Police and Mental Illness: Models that Work

Factors that Increase Police Contact

Police contact with persons affected by mental illness has increased in recent years due to a variety of factors, including displacement from institutional settings without adequate increases to community support, below-poverty-level disability assistance rates, homelessness, and reduced provincial and general hospital psychiatric capacities resulting in inadequate treatment stabilization. All of these factors lead to an increase in police interactions with persons with mental illness. These interactions occur most often when a person is having a mental health crisis. When people are in crisis, they require a medical response, but police are often called on instead as first responders.

The typical police responses to suspected criminal activity (containment, interrogation, detention) are usually not appropriate when dealing with a person with mental illness, especially when in crisis. Mental illness becomes criminalized when a mentally ill person acts inappropriately due to symptoms of mental illness; many persons with mental illness end up with extensive criminal records for petty crimes when they really need treatment for their illness.

Likewise, when someone with a mental illness is in crisis, their perceptions are disturbed: they may be delusional or paranoid, and often terrified. As a result, the person may respond aggressively or inappropriately to people attempting to control them, which often results in charges of assault or resisting arrest. If the situation escalates, it can result in injury, trauma, or death – usually to the person with mental illness.

New Models for Police Response

Many communities have realized that this must change, and have developed different models, each suited to the identified needs and assets in a particular community. Some are based in the mental health system, some in the police system, some are a true collaboration, and some are based in the community itself. Following are examples of models which have met with success in specific communities:

Police/Mental Health Team – This model consists of a specialized mental health crisis intervention team, wherein plainclothed police and mental health professionals respond in unmarked police cars, defuse the situation, and ensure the person with mental illness is dealt with appropriately – either through the provision of appropriate medical/psychiatric care, civil certification and hospitalization – or, where appropriate, arrest and detention with psychiatric evaluation. The team is supported by psychiatric nurses on a mental health crisis line which vets calls for team response or on-call support to regular officers, and psychiatrists who provide on-call advice and will attend for on-the-spot certifications where deemed necessary. Example: Vancouver's Car 87. There are two variations of this model:

- mental health professionals are employed by police agencies as 'civilian officers' who do not carry weapons or have the police powers to arrest. These civilian officers provide advice and education to the police agency, and respond to calls involving mentally ill persons where typical police non-violent crisis intervention techniques have not been successful. Example: Birmingham, Alabama
- trained crisis intervention volunteers perform the same function in response to calls. Example: New Orleans, Louisiana

Reception Centre – In this model, once trained police officers recognize signs of mental illness, the person is transported to a reception centre where specially trained police or mental health professionals conduct a more thorough assessment and, if necessary, refer that person to mental health services. Examples: Knoxville, Tennessee; Los Angeles, California.

Specialized Police Crisis Intervention Team – At least one specialized officer is scheduled to work each shift in each catchment area (geographical district), performing mental health crisis intervention along with regular police duties. These specialized officers are called to respond to incidents involving mentally ill persons. The incidents are either resolved on site, or the person is transported to a medical centre or referred to other types of mental health services, as appropriate. The team is supported by the medical centre's 'no reject' policy and a priority service agreement (i.e. persons brought in are seen within 15 minutes, and none are refused medical/psychiatric attention). Example: Memphis, Tennessee

Joint Protocols – A simple protocol between police and mental health services to each provide appropriate service. If first contact is with the police, and the person is known or suspected of having a mental illness, the mental health team is contacted. If no violence is involved, the mental health team takes primary responsibility for the person. If violence is involved, police will transport the person to the hospital, where emergency physicians can obtain any mental illness history, assessment and consultation from the mental health centre. The relevant parties (police, mental health centre staff, hospital staff) meet monthly to discuss issues. Example: Dawson Creek, BC

Best Practices for Model Development

Research shows that a best practice model would contain the following elements:

- careful selection of a core group of specialized police officers who can regularly use their skills
- specialized officers are used as 'first responders' to calls involving persons with mental illness
- specialized and ongoing crisis intervention skills training for all police officers
- specialized system of dispatch, with training for dispatchers and use of questions for callers which would identify mental health issues and provide as much information as possible
- a shared information system between the mental health system and police
- accessibility 24/7 and throughout the whole geographical area
- protocols for close collaboration between police, mental health service providers, and hospital services
- a dispute resolution mechanism to resolve issues as they arise between collaborating parties
- evaluation process to measure outcomes and disseminate results

Police and other emergency responders have become more educated about the symptoms and experience of mental illness and mental health crisis. The recognition that police and other emergency agencies must respond differently to persons with mental illness is becoming more widespread. Most importantly, perhaps, is the advent of collaborations between police, emergency services, mental health services, hospitals, and those who experience mental illness. Through these collaborations, comprehensive and sustainable networks can be developed to address the needs of persons with mental illness in the community to prevent and to provide appropriate help in times of crisis.

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