The PoliceChief
The Professional Voice of Law Enforcement

March 2014

Police Approaches That Improve the Response to People with Mental Illnesses: A Focus on Victims

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Police officers routinely provide the first line of crisis response for situations involving persons with mental illnesses. These calls for service are common (they constitute between seven and 10 percent of all police contacts). But they pose operational problems for officers and managers and can significantly alter the lives of persons with mental illnesses and their families.[1] Specifically, these encounters challenge police agencies for three critical reasons:

- These incidents present an increased risk of injury to the person with mental illness and to the officer.
- In the absence of appropriate community-based treatment alternatives, persons with mental illness who come into contact with police are frequently arrested for minor offenses and thus present prosecutors and correctional systems (jails and prisons) with the task of managing a large group of relatively minor but high-maintenance offenders.
- The relationship between the police and their community can be strained by cases where force is used, regardless of legal justification.

Some police agencies have

Quick Facts:
Persons with Mental Illness

- Approximately 5 percent of the United States population has a serious mental illness.
- About 16 percent of the population in prison or jail has a mental illness.

- The Los Angeles County Jail, the Cook County Jail in Chicago, and Riker's Island in New York City each hold more people with mental illness on any given day than any hospital in the United States.
- Nearly three-quarters of inmates with mental illness have a co-occurring substance abuse problem.
- Nearly half the inmates in prison with a mental illness were incarcerated for committing a nonviolent crime.
- In the last four years, almost half of the states have established special commissions or task forces to look into some aspect of the mental health system.
- When a person with mental illness commits a violent crime, more than half the time, the victim is a family member, a friend, or an acquaintance.
- A North Carolina study found that people with mental illness are almost three times as likely to be victims of violent crime than people without mental illness.

Source: Consensus Project Fact Sheet (http://consensusproject.org).

developed specialized approaches to managing field encounters involving persons with mental illnesses. The objective of these efforts typically is twofold: to reduce injuries or use of force in the encounters, and to improve outcomes so that cases involving people with mental illnesses can be resolved in the most appropriate system, either the criminal justice system or the mental health system. Ultimately, the goal of these efforts is to give persons with mental illness and their families access to services, support, and resources to improve their lives and to enhance community safety.

Part of fulfilling this goal involves the police assistance to victims. Typically, we think of victims in this context as those who may be injured or threatened by the person who has a mental illness. Often, these victims are those closest to the person with mental illness—family members, friends, and associates. The less familiar crime victim is the person with mental illness, who, because of his or her vulnerability, is at an increased risk of being victimized.

A recent report issued by the Council of State Governments (CSG), a nonprofit, nonpartisan organization of state legislators, provides some guidance for police in developing new approaches to these encounters and enhancing the response to victims of both types. The report was the product of the Criminal Justice/Mental Health Consensus Project, which involved a partnership among the Police Executive Research Forum (PERF), the Pretrial Services Resource

Center (PSRC), the Association of State Correctional Administrators (ASCA), the National Association of State Mental Health Program Directors (NASMHPD), the Bazelon Center for Mental Health Law, the National Alliance for the Mentally Ill (NAMI), and the Center for Behavioral Health, Justice, and Public Policy. The Consensus Project report details a series of policy recommendations for criminal justice and mental health system stakeholders on how to improve their responses to people with mental illnesses. This article reviews important sections of the Consensus Project report, including variations on the police response to people with mental illnesses that evolved to improve outcomes for this population.

New Approaches to the Police Response

Law enforcement officers encounter people with mental illnesses in five general situations: as a victim of a crime, as a witness to a crime, as the subject of a nuisance call, as a possible offender, and as a danger to themselves or others. It is also true that a person with a mental illness may fall into more than one category at a time. It is critical for the officer who responds to the scene to recognize whether mental illness may be a factor in the incident, and to what extent, before deciding which response is best. This process can be difficult given the complexity of mental illness.

Several approaches have been developed that enable officers to assess situations involving people with mental illnesses effectively so as to reduce their contacts with the criminal justice system and ensure on-scene safety. The safety of all involved parties—the person with mental illness, family members, bystanders, and police—is of paramount importance. The desired outcome of these contacts is a resolution that entails fair and dignified treatment of persons with mental illnesses.

