



IACP NATIONAL LAW ENFORCEMENT POLICY CENTER

# Responding to Persons Affected by Mental Illness or In Crisis

Concepts and Issues Paper

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## I. INTRODUCTION

### A. Purpose of the Document

This paper was designed to accompany the *Model Policy on Responding to Persons Affected by Mental Illness or in Crisis* developed by the IACP National Law Enforcement Policy Center. This paper provides essential background material and supporting documentation to provide greater understanding of the developmental philosophy and implementation requirements for the model policy. This material will be of value to law enforcement executives in their efforts to tailor the model policy to the requirements and circumstances of their community and their law enforcement agency.

### B. Background

Law enforcement agencies across the country are increasingly required to respond to and intervene on behalf of people who are affected by mental illness or in emotional crisis. Many trends have converged to result in larger number of persons affected by mental illness being housed in jails, prisons, and juvenile detention centers rather than publicly funded mental health treatment facilities. With the movement to deinstitutionalize the nation's mental health system in the 1960s and 1970s, there was no associated mechanism for adequate funding or provision of public resources into community mental health options. To this day, resources that were supposed to accompany deinstitutionalization have never

materialized. Thus, people affected by mental illness who are unable to obtain effective treatment through the limited available resources are likely to behave in ways that bring them into contact with law enforcement. In far too many communities the local jail is the primary or only location available for police to bring those who are behaving erratically due to mental illness or emotional crisis.

Another trend that has increased the likelihood that persons affected by mental illness will be arrested is an increased emphasis on responding assertively to "quality-of-life" crimes. These include petty theft, aggressive panhandling, public urination, littering, and trespassing; offenses that often characterize the behavior of homeless people affected by untreated mental health disorders. Unless enhanced enforcement is accompanied by increased access to treatment and support services, persons affected by mental illness who commit these "nuisance" offenses will likely become trapped in a repetitive cycle of arrest, short jail stays, and return to the streets without treatment, only to commit more minor illegal acts that result in their re-arrest.

Over the past several decades, the net result is that the United States has replaced one inadequate system for addressing the needs of persons affected by mental illness—state hospitals that were often merely warehouses for persons affected by mental illness—with another—local jails and state prisons, which are unsuited and unable to provide appropriate mental health treatment. A more effective approach involves redirecting societal resources

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from containment to treatment of people affected by mental illness whose behaviors are seen as annoying, troubling, or threatening. In a number of jurisdictions, law enforcement agencies have partnered with justice system, mental health, and other community agencies to develop more compassionate and cost-effective approaches that emphasize providing community-based treatment instead of arrest and incarceration for adults and juveniles affected by mental illness. Ideally, the only persons affected by mental illness who should come into contact with law enforcement are those who are suspected of committing crimes or who are a danger to themselves or others. Those who do not fall into this category of potentially dangerous behavior are more appropriately handled by mental health provider response and referral. Also, if mental health services and other social support systems were functioning optimally, a much smaller proportion of persons affected by mental illness would likely engage in criminal, threatening, or suicidal behavior that becomes the focus of a law enforcement response.

Since these ideals are not yet the standard, the need to assess the mental state and intention of individuals remains a routine requirement of officers performing enforcement and investigative functions. Persons experiencing a mental health crisis and their families rely on first responders, particularly law enforcement officers, to behave in an effective manner, treating the person affected by mental illness with compassion and respect. Law enforcement officers who face these complex situations must be as fully prepared as possible so that they can respond in ways that ensure their safety, the public's safety, and the safety of the person in mental health crisis. Unfortunately, due to the current lack of consistent policy, procedure, training, and education among law enforcement agencies, too many of these calls end badly for all involved. Most response calls involving persons affected by mental illness are not the result of criminal behavior, but of behavior associated with emotional crisis. While law enforcement officers may arrest anyone who is breaking the law, it is critical for the officer responding to a mental health call to have the information needed to adequately assess the situation and the support required so that a determination of the appropriate action can be made in the best interests of the subject, the officer, and the community.

