearing and domineering.

Avoid issues that appear to inflame the situation or upset the person. Officers should be sure to remind the person the police are there to assist them. Allow the person to express their feelings and emotions as much as possible in order to provide venting and possibly find out why the person is upset. No matter how bizarre the person may be, continue building rapport with them by allowing them to vent their frustrations. Do not lie or attempt to deceive the person as this will provide additional problems in dealing with the person at another time for you or another officer. Any promises made must be kept if at all possible.

If an arrest is required, do not telegraph your intentions or tell the person they are going to be arrested or confined. Always call for additional units even if the person is cooperative and has complied with your requests. Once they realize they are being arrested or taken to a hospital they may become combative and fight with officers.

Remember that police officers are not therapists and should not engage in trying to treat the person or diagnose their problem. Officers are best suited for recognizing when referral is necessary, and should make those referrals to appropriate mental health professionals.

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Once the situation has been brought under control the officer must decide upon a final disposition for the subject. In information provided by the Illinois Law Enforcement Executive Institute (2002), the least often used disposition would be the most preferred disposition: hospitalization (11.8%). Arrest is the chosen disposition in 16.5% of all cases. By far the most common disposition for police contacts with mentally ill subjects is informal dispositions (71.8%).

These less obvious, but still effective solutions are some of the informal dispositions available to police officers. Examples of these informal dispositions are to provide the appropriate assistance to a victim or witness; counsel the person

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with release and referral to a mental health treatment center; counsel and release to another family member, friend, or support network with referral to a mental health center; consult with a local mental health professional; or obtain a voluntary consent for mental health facility admission (IACP Training Key #487, 1997, 41).

Conclusion

People with mental illness, given proper treatment and training, can live within society and have productive and useful lives. Unfortunately, with the closing of mental health facilities and the reduction of funding to programs to help these people, they are often left to their own abilities. More often than not these people become the victim rather than the perpetrator.

Police, being the most visible government service, and having a wide range of powers including the ability to detain and use force when necessary, are often expected to deal with these subjects. Police officers cannot allow a lack of understanding or information to dictate their reactions to persons who are not able to function within society without the help they desperately need. We as police officers must balance a duty to protect the public, to protect the rights of all citizens, and to do both while remaining safe so the officers can return to their family. By having a greater understanding of mental illness, and how to respond to mental illness, officers can make the balance and return home safe.

References

Amada, G., "Mental health and student conduct issues on the college campus: A reading," College Administration Publications, Inc., Asheville, NC, 2001.

IACP Training Key #487, "Dealing with the mentally ill," International Association of Chiefs of Police, Alexandria, VA, 1997.

Illinois Law Enforcement Executive Institute, "The police response to mental health illness: Train-the-trainer materials." Macomb, IL, 2002.

Federal Bureau of Investigation, "Law Enforcement Officers Killed and Assaulted" 2000. Department of Justice, Washington DC, 2001.

Monahan, J., "Mental illness and violent crime," National Institute of Justice: Research Preview, Washington, DC, 1996.

Police Executive Research Forum, "The police response to people with mental illness," Washington, DC, 1997.