

# Police and Mental Illness: Increased Interactions

## Reasons for Increased Interactions

Across North America, a number of changes have led to increasing interaction between police and persons with mental illness. A shift from institutionalized care to community-based care has resulted in more persons with mental illness in the community. Unfortunately, community support systems have not received sufficient funding to grow proportionately to the increased need. Existing crisis response services (crisis lines, mental health teams, hospital emergency wards, for example) are limited in scope and are often not well integrated. Reductions in hospital beds and services result in hospital admission only for those in acute crisis, and, even then, only for very short periods of time.

These factors and the general lack of understanding and awareness about mental illness result in many people with mental illness in crisis coming into contact with police. A Canadian Mental Health Association, BC Division study found that over 30% of persons with serious mental illness interviewed had contact with police while making, or trying to make, their first contact with the mental health system. Police officers are, by default, becoming the first point of access to mental health services for persons with mental illness, earning them the nickname 'psychiatrists in blue.' But is this an appropriate role for police? Are they trained and given the proper resources and support to fulfill this role? What are the impacts of this situation – for persons with mental illness, for the police, for the public?

## Impact of Increasing Interaction

There is an ambivalence among police officers about whether they should in fact be dealing with mental health issues. The police mandate is generally to ensure safety and to provide protection to the public, but some police officers do not consider this mandate to include protecting or providing safety for people with mental illness in crisis – this being the responsibility of the mental health system. This ambivalence is reinforced if there is a lack of comprehensive, ongoing training of police officers in the recognition of mental illness and in mental health crisis intervention, and a lack of contact and support from mental health and emergency services.

The results for persons with mental illness can be serious: long delays in receiving necessary diagnosis and treatment, unnecessary and damaging trauma, criminalization of illness-induced behaviour. The estimates of untreated mental illness in the criminal justice system range from 15–40% of the incarcerated population. When police respond to a person in mental health crisis as they are trained to respond to a typical criminal emergency situation – with a show of force and authority – they may in fact escalate the crisis to a point of risking injury or death for police or the public, but most often for the person in mental health crisis.

The impact on police can be traumatic: police officers have been traumatized by the police shooting deaths of persons in mental health crisis, deaths which might well have been prevented if officers had received appropriate training. As well, police suffer frustration at long wait times at emergency departments, refusals to admit persons to hospital, a lack of mental health service alternatives, and a lack of coordinated support.

The general public suffers also. Family and friends of persons with mental illness experience the trauma and frustrations of such interactions, as well as the impact of the criminalization of mental illness. The general public experiences the loss of police response when hours of police time are spent waiting for a person in crisis to be admitted to hospital. The public also receives reinforcement for the

false perception that mental illness is a crime rather than an illness, and that persons with mental illness are a public danger – a common and erroneous belief which hurts both persons with mental illness and the public.

## Solutions

A number of communities, recognizing the need to improve the response to persons in mental health crisis, have developed special programs for intervening with persons who have a mental illness. In most cases, the programs were developed through collaboration between police and mental health service providers, and others involved or invested in the issue. The range of programs includes:

- mobile teams of police and mental health professionals to respond to mental health crises
- police ‘reception centre’ where police can take persons suspected of having a mental illness for further assessment and referral by specially trained police officers
- ‘crisis intervention teams’ located in each police catchment area to respond to mental health crises as well as perform regular duties
- joint protocols between police and a mental health centre or hospital, with continued joint assessment and problem-solving

A number of factors have been found to contribute to the success of programs. Key among these are:

- **training** – ongoing mental health awareness training for all officers and specialized crisis intervention skills training for specialized officers
- **information systems** – an information system which tracks crisis interventions and outcomes (i.e. what works and what doesn’t), trains dispatchers in recognition of mental health issues, and a system of dispatch which relays all relevant information on mental illness and crisis issues
- **accessibility** – accessible 24 hours a day, 7 days a week throughout the area served
- **collaboration** – protocols for close collaboration with mental health services and dispute resolution mechanism for collaborators
- **evaluation** – measuring outcomes and disseminating results to make necessary changes for improvement.