Law enforcement agencies across the country have developed approaches that fall into four broad categories, which are adapted to the specific needs of a community. These categories include crisis intervention teams, comprehensive advanced responses, mobile crisis teams, and teams of mental health professionals and police officers.

Crisis intervention team (CIT): This approach employs specially trained uniformed officers to act as primary or secondary responders to every call in which mental illness is a factor. Ideally, officers are chosen to participate based on their willingness to provide services to persons with mental illnesses. CIT officers are available for each shift to assist consumers and their families and to facilitate emergency mental health assessments. This approach was pioneered in the Memphis Police Department and has been adapted in numerous other jurisdictions nationwide.

Comprehensive advanced response: This response model uses a traditional response but mandates advanced, 40-hour training for all officers in the department. Some departments that use this approach

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address responses to persons with mental illnesses as part of their training and responses to a larger group of "special populations."

Mobile crisis team (MCT): Generally, MCTs are composed of civilian personnel who are licensed mental health professionals. To ensure an effective, safe response, MCTs act only as secondary responders who are called out once law enforcement has secured the scene. Law enforcement officers call MCTs if they believe the person involved may be a danger to themselves or others, or if the person needs services. Also, in some jurisdictions, if no crime has been committed, MCTs can provide transportation to a mental health facility (if it appears the person might meet the criteria for civil commitment) or other services (such as counseling or drug treatment). MCT personnel are knowledgeable about criteria for involuntary commitment, bring extensive information to the scene, and are able to provide follow-up services.

Teams of mental health professionals and police officers: Some police agencies hire licensed mental health workers as secondary responders. These civilians serve in units located either inside the police department—under the supervision of the chief—or outside the department in cases where they require shared staffing with other county or city mental health providers. These civilian workers either ride along with officers in special teams or respond when called by an officer after the scene has been secured for a variety of crisis calls, including those involving persons with mental illnesses. The civilian employees are responsible for developing relationships with community-based organizations and finding available services.

Regardless of the particular approach chosen, on-scene officers must recognize signs or symptoms of mental illness; stabilize the scene; determine whether a serious crime has been committed; consult with mental health personnel; and determine whether the person might meet the criteria for emergency evaluation. Once these determinations have been made, the responders must decide what, if any, action to take next. Whatever the next step, law enforcement should not overlook the opportunity to provide services and resources to victims.

Law Enforcement Role in Victims' Assistance

The Consensus Project report addresses law enforcement's role in assisting persons who have mental illnesses who are victims of crime and assisting those who are victims of crimes perpetrated by people with mental illnesses. Two specific policy recommendations in the report apply to these victims. First, the report recommends providing information to victims who have mental illnesses and their families to help prevent revictimization and increase understanding of criminal justice procedures.

Second, it recommends informing victims of persons who have a mental illness and other affected individuals, including family members, about what to expect and

what community resources are available.

The following sections are adapted from the Consensus Project report.

Crime Victims with Mental Illnesses

Research has shown that persons who have mental illnesses, like many persons who have disabilities, are at a greater risk for victimization.[2] Persons with mental illnesses have been shown to be vulnerable to sexual assault as well as other violent crimes.[3] These crimes are also disproportionately unreported, probably because these victims fear reprisals or retribution from their abusers for coming forward or fear the police won't believe them.

Unfortunately, when victims with mental illnesses do report their crimes, they are sometimes viewed as unreliable witnesses and their cases dropped. Questions about reliability can arise partly because persons who have mental illness who have been victimized repeatedly may confuse the different events in their reports to law enforcement. This confusion does not negate their victimization and the importance of investigating the crime. In fact, persons with mental illnesses may experience the trauma of victimization more acutely than other victims, partly because it triggers memories of past abuse. This history of abuse is relevant to case investigation and should be explored.

Law enforcement officers can become more informed about the complexities of working with victims who have mental illness by collaborating with their mental health partners. These professionals can help law enforcement officers sort out these issues, help to increase the reliability of evidence, and thereby improve case outcomes. Resources for responding to crime victims who have disabilities can be obtained through the U.S. Department of Justice's Office for Victims of Crime (www.ojp.usdoj.gov/ovc).[4]

Law enforcement agencies should provide information to these victims about available services that can help reduce their vulnerability, and promote positive contacts with the criminal justice system agents who can inform them of case progress. Law enforcement can also work with consumers and their advocates to conduct crime prevention outreach.