To this end, it is helpful for officers to understand the symptomatic behavior of persons who are affected by some form of mental illness or emotional crisis. In this way, officers are in a better position to formulate appropriate strategies for gaining the individual's compliance and determining whether medical or other assistance is required, whether detention is appropriate or required, and, whether the suspect is in a suitable state to be questioned. This is not to say that a law enforcement officer should

ever attempt to diagnose persons who appear to be affected by mental illness. Mental illness is often difficult for even the trained professional to diagnose under controlled circumstances; for an officer who confronts such an individual in an enforcement setting with other aggravating factors in play, the task would be even more complex and uncontrolled. But officers can and should be able to recognize behavior that is characteristic of mental illness and particularly that which is potentially destructive and/or dangerous. This is the primary focus of the *Model Policy on Responding to Persons Affected by Mental Illness or in Crisis*, the elements of which are discussed in the following section of this discussion paper.

## II. POLICY RECOMMENDATIONS

### A. Symptoms of Mental Illness

Mental health problems are health conditions involving changes in thinking, mood, and/or behavior and are associated with distress or impaired functioning. When these conditions are more severe, they are called mental illnesses. Mental illness is an impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental illness if he or she displays an inability to think rationally (e.g., delusions or hallucinations); to exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or to take reasonable care of his or her welfare with regard to basic provisions for clothing, food, shelter, or safety. Some types of mental illness include anxiety disorders, attention-deficit/hyperactivity disorder, depressive and other mood disorders, eating disorders, schizophrenia, and other disorders. The following are some of the more commonly encountered conditions of mental illness.

**Schizophrenia.** More than 3.5 million Americans at any one time experience schizophrenia; the prevalence is 1.1 percent of the population.<sup>1</sup> It is equally common in men and women. Schizophrenia tends to appear earlier in men than in women, showing up in their late teens or early 20s, as compared to their 20s or early 30s in women. Schizophrenia often begins with an episode of psychotic symptoms like the individual hearing voices (i.e., hallucinations) or irrationally believing that others are trying to control or harm him or her (i.e., delusions). The delusions— thoughts that are fixed, bizarre, and have no basis in reality—may occur along with hallucinations and disorganized speech and behavior, leaving the individual frightened, anxious, and confused. The person with

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<sup>1</sup> "Schizophrenia," National Institutes of Health, <http://www.nimh.nih.gov/statistics/1SCHIZ.shtml> (accessed August 4, 2013).

schizophrenia may exhibit grandiose delusions, such as “I am Christ,” or persecutory delusions such as “Everyone is out to get me.” Delusional persons may also have generalized fears or beliefs such as unrealistic fears that they are being constantly watched; that their conversations or even their thoughts are being overheard, recorded, or monitored; or, that they are being talked about, followed, or otherwise persecuted, harassed, or controlled.

Hallucinations are usually present with schizophrenia. Hallucinations may involve any of the five senses, but hearing or seeing things that are not based in reality are the most common. For example, the individual may hear voices commanding him or her to act in a particular way, may feel his or her skin “crawl,” smell strange odors, or see “devils” or “ghosts.” While hallucinations are usually symptomatic of schizophrenia, they may also be caused by controlled substances or alcohol.

**Bipolar Disorder.** Bipolar disorder, formerly called manic-depressive illness, is a type of mood disorder characterized by recurrent episodes of highs (mania) and lows (depression) in mood. These episodes involve extreme changes in mood, energy, and behavior. Manic symptoms include extreme irritable, euphoric, or elevated mood; a very inflated sense of self-importance (grandiosity); increased high-risk behaviors; distractibility; increased energy; and a decreased need for sleep. Depressive episodes of bipolar disorder involve a period of a pervasive sense of sadness and/or loss of interest or pleasure in most activities that interferes with the ability to work or function. This is a severe condition that can impact a person’s thoughts, sense of self-worth, sleep, appetite, energy, and concentration. It is frequently associated with thoughts of suicide. The course of a bipolar disorder will demonstrate alternating cycles of a mood disturbance with repeated episodes of depression, mania, or a mixture of both.