For a more complete analysis of these issues, please see *Study in Blue and Grey: Police Interventions with People with Mental Illness* (2003) on our CMHA BC website at [www.cmha-bc.org/research](http://www.cmha-bc.org/research).

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# Criminalization of Mental Illness

## The Issue

The long-term trend of deinstitutionalizing people with mental illness – that is, releasing people from psychiatric hospitals to reside and be treated in the community – has been heralded by many as a step forward in the social acceptance and respectful treatment of people with mental illness. With the advent of new, more effective medications and better understanding of the range and types of community supports people with mental illness require, many people with mental illness live successfully in the community.

For a minority of people, usually those with multiple complex needs, deinstitutionalization combined with a lack of comprehensive community support systems has resulted in another type of ‘institutionalization,’ within prisons and jails rather than hospitals.

This is only one of the factors leading to an increase in what is generally known as the ‘criminalization of mental illness,’ i.e., where a criminal, legal response overtakes a medical response to behaviour related to mental illness. This is a distressing trend, with a number of contributing factors.

## Ways Mental Illness is Criminalized

Research consistently shows us that a person with mental illness is more likely to be arrested for a minor criminal offence than a non-ill person. The majority of these arrests are for crimes – such as causing a disturbance, mischief, minor theft, failure to appear in court – directly or indirectly related to the mental illness. The majority of these arrests are also initiated by a report from a member of the public, rather than the police.

The range of mentally disordered offenders (i.e. persons with mental illness convicted of an offence) currently in jails and prisons is somewhere between 15 to 40%; highly disproportionate to the occurrence of mental illness in the population at large.

A number of factors contributing to the disproportionate incarceration of persons with mental illness have been identified in research literature:

- **Lack of sufficient community support** including housing, income, and mental health services. Persons with mental illness have a harder time finding employment and housing, and maintaining consistent contact with friends, relatives and treatment providers. It is estimated that 30%–35% of Canada’s homeless population have a mental illness. Many become isolated, homeless, hungry, and poor due to the symptoms of their illness.
- **High rate of substance abuse.** Over 50% of people with mental illness have a co-occurring substance use disorder. Co-occurring disorders (mental illness and substance use disorder) are more difficult to treat than either mental illness or substance abuse alone, and there are insufficient treatment programs for the growing demand.
- **The ‘Forensic’ label.** Treatment is sometimes refused to persons who have committed a criminal offence or have been previously incarcerated. Hospital staff may refuse admission because it is considered a criminal matter, or the person may be considered too dangerous or disruptive for treatment by community resources – even if the offence for which the person was arrested or convicted does not involve violence.

- **Problems with treatment.** Some persons with mental illness try numerous treatments without success. Others refuse treatment because they cannot accept that they have an illness, they dislike medication side-effects, or due to symptoms of the illness itself. Lack of sufficient housing, income, and support also interfere with the ability to maintain treatment.
- **Lack of specialized cross-training for both criminal justice and mental health professionals.** Both systems need to provide information and training to staff on understanding mental health and law enforcement issues, respectively, in order to create successful collaboration.
- **Lack of timely access to mental health assessment and treatment.** Easy access is necessary for early intervention and prevention of deterioration, and also to provide law enforcement, courts, corrections, and communities the ability to access appropriate treatment for individuals in a timely way.

Research also indicates that incarceration is more problematic for a person with mental illness. People with mental illness also are more likely to be victimized by others and may exhibit disruptive behaviour as a symptom of their illness. Disciplinary measures including segregation or solitary confinement can be highly traumatic and cause breakdown or psychosis for a person with mental illness.

For a number of reasons, persons with mental illness are more likely to be arrested, detained, incarcerated, and more likely to be disciplined, rather than treated, while incarcerated. Once arrested and convicted, persons with mental illness are more likely to be arrested and detained again, repeating the cycle.

### What Needs to Change

Most people would agree that a person with mental illness should be treated rather than punished. Police must be better trained to recognize symptoms of mental illness and have the capacity to immediately refer to mental health services instead of the criminal justice system. The courts must become more educated on the issues and solutions for persons with mental illness, and the corrections service must develop screening and appropriate treatment and care for offenders with mental illness and ensure appropriate post-release support. Most importantly, people with mental illness must have adequate and appropriate support in the community in terms of housing, income, job skill development and, above all, timely access to assessment and treatment through the mental health system.