Victims of Persons with Mental Illnesses

Persons affected by a person with mental illness who has committed a crime can include victims, family members, and others who share a home or part of their lives with people with mental illness (such as employers). As in other similar situations, these persons need a variety of supports and may look to law enforcement for help in accessing resources. In particular, victims (who may also be family members)

should be apprised of the course of action and the expected outcomes law enforcement and mental health officials have planned. They should also be made aware of national resources for victim assistance, including the National Organization for Victim Assistance, the National Center for Victims of Crime, and the Justice Department's Office for Victims of Crime.

In addition, police departments and their mental health partners can provide information on peer supports, such as consumer-managed neighborhood projects, drop-in centers, and so-called warmlines, which offer nonemergency support to consumers by telephone. Regional NAMI affiliate organizations, community chapters of the Depressive-Manic-Depressive Association, and local United Way organizations are all good resources for peer support and services. Families may also contact statewide consumer-managed organizations, such as the Tennessee Mental Health Consumer Network.

If police have been called to a home as a result of a threat or threatening action, they should also be able to inform family members about ways to protect themselves. Even in instances where the threatening person is placed in treatment, voluntarily or involuntarily, he or she will likely be at liberty in a matter of days. Families should be made aware of the process for obtaining a protective order, the associated risks and benefits, and what is likely to happen should such an order be violated by the ill family member.

The Consensus Report recommends that law enforcement agencies work with their mental health partners to prepare packets of information on available community-based resources for people with mental illnesses and substance abuse, and for their families. These packets should accommodate the full range of cultures and languages present in the community.

The Street Worker Project in Burlington, Vermont

An example of a police approach that provides service to victims is operating in Burlington, Vermont. In May 2000 the Burlington Police Department sought a more effective way to work with people with mental illness who were experiencing difficulty on the Church Street Marketplace, Burlington's central retail and restaurant district. The police learned that merchants wanted the area to feel more comfortable and secure for patrons, while the community mental health agency (the Howard Center) wanted to improve the public perception of people with mental illness. The Street Worker Project was developed to meet a number of goals, including the following:

- Providing outreach services, interventions, and referrals for adults and adolescents with acute and chronic mental illness
- Reducing antisocial behavior in downtown Burlington

- Reducing unnecessary mental health admissions to the emergency room from the downtown area
- Improving mutual respect and communication between merchants, police, service providers, patrons, and clients
- Improving connections and coordination between all downtown service providers
- Reducing the need for police involvement in incidents involving persons with mental illness

The Street Worker Project provides support for any unmet social service need in the downtown business district including those connected to victimization, health crises, and general disorder. According to Matt Young, the project coordinator and a service provider himself, "All calls are appropriate."

Using Law Enforcement Resources More Efficiently in Memphis

In Memphis, Tennessee, before the implementation of the crisis intervention team (CIT), police officers spent four to six hours at the medical center for mental health admissions; today, the average wait is about 15 minutes. Shortly after the Memphis CIT was implemented, reported injuries suffered by persons with mental illnesses caused by police decreased by nearly 40 percent.

Source: Consensus Project Fact Sheet (http://consensusproject.org).

The program relies on community support workers, also known as street workers, who provide crisis response to the downtown area for approximately 12 hours every day. There are often two street workers on duty five days per week. These mental health or social work generalists work for the Howard Center (the county's mental health agency) and receive funding from federal grants, the city of Burlington, the Fletcher Allen Foundation, the Burlington Business Association in conjunction with the United Way of Chittenden County, and the Vermont Department of Developmental and Mental Health Services.

The street worker's job is to assess, support, and provide appropriate responses for persons coming to their attention either through direct contact, or a referral from a merchant, a citizen, or the Burlington Police Department. Services can include de-escalation, assurances of shelter and food, rapport building, intervention by the police, or others. If an assessment reveals a major mental illness, the person is gently offered a variety of options including treatment or daily support and a so-called reality check around the potential consequences of the behaviors. The street worker will continue to act as a support and will coordinate follow-up services to complete or modify a treatment plan. Street workers also educate business owners and patrons on the realities and myths of mental illness to break down misperceptions and eliminate fear. It is estimated that the street workers make 3,400

contacts each year, or nine per day, and this number is increasing. In about 50 percent of these cases, the person is not seen again.