**Major Depressive Disorder.** Like the periods of depression in a bipolar disorder, major depressive disorder involves a pervasive sadness and/or loss of interest or pleasure in most activities. The disorder interferes with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. The condition can impact a person’s thoughts, sense of self-worth, sleep, appetite, energy, and concentration. Suicidal thoughts are prominent. The condition can occur as a single debilitating episode or as recurring episodes. It differs from bipolar disorder in that it is unipolar—the person suffers only from periods of depression.

**Post-traumatic Stress Disorder (PTSD).** Post-traumatic Stress Disorder affects about 7.7 million adult Americans.<sup>2</sup> PTSD occurs after an individual experiences a terrifying event such as a frightening accident, military combat, sexual or physical assault, automobile accidents, or a natural disaster. First responders can be traumatized by exposure to calls such as collecting human remains or through repeated exposure to details of child abuse. With PTSD, individuals struggle with re-experiencing the original trauma either through nightmares or disturbing, intrusive thoughts throughout the day that may make them feel detached, numb, irritable, or aggressive. Attempts to avoid thinking about the trauma are present including amnesia for all or part of the event. Persistent negative thoughts or feelings (e.g., survival guilt) continue beyond the trauma. Ordinary events may serve as reminders of the trauma and may cause flashbacks, hyperarousal, or panic. Some people recover a few months after the event, but others will suffer lasting or chronic PTSD.

**Personality Disorders.** Personality disorders are conditions marked by enduring maladaptive personality traits and characteristics. No psychotic symptoms (i.e., hallucinations and delusions) are present. Two of these conditions are frequently encountered by law enforcement: Borderline Personality Disorder and Antisocial Personality Disorder. However, while Antisocial Personality Disorder is commonly seen by law enforcement personnel, it usually does not present in a way that rises to the level of distress or emotional crisis that is the topic of this paper.

**Borderline Personality Disorder.** Borderline Personality Disorder causes uncertainty about the person’s identity or view of themselves. As a result, his or her interests and values can change rapidly and behavior is fickle and unstable. The individuals affected by the disorder tend to view things in terms of extremes, such as either all good or all bad. Their views of other people can change quickly. A person who is looked up to one day may be looked down on the next day. These suddenly shifting feelings often lead to intense and unstable relationships, extreme fear of being abandoned, intolerance for being alone, recurring feelings of emptiness and boredom, and frequent displays of inappropriate anger and impulsiveness, such as with substance abuse or sexual relationships. Recurring suicidal behaviors or threats or self-harming behavior, such as cutting, frequently occur.

## **B. Other Causes of Abnormal Behavior**

Officers should not confuse mental illness with abnormal behavior that is the product of other physical disabilities. This includes intellectual disability or other

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<sup>2</sup> “Post-Traumatic Stress Disorder,” fact sheet, National Institutes of Health, <http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?cid=58&key=P#P> (accessed August 4, 2013).

developmental disabilities that may manifest some of the characteristic behaviors of mental illness. There are important differences between individuals affected by these other medical conditions and those affected by mental illness. These conditions include the following.

**1. Intellectual Disability.** Intellectual disability refers to subnormal intellectual capacity and deficiencies in a person's ability to deal effectively with social conventions and interaction. The intellectually disabled may display behaviors that are rational but that are similar to younger persons who are not disabled. By contrast, individuals affected by mental illness may not be impaired intellectually and may act in many instances as rational, functional members of society. Their behavior generally fluctuates between the normal and the irrational. The intellectually disabled individual does not demonstrate this type of behavioral fluctuation. Intellectual disability is evident during one's early years and is a permanent condition for life, whereas mental illness may develop during any period of an individual's life. Additionally, mental illness may not be a permanent condition, and many forms of mental illness can be cured or at least controlled by therapy and/or medication.

Another important distinction is that the intellectually disabled individual does not usually engage in violent behavior without the types of provocations that may initiate violence among the non-disabled person. On the other hand, a person affected by mental illness, depending upon the nature of the illness and the circumstances of the situation, may become violent for no apparent reason because of the individual's distorted perception of reality.