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# Violence and Mental Illness: Unpacking the Myths

## The Myth

A common portrayal of mental illness in the media is that persons with mental illness are antisocial, criminal, violent and dangerous. In drama – books, movies, television shows – persons with mental illness are often portrayed as dangerous ‘psychos’; mental illness is used as an explanation for antisocial and violent behaviour. In news reports, any hint or suspicion of mental illness is highlighted as a probable cause of violent or unpredictable behaviour.

This plays upon the public’s general fear of what they don’t understand, and of behaviour, however harmless, that does not conform to society’s norms. As a result, public perception that all people with mental illness are potentially dangerous has increased, even with recent improvements of the public’s awareness about mental health disorders.

## The Truth

Persons with mental illness are in fact two and a half times more likely to be *victims* of violence than members of the general public. Persons with mental illness are *no more likely* than anyone else to harm strangers. There are some mental illnesses which may in fact decrease the likelihood of violence to others. The risk of violence is mainly confined to a small subgroup of people with severe and persistent mental illnesses and with specific kinds of symptoms which are not being appropriately treated.

For the most part, the indicators for violence among persons with mental illness are the same as for the general public: gender (male), childhood abuse, socioeconomic status, age, substance abuse, stressful and unpredictable environment with little or no social support. These factors are much stronger predictors of violence than mental illness alone. The strongest predictor of violence is a history of violence. While the link between mental illness, substance use and violence continues to be examined, we do know that substance use among people with mental illness seems to increase the risk of violence significantly. Within the general population, substance use increases the rate of violence by two and a half times, while within the population of people with mental illness, substance use increases the rate of violence by seven times.

What factors of mental illness may increase violent behaviour? The main indicator is lack of effective treatment for symptoms of some types of neurological impairment (lack of emotional and behaviour controls), or psychoses (delusions of control, command hallucinations). Most often, the violence is a result of a real or perceived threat to the person with mental illness rather than aimless aggression. With appropriate treatment and support, people with mental illness are no more dangerous than the general population.

## Dealing with Potentially Aggressive Behaviour

So what should a person do when faced with potentially aggressive behaviour?

- 1 • Be aware that not all unusual behaviour is dangerous or violent. If behaviour is threatening, however, take the threat seriously and protect yourself by removing yourself from the situation and calling for help.
- 2 • Avoid touching the person, and allow maximum personal space. Do not stand between the person and an exit, but make sure that you have access to a safe exit also. This reduces the perception of you as a threat.

- 3 • Speak slowly, calmly and quietly; do not respond to insults or aggressive talk but do respond to other questions with short answers so that the person can understand and does not feel ignored. Often persons in psychosis are experiencing auditory hallucinations (hearing voices) and cannot hear or deal with more than short, simple statements or questions. It may be necessary to repeat yourself before the person can hear and understand you.
- 4 • Do not exhibit nervous or aggressive behaviour such as crossing your arms, pointing at the person, standing with your hands on your hips, or making abrupt or quick movements. Again, this reduces any perception that you are a threat.
- 5 • Explain what is happening – not in terms of the person's own experience, but what you or others are doing to help them. If the person is hearing voices, tell them that you cannot hear them but understand that they do. It's okay to ask if they are hearing voices and what the voices are saying; this may help the person's anxiety. Explain who you are and who others are who may arrive. Explain that you are all trying to help.

The common misconception that persons with mental illness tend to be violent needs to be overcome, particularly with professionals such as police officers and ambulance service personnel who deal with persons with mental illness on a day-to-day basis. Awareness of the facts, understanding of what it is to experience a mental health crisis, and knowledge about the best responses for dealing with someone who may be exhibiting signs of a mental health crisis will go a long way to improve interactions with people with mental illness, for all concerned.

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# 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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# Mental Health Crisis: Frequently Asked Questions

Most people who have little or no experience dealing with persons in mental health crisis may be fearful and uncertain as to how best to help a person in this position. Unfortunately, popular media (television, in particular) do not always present an accurate portrayal of the symptoms of mental illness and the best response to persons suffering from a mental health crisis – leading to some common misconceptions about the level of dangerousness of people in crisis and corresponding need for aggressive force in response.