The street workers also address the needs of people with mental illness who are crime victims. They offer support at the time of the incident and help process the grief associated with victimization. If needed, street workers make referrals to counseling and advocacy services. When the person with mental illness is the victim, the street worker assists with processing the incident; coordinates follow-up with that person's case worker; makes referrals to services and advocates for both the person and his or her families; and works with the police department as a liaison in helping identify the perpetrator. For more information, call Matt Young at 802 -343-7504, or send an e-mail message to him at matty@howardcenter.org. The Howard Center for Human Services is located at 300 Flynn Ave, Burlington, VT 05401.

Lessons Learned

Experience has shown that when communities address the issues and challenges created when persons with mental illness interact with the criminal justice system, it takes a broad-based commitment from a host of actors. The Criminal Justice/Mental Health Consensus Project was created to open lines of communication and initiate creative thinking so that proactive solutions are implemented. All across the United States and Canada examples of communities implementing personalized solutions and approaches abound. The result is a growing number of people getting the services they need and a lessening burden on the criminal justice system. Whether help arrives as part of the first response of a police officer that activates local resources or at the presentencing hearings where decisions are made concerning alternatives to incarceration and treatment, the end result is a more humane, compassionate, and effective criminal justice system.

The Consensus Project report outlines only a few of the many examples nationwide of police and mental health services working together. The real success of the project depends on the extent to which community leaders, politicians, magistrates, and police leaders use the recommendations in the report to improve the response to people with mental illness who come into contact with the criminal justice system and to improve assistance to victims. A copy of the report can be obtained on the Web site dedicated exclusively to the project: consensusproject.org. ♦

[1] See Randy Borum, Martha Williams Deane, Henry J. Steadman, and Joseph Morrissey, "Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness," *Behavioral Sciences and the Law* 16 (1998): 393-405; Martha Williams Deane, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph Morrissey, "Emerging Partnerships Between Mental Health and Law Enforcement," *Psychiatric Services,* 50, no. 1 (1999): 99-

101; and James Janik, "Dealing With Mentally Ill Offenders," Law Enforcement Bulletin, vol. 61, no. 7 (1992): 22-26.

[2] James A. Marley and Sarah Buila, "When Violence Happens to People with Mental Illness: Disclosing Victimization," *American Journal of Orthopsychiatry*, 69, no. 3 (1999): 398-402; and Virginia Aldigé Hiday, Marvin S. Swartz, Jeffrey W. Swanson, Randy Borum, and H. Ryan Wagner, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services*, 50, no. 1 (1999): 62-68.

[3] Daniel D. Sorensen, "The Invisible Victims" (2002) available at http://www.aspires-relationships.com/the_invisible_victims.pdf.

[4] U.S. Department of Justice, Office for Victims of Crime, "First Response to Victims of Crime Who Have a Disability," October 2002.

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From The Police Chief, vol. 70, no. 11, November 2003.

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Top 10 Myths about Mental Illness

BY PAMELA KULBARSH (/CONTACT/10220427/PAMELA-KULBARSH)
CREATED: MARCH 9, 2011

Mental illness is grossly misunderstood not only by the sufferers; but by the community at large, including law enforcement.

People, by nature, fear what they do not understand. Mental illness is grossly misunderstood not only by the sufferers; but by the community at large, including law enforcement. This misunderstanding inevitably leads to misconception and results in stigmatization (stigma is defined as *a mark of disgrace*). More than 54 million Americans suffer from mental illness in any given year. 2/3rd of all people with a diagnosable mental disorder do not seek treatment. A majority of these individuals hesitate to get help for their mental health problems because of stigmatization. This is extremely unfortunate because effective treatment exists for almost all mental illnesses.