**2. Cerebral palsy.** Persons affected by cerebral palsy exhibit motor dysfunction that may, at first glance, be confused with some characteristics of either an intellectually disabled or mentally ill person. These include awkwardness in walking, involuntary and uncontrollable movements, or seizures and problems in speech and communication.

**3. Autism Spectrum Disorders.** The characteristics of a person affected by an autism spectrum disorder may also be confused with those of intellectual disability or mental illness. Autistic persons often engage in compulsive behavior, or repetitive and peculiar body movements, and can become very distressed over minor changes in their environment. They may also display unusual reactions to objects or people they see around them; appear insensitive to pain; and may be hyperactive, passive, or susceptible to tantrums. Such persons may also appear intellectually disabled in some areas, but highly capable or even gifted in others.

## C. Persons in Crisis

Without regard to whether a person is affected by mental illness, he or she may react in inappropriate ways or display bizarre behavior if in crisis. "Crisis," for purposes of this discussion and policy, relates to an individual's emotional, physical, mental, or behavioral response to an event or experience that results in trauma. A person may experience crisis during times of stress in response to real or perceived threats and/or loss of control and when normal coping mechanisms are ineffective. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting/stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions, including the trigger of a "fight or flight" response. Any individual can experience a crisis reaction regardless of previous history of mental illness.

## D. Police Response to Persons Affected by Mental Illness or in Crisis

The dynamics and circumstances of response to a call involving a person believed to be affected by mental illness will be determined to some degree by the manner in which the contact is initiated. Possibly the largest percentage of police officer contacts with mentally ill persons are initiated by officers as the result of their observation of bizarre, disruptive, or other abnormal behavior. In many cases, however, persons affected by mental illness will seek out assistance from law enforcement, particularly when there is a degree of familiarity between the officer and person based on prior contacts. Family members of a person affected by mental illness are also frequently the initiators of police contact, often when the affected person has created a family disturbance. Such family disturbances can be the source of complex and challenging dilemmas for police. Family members usually call asking for assistance in the hopes of gaining access to treatment for their mentally ill family member. These situations often have a high potential for noncompliance and resistance from the mentally ill family member to the police, which frequently leads to misunderstandings and dissatisfaction, particularly when the situation results in a use of force and/or an arrest.

Possibly one of the more significant points of contact between law enforcement and a person affected by mental illness is on city streets and in other public places. In both enforcement and investigative capacities, officers often encounter persons affected by mental illness among the homeless population inhabiting public places on a full-time or part-time basis. A large proportion (possibly as high as 50 percent in some areas) of these individuals are affected by serious mental illness, often schizophrenia. Other homeless persons may have milder forms of mental

illness that often allow them to move between living on the street and the homes of relatives and friends, shelters, care homes, or other living arrangements. Among these are also persons who are affected by a combination of mental illness, alcoholism, drug abuse, head injury, and degenerative or incapacitating diseases.

### **E. Assessing Risk**

Due to the unpredictable nature of some persons affected by mental illness, when dealing with those individuals, officers must be particularly conscious of their own safety and that of bystanders. Promotion of a more thoughtful approach to calls involving persons affected by mental illness does not reduce the emphasis on officer safety. Assessment of the individual and the situation must be ongoing throughout the contact beginning with the receipt of basic information about the individual and continuing until the contact is over. The more the officer can obtain health-related information about the individual (e.g., does he or she have a diagnosed condition, is he or she taking medication, is there a mental health provider), the better prepared the officer is to make responsive decisions. If the initial contact is made through a dispatched call for service, some basic information can be obtained from the dispatcher. The same type of information should be obtained if possible from other sources of the police contact, whether that is a concerned citizen, another officer, the court, jail personnel, family member, or other individual.

For example, responding officers should seek information, as available, on the characteristics and specific behavior of the subject, relationship of the complainant to the subject (if any), whether a crime is involved, the availability of weapons to the subject, prior police contact with the person, and the nature of any previous mental health dispositions.

Once armed with all the available information, the responding officer can better determine an appropriate response. Unless a crime of violence has been committed and/or a dangerous weapon is involved, officers should normally respond to the incident or approach a person who is known or believed to suffer from mental illness in a low-profile manner. Emergency lights and sirens should be used only when urgent response is critical, and these devices should be turned off as soon as possible upon arrival. Emergency equipment can have a disturbing and altogether negative impact on a person affected by mental illness, may potentially heighten the person's anxiety, and hinder the officers' efforts to calm the situation. When circumstances allow, contacts with persons affected by mental illness should be slowed down. Officers should try to establish themselves as helpers, rather than enforcers; the uniform, duty weapon, and

badge always imply that a uniformed officer is capable of using force and is authorized to engage in enforcement, so it need not be emphasized. Before attempting to gain compliance, officers should try to understand the person's issues and concerns and focus on developing rapport—so the relationship can increase an officer's ability to use influence rather than force to gain compliance.

Where there is reason to believe that the subject is in a crisis situation, such as threatening suicide or involved in a hostage and/or barricade situation, officers should request any specialized crisis intervention assistance available while taking initial steps necessary to moderate or defuse the situation. This may include summoning officers with special training in crisis negotiations, such as CIT-trained officers or hostage negotiators.

At the scene of an incident involving a person believed to be affected by mental illness, officers should first take time, if possible, to assess the situation and gather necessary information, avoiding hasty and potentially counterproductive decisions and actions. Such calls usually have a better outcome if slowed down and time is used to an officer's advantage. Often, circumstances preclude such inquiries, but, where time permits, family members or friends of the individual can often lend some insight into the person's background and specifics about his or her behavior. Friends or acquaintances may be able to provide some insight into the cause of the person's present behavior problem. Pinpointing the cause of the behavior, as perceived by the individual, can provide officers with a basis for discussion and possible moderation of the person's distress and behavior. It can also help the officer decide if the problem is the result of a disability.

Also important is information on the person's present or past use of psychiatric medication. Many persons who suffer from mental illness fail to use medication that has been prescribed for their diagnosed mental illness. This is common, for example, among persons affected by schizophrenia and bipolar disorder. Many people affected by schizophrenia receive treatment on an outpatient basis and gain a degree of self-control and remission of symptoms as long as that treatment is continued. However, without medical supervision, many are incapable or unwilling to maintain the prescribed treatment regimen on their own, either due to lack of insight into their illness, inability to afford or access medication, or substantial discomfort from the medication's side effects. As such, they often revert to their previous pattern of bizarre behavior.

In addition, many persons affected by mental illness attempt to alleviate their anxieties and related mental illness symptoms through self-medication with alcohol, controlled substances, or a combination of these. The use of these drugs tend to exacerbate existing mental problems,

compound the difficulty in diagnosing and treating these individuals, and cause additional difficulty for officers in their attempts to gain control of the individual's behavior.

Before approaching the person believed to be affected by mental illness, officers should attempt to control the immediate surroundings and establish a perimeter. Persons affected by mental illness are generally adversely influenced by distractions including noise and crowds. Crowds of curious bystanders generally, and antagonistic or rowdy persons, in particular, can excite and unduly agitate a person affected by mental illness, particularly those who are in a crisis mode such as one who is threatening suicide or violence. Therefore, where such crowds or bystanders are on hand they should be controlled and preferably removed so officers may better communicate with and control the subject. Family members who create disruption or who contribute to the confusion of the subject are no exception. However, witnesses and those who can provide information or assistance that is helpful in resolving the situation should be asked to remain nearby.

Once the immediate surroundings are under control, attention should be directed toward determining whether the individual represents a danger to himself, herself, or others. The presence of a dangerous weapon is an obvious indication that violence is possible, but there are other behavioral characteristics that an officer can use to help determine whether the subject is prone to dangerous conduct toward self or others. The model policy cites the following as examples.