The stigma of mental health/illness in the field of law enforcement is twofold. First off, law enforcement officers are as susceptible to mental illness as is anyone else. Secondly, officers interact daily with mentally ill individuals in the community. Not only does an officer have to overcome an internal stigma, he/she must possess accurate knowledge of mental health and illness when dealing with citizens, victims, and/or suspects who have mental disorders. This is hugely significant considering that approximately 9% of all law enforcement emergency dispatch calls are related to a mental illness crisis. Misconceptions can only be corrected by educating yourself about mental health and illness. Dispelling common myths is an essential step toward abating the stigma and diminishing the fears associated with mental illness

Top 10 Myths about Mental Illness for Law Enforcement Officers

Myth #1:*Mental health problems are uncommon.*

Fact: Mental illnesses are surprisingly common. In fact, mental illnesses are more common than cancer, diabetes, or heart disease. The U.S. National Institute of Mental Health estimates that 26.2% of the population suffers from mental illness. Psychiatric disorders affect almost every family in America. Mental illnesses do not discriminate; they can affect anyone regardless of gender, race, age, ethnicity, and socio-economic status. According to the World Health Organization, four of the ten leading causes of disability in the United States and other developed countries are mental disorders.

Myth #2:*People with severe mental illness are dangerous and violent.*

Fact: The vast majority of people with mental illnesses are no more violent than anyone else. In the cases when violence does occur, the incidence typically results from the same reasons as with the general public, such as feeling threatened or excessive use of alcohol and/or drugs. The media often sensationalizes accounts of crime by a mentally ill individual. Actually, people with mental illnesses are much more likely to be the victims of crime. More than 25% of persons with severe mental illness were victims of a violent crime in the past year, a rate more than 11 times that of the general population.

Myth #3:*Mental illnesses are not real medical problems or diseases*

Fact: The definition of disease is *A pathological condition of a part, organ, or system of an organism resulting from various causes.* The brain is an organ; lungs, the heart, liver, kidneys, skin, etc are examples of other organs. Mental illness is a disorder of the brain. Brain disorders are related to anomalies of the brain's chemistry at nerve cell junctions and metabolism in different brain regions. Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Myth #4:*People who talk about suicide do not commit suicide.*

Fact: Few people commit suicide without first letting someone else know how they feel. 8 out of 10 people who commit suicide have spoken about their intent before killing themselves. Suicidal comments have to always be taken seriously as they often lead to plans, attempts, or completions.

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Top 10 Myths about Mental Illness

BY PAMELA KULBARSH (/CONTACT/10225427/PAMELA-KULBARSH)
CREATED: MARCH 6, 2011

Mental illness is grossly misunderstood not only by the sufferers; but by the community at large, including law enforcement.

Myth #5: *Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or "bad".*

Fact: Addiction is a neurobiological disease that results from changes in the brain's chemistry. It is not the result of a character flaw or weakness. Addiction often results when a person with untreated mental illness tries to self-medicate using drugs and/or alcohol. Addiction may also mask additional underlying mental illnesses. It frequently results in behavioral and emotional problems. Addiction has nothing to do with being a *bad* person.

Myth #6: *Mental health disorders are often life-long and difficult to treat.*

Fact: Many times individuals, with a newly diagnosed disorder such as depression or anxiety, are prescribed medication. Yet, when they question their physician about how long they must remain on medication, they are only told *As long as you need to be*. Actually, most medications, with a few exceptions, (such as those prescribed for bipolar disorder and schizophrenia) prescribed for mental disorders should be taken for short-term (under a year) symptom relief

Myth #7: *Persons with mental illness never recover.*

Fact: Studies have shown that people with mental illnesses can recover and resume normal activities. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. With treatment and support most mentally ill individuals can lead productive lives, work, pursue education and religion, enjoy hobbies, recreational activities, and contribute actively to society. For others, recovery implies the reduction or complete remission of symptoms.

Myth #8: *Mental health problems are best treated by my primary care physician.*

Fact: Mental disorders should be taken as seriously as any potentially chronic and disabling medical condition; therefore, mental disorders are best treated by a trained specialist, a mental health professional; psychiatrist, psychologist, or other clinician specially trained to diagnose and treat mental health problems. If you were diagnosed with cancer, wouldn't you want to consult with an oncologist? Your primary care doctor is a good place to start to discuss your symptoms, rule out other medical conditions or medication side effects that may help explain your symptoms, and to get an appropriate mental health referral. It has been estimated that up to ½ of all visits to primary care physicians are due to conditions that are caused or exacerbated by mental illness.

Myth #9: *Depression is a normal part of the aging process.*

Fact: It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed or misdiagnosed. Depression is not synonymous with dementia. Elderly white males have the highest suicide rate when compared to all other groups (triple the overall rate). With treatment and support, depressed older individuals can enjoy their golden years.