**1. *Statements of the subject.*** Any threatening statements made by the subject should be given serious consideration and should not be dismissed simply as the ramblings of a confused or troubled individual. This is particularly the case where the capacity or capability to engage in dangerous conduct exists. Such statements may range from subtle innuendo to direct threats. Comments that suggest intent to commit a dangerous act do not have to be taken at face value. When taken in conjunction with other information, such threats can paint a more complete picture of the potential for violence. Inasmuch as a direct threat is not required to conclude a person is dangerous to himself or herself or others, the officer should assess in totality whether the subject poses a serious threat of substantial harm to himself or herself or others.

**2. *Personal history.*** It is not uncommon for police officers to have some familiarity with a person affected by mental illness based on prior contacts with them in the community. Under such circumstances, officers are in a better situation to assess the individual's propensity for violence as well as the predictability of the individual's behavior. Where the subject is unknown to the officers, friends, family, or others may be able to provide some insight into the individual's behavior and capacity for

dangerous behavior. With or without such information, officers should be cautioned that individuals affected by mental illness may be unpredictable. Even the familiar and often compliant person affected by mental illness can sometimes react in a dangerous manner without perceived provocation.

**3. *Observed actions.*** The subject's actions while officers are on the scene as well as those that were observed prior to the officers' arrival are relevant to a determination of the individual's propensity for dangerousness. Acts of violence or threats of violence during those periods should be taken seriously. Failure to act in a dangerous manner prior to an officer's arrival does not guarantee that there is no danger, but it does tend to diminish the potential for danger.

Officers should make mental notes of the precise actions and behaviors taken by the individual so that these can be entered into their report. Descriptions of the exact actions of an individual who is suspected of being affected by mental illness are particularly important when justification is required for arrest or evaluation and possible commitment to a mental health facility. Use of generalized terms such as "bizarre" or "crazy" to describe the nature of an individual's actions are not sufficient and should be substantiated with concrete illustrations of actual behavior. Verbatim quotes are very helpful when providing a description of the subject's comments, both when taking a subject in custody for a mental health evaluation or during an arrest for a crime that may lead to later questions regarding the arrestee's mental state at the time of the crime.

**4. *Degree of control.*** The amount of control that an individual demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. In addition, clutching oneself or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control.

**5. *Volatility of the environment.*** The general environment surrounding the event should also be taken into consideration. This potentially covers a broad range of issues in addition to those involving crowds, noise, and confusion already mentioned. For example, if a criminal offense is involved and an arrest is required, attempts to restrain the individual can be the source of agitation and confrontation between the officers and the person affected by mental illness if not handled wisely and skillfully. In open public spaces where attention is being drawn, the individual may be more easily distracted and/or agitated as opposed to isolated or private settings.

## **F. Approaching and Dealing with Persons Affected by Mental Illness**

When officers are preparing to approach a person thought to be affected by mental illness, they should take several factors into consideration. The model policy includes the following factors as among the most important. First, officers should always be aware of their personal safety when dealing with persons who exhibit characteristic behavior of mental illness. When possible, a backup officer should be summoned to provide assistance. This is particularly necessary prior to efforts to take the person into custody.

Officers should also recognize that they are not in a position personally to solve the problems of a mentally ill person. However, it is entirely possible that this same person will again come into contact with the police in a similar or related context, so officers should remember that their actions may have a long-term impact on the perceptions of that person toward the police. Dealing with persons affected by mental illness can be one of the more trying of police tasks and one that few inexperienced officers would normally invite. But dealing with those persons in a dismissive manner or with disdain is neither a humane approach nor one that will reap any long-term benefit for either law enforcement or the person affected by mental illness. It will also invariably create difficulty for the same or other officers in future interactions with that individual. In a worst-case scenario, failure to deal responsibly and fairly with the individual may lay the groundwork for a later, more serious confrontation with the police and the community involving potential physical injury or loss of life.

When approaching a person suspected of being affected by mental illness, officers should assume a physically defensive posture in relation to the individual while attempting to slow things down and build rapport by speaking in a calm and relaxed manner. Officers should avoid closely approaching the subject until a degree of rapport has been developed if this is at all possible. When speaking with the individual, officers should attempt to exhibit a caring attitude without becoming authoritarian, overbearing, condescending, or intimidating. While the person affected by mental illness may not be in command of his or her behavior at all times, he or she does not necessarily lack intellectual abilities or insight, and may be provoked by demeaning, condescending, arrogant, or contemptuous attitudes of others. Attempts to deal constructively with the person in a calm, non-judgmental manner, develop some understanding, and demonstrate some empathy for the individual's problems or concerns while avoiding a tough or threatening manner should greatly assist in gaining compliance.

Officers should engage in active listening (e.g., reflection of feelings, restating, paraphrasing, and supportive statements) by asking the person to express his or her concerns. This verbal tactic is a control strategy that helps de-escalate or defuse an agitated, fearful, or angry subject. The officer can enhance the person's willingness to engage by frequent communication of the officer's understanding of the person's concerns. In addition, avoiding issues and topics that may serve to agitate the individual is recommended along with efforts to guide the conversation toward subjects that help bring the subject back to reality. Officers should reassure the individual that the officers are there to help and that an appropriate resolution of the problem can be reached. All attempts should be used to reassuringly communicate with the person first by allowing him or her to vent in order to determine the possible source of agitation or conflict. Efforts should be made to relate the officer's concern for the individual's feelings and an appreciation for the problems and concerns that the individual describes, no matter how trivial or bizarre they may appear. The emphasis here is to slow things down and develop a rapport with the individual that will provide reassurance that the officer is not there simply in an authoritarian role but there to assist the individual. In attempts to assist, however, officers should always attempt to be truthful with a person displaying behaviors associated with mental illness. If the person becomes aware that officers are deceiving him or her, he or she may withdraw from contact in distrust and may become hypersensitive or retaliate in anger.

The individual should not be threatened with arrest or other enforcement action as this will only add to his or her fright and stress and may potentially spark aggression. However, should arrest or detention be necessary, the officer should inform the person of what is about to occur, ask for his or her cooperation, and proceed with taking him or her into custody. In doing so, the officers should consider the following.

## **G. Taking Custody or Making Referrals to Mental Health Professionals**

Based on the overall circumstances of the situation, applicable state law, and departmental policy, an officer may take one of several courses of action when dealing with an individual who is suspected of being affected by mental illness. The options for dealing with such individuals generally fall into one of four response categories as suggested by the model policy.

**1. Counsel and/or refer.** When a criminal or other offense is not involved and there is not sufficient grounds for taking the person into custody for his or her own protection, the protection of others, or for other reasons (e.g., grave disability) as specified by law, it is often best

to make mental health referrals and provide some basic guidance for the individual. For the person affected by mental illness who resides in public places, referrals to community mental health facilities are often futile efforts. Many individuals in this situation do not have the presence of mind to recognize their mental health problems and even less ability or interest in acting upon referral recommendations. If the agency keeps track of calls involving the mentally ill or works with liaisons in the mental health community, notifications should be made to these individuals. Some mentally ill persons go through periods of relative lucidity during which they may be able to recognize their needs and act upon an officer's suggestions, particularly if the location and telephone number of local mental health facilities has been provided to them in writing.

In cases where persons affected by mental illness have friends, family, and other support systems in the community, information on mental health facilities may also be provided directly to these individuals. With this information, they may be in a better position to seek assistance for their friend, acquaintance, or relative who is affected by mental illness.

In cases where the individual is extremely agitated, it is generally inadvisable to leave him or her unattended. In many such cases, when left alone in a highly emotional state, the person affected by mental illness may resort to the same behavior that was the basis for police intervention in the first place. In such cases, officers may, if permitted by departmental policy, provide transportation for the individual to a group home, respite care, or other facility that can provide shelter, counseling, or related mental health services or, to the home of a friend, family member, or acquaintance who may be willing to provide assistance.