Myth #10: *I can handle my own mental health problems, and if I can't, I'm weak.*

Fact: The first part of this statement may not be so much a myth; most people who have a mental health problem do not seek treatment. They rely on traditional coping mechanisms (exercise, socializing, working harder, etc.) to deal with their symptoms. Many diagnostic mental health problems may be mild enough for this type of self-care to be sufficient. Talking with friends, reading a self-help book on the subject, or visiting an online self-help support group may be enough to get you through tougher times. However, a serious mental illness cannot be willed away. When problems become chronic or even worsen despite your efforts to cope, you should take that as a strong indication that additional help is needed. Ignoring the problem does not make it go away. Getting treatment for a mental illness does not mean you are weak, weak-minded or weak-willed. It simply means that you realize and accept your human and natural limitations. It takes courage to seek professional help.

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Top 10 Myths about Mental Illness

BY PAMELA KULBARSH (/CONTACT/10226427/PAMELA-KULBARSH)
CREATED: MARCH 8, 2011

Mental illness is grossly misunderstood not only by the sufferers; but by the community at large, including law enforcement.

Implications for Law Enforcement Officers

Fact: If you deal with four people today, statistically, one of them will be suffering from a diagnostic mental illness

When interacting with these individuals arm yourself with actual knowledge, not misguided assumptions about psychiatric disorders. In order to effectively communicate with mentally ill individuals, choose your words carefully. Use accurate and sensitive words when talking to anyone about the mentally ill. Your positive attitude can affect everyone with whom you have contact, including other officers and medical staff. Words like *crazy, cuckoo, psycho, wacko* and *nutso* are a few examples of words that keep the stigma of mental illness alive. Although these words are often used without intentional harm, they can be quite belittling and demeaning. They also perpetuate the stigma of mental illness. Stigmatization is the #1 reason people with a mental illness do not seek treatment.

If you believe you may have symptoms interfering with your mental health, seek appropriate treatment. Officers are susceptible to depression, anxiety, PTSD, etc. Effective, confidential treatment is available. Usually the stigma of mental illness is far worse than the illness itself. Serve and protect yourself.

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Dependence, tolerance and addiction are all terms bandied around by those either in the caring professions who are helping to solve drug addiction, or by those trying to understand and often missing the point. Drug Addiction Myths

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Dana Hoffman 1109 days ago

Try this link and see if there is something they can do for you
http://bakeract.fmhi.usf.edu/

Good Luck!

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Nicki 1111 days ago

Hi, My sister resides in Florida She has been abusing herself with alcohol and any substance she can get her hands on for about 15 years . She is 30. She has been physcally abused, raped for her pills that are given to her by Doctors. She had a serious car accident at the age of 17 that began this road, she was given oxycotin. From there she has lead a bizzare life filled with pills, alcohol and physcial abuse and trama. She has been Baker Acted many times in Florida, fooling all of them, convincing them that she is not in need of help It continues, is there anything we can do with police help to try to save her life down in Florida? We were raised with our Father being a poitce Officer, he is no longer around, my Mom and I just need some direction and help before it is too late! If anyone is familiar with which county in Florida has successful rates with the Marchman Act or baker Act or Ex-potre, please , please give me some advice...quickly. She is going to get killed or kill herself

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Reply

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Things to AVOID

- Maintaining continuous eye contact.
- Crowding or "cornering" the individual.
- Touching the individual unless you ask first or it is essential for safety.
- Letting others interact simultaneously with the individual.
- Negative thoughts ("God, this is another one of those homeless people.").
- Expressing anger, impatience or irritation.
- Inflammatory language ("You are acting crazy.").
- Feeling as though you have to rush or feeling like you are stuck if it takes time to get the individual talking.
- Interrupting or talking over the individual.
- Saying "You need to calm down."
- Shouting or giving rapid commands.
- Arguing with the individual.
- Taking the words or actions of the individual personally.
- Lying, tricking, deceiving, threatening the individual to get her to comply.
- Asking why questions.
- Forcing discussion
- Minimizing the individual's situation as a way to elicit conversation ("Things can't be that bad, can they?")
- Suggesting that things will get better; they may not
- Making promises that you may not be able to keep
- Telling the individual "I know how you feel."
- Asking a lot of questions of the individual in the beginning.