**2. Professional assistance.** Because it is not possible for officers to diagnose mental illness or understand the degree to which some persons may need professional care in order to avoid violence to themselves or others, use of a trained mental health professional is often a preferred option. Some agencies are fortunate to have a mental health professional, such as a counselor or crisis intervention specialist on staff who may be employed in this capacity. Agencies may also have contract community mental health providers who can assist (such as a MAC team). In any of these cases, officers may, based on the nature of the situation, request assistance by either direct intervention at the scene of the incident, by telephone consultation with a mental health professional, or by transporting the subject to a centralized location where assessment and other treatment can be obtained.

Refusal to submit to voluntary examinations or professional assistance can be expected in many instances since many persons affected by mental illness lack an

understanding that they are ill. However, it is entirely acceptable for officers to explain that such refusal may leave the officer with no other option than to seek alternative remedies, such as arrest where justified or detention for an involuntary examination in a mental health facility where legal grounds exist. Many persons affected by mental illness, recognizing that they are not fully in control of their actions and/or thoughts, and who may be aware of stories of confinement related by other mentally ill acquaintances, fear mental health professionals and examinations. Officers can dispel some of that fear by explaining that an examination does not mean incarceration or confinement in a mental health facility but may provide them with much-needed assistance and possibly allow them to avoid future confrontations with others, including the police.

**3. Involuntary examination.** State laws provide the legal criteria and limitations for involuntary commitment of individuals for mental health examinations. While state statutes vary, they generally provide for a brief involuntary examination when the person is a danger to self or others, is gravely disabled by mental impairment, and/or is so impaired as to not understand the need for mental treatment. Officers must refer to specific state statutes for details in these regards and should be aware of the rights of those who are detained for mental health examinations and any special requirements expected of the officer in such situations. Where the criteria for involuntary mental examination has been satisfied, and a misdemeanor or other less serious violations have also been committed, officers may, depending upon departmental policy, choose the course of involuntary commitment in lieu of or in addition to lodging criminal charges (and may ask for notification from the facility at the time of discharge from the commitment, if permitted by law in the jurisdiction).

The issue of involuntary examination may be problematic for officers and others involved. Many state and local institutions have limited resources or have a full census, and under such circumstances it becomes difficult and time-consuming for officers to deal with persons affected by mental illness in this manner. At the same time, failure to take action when there are sufficient grounds to believe that a person affected by mental illness may be a danger to himself or herself or others can have serious consequences. In such situations, officers may place themselves and/or their agency in jeopardy of civil liability should a serious incident develop as the result of their inaction. Jurisdictions that have developed a coordinated police-mental health partnership to deal with persons affected by mental illness are in a far better position to deal with these and other related issues than those that have lacked interest, concern, and/or resources to adequately address the mental health problem within their community.

**4. Arrest.** As noted in the foregoing, arrest may be used solely or in combination with involuntary commitment. However, when a felony or other serious offense is involved, officers should normally make the arrest and rely on supervisory and other command-level personnel to determine whether an involuntary mental health examination is warranted.

Before taking a person into custody under arrest or for involuntary mental examination, officers should consider summoning a supervisor. As noted, taking custody of a person who is possibly affected by mental illness can be a difficult undertaking. Once a decision has been made to take a suspected mentally ill person into custody, it should be done as soon as possible to avoid prolonging a potentially violent situation. Officers should immediately remove any objects that can be used as a dangerous weapon and restrain the person if necessary. While the use of restraints can, with some individuals, aggravate their aggression, officers should take these and related security measures necessary to protect their safety and the safety of others with whom the mentally ill person will come in contact.

Every effort has been made by the IACP National Law Enforcement Policy Center staff and advisory board to ensure that this document incorporates the most current information and contemporary professional judgment on this issue. However, law enforcement administrators should be cautioned that no “model” policy can meet all the needs of any given law enforcement agency. Each law enforcement agency operates in a unique environment of federal court rulings, state laws, local ordinances, regulations, judicial and administrative decisions and collective bargaining agreements that must be considered. In addition, the formulation of specific agency policies must take into account local political and community perspectives and customs, prerogatives and demands; often divergent law enforcement strategies and philosophies; and the impact of varied agency resource capabilities among other factors.

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