The following is reprinted from a manual for front-line officers produced by the Centre for Addiction and Mental Health, Ontario Police College and St. Joseph's Health Care in Ontario, entitled *Not Just Another Call...Police response to people with mental illnesses in Ontario: A Practical Guide for the Frontline Officer*. These are real questions from front-line officers in Ontario, and the responses.

## **If you encounter psychotic symptoms (e.g. hallucinations) can you be certain that the person suffers from a mental illness?**

There are many reasons why a person might exhibit psychotic symptoms including brain injury, substance abuse, medical conditions, response to trauma, victimization, etc.

## **How powerful are the drugs used to combat mental illness?**

The group of drugs known as anti-psychotics, if taken as prescribed, can reduce and even eliminate, symptoms of psychosis. Note: the emphasis is on 'reduce' and 'even eliminate' the symptoms. That is, the drugs can often help make the voices stop and/or visions cease, but they cannot cure the illness.

## **Is it acceptable to use deception with a mentally ill person if it is not used with intent to belittle or if it aids in securing compliance?**

You should avoid using deception as a means of ensuring compliance. The deception could possibly undermine trust and this could have serious consequences on the next time you or a fellow officer interacts with this individual.

## **What is the delusion most frequently encountered by police?**

Feelings of persecution or 'paranoia,' that is, the feeling that something or someone is attempting to inflict harm on the individual.

## **How can you calm someone who displays signs of paranoia?**

If you move too quickly, invade personal space or touch (the person), you could increase the paranoia; that is, they may think you are trying to hurt them. Invasion of personal space can escalate the situation. (Note: see the Fact Sheet "Responding to Hallucinations and Delusions" or *Not Just Another Call* section on strategies for delusions)

## **Is humour effective when interacting with someone who has a mental disorder?**

We are talking about officer-generated humour which, generally speaking, is not an appropriate response to anyone who is experiencing pain or trauma.

## **Is it true that on the average, people suffering from a mental illness are less intelligent?**

There is no evidence to suggest either lower or higher levels of intelligence.

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## **Is it true that attempting to commit suicide is a cry for help, that in most cases, it is just a way of drawing attention to oneself?**

The police officer is not a therapist and is not in a position to comment on whether or not a person is serious about a suicide attempt. All suicide attempts or expressed ideas concerning suicide must be taken seriously.

## **Can hallucinations or delusions occur simultaneously?**

Hallucinations and delusions often appear together. For example, the person might taste poison or smell smoke (hallucination) and think someone is trying to kill them (delusion).

## **What is the most frequently encountered hallucination?**

Hearing voices.

## **Is pepper spray less effective on someone who is suffering from mental illness?**

Pepper spray may be less effective on anyone who is experiencing an adrenalin pump. This is not restricted to persons diagnosed with a mental illness.

## **Does a person suffering from mental illness have superhuman strength?**

The supposed superhuman strength comes from the adrenalin pump and you do not have to be diagnosed with a mental disorder for this to occur.

For more information on these topics and answers to more questions, check out *Not Just Another Call* at [www.oacp.on.ca/uploads/news/CAMH\\_final.pdf](http://www.oacp.on.ca/uploads/news/CAMH_final.pdf)

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# Hallucinations and Delusions: How to Respond

## Hallucinations and Delusions

Police officers, emergency workers, family members and friends, may at some time have to respond to a person in mental health crisis. It can sometimes be a frightening experience not understanding what is causing the person in crisis to act the way they do and not knowing how to respond most effectively. The most important tool you can have is information: a basic understanding of mental illness and the symptoms of different mental illnesses and, perhaps most importantly, what the person in a mental health crisis is experiencing and how you can best respond to help them.

Hallucinations and delusions can be symptoms of a number of different mental illnesses. Some types of drugs (legal or illegal) may also induce hallucinations and delusions. Hallucinations are when a person senses (sees, hears, feels, smells, tastes) things that do not exist. Delusions are when a person holds personal beliefs that are false, inaccurate or exaggerated (e.g., that people are after them, that they are royalty or a spy or a specific well-known person such as Elvis Presley or the Pope).

## Recognizing and Understanding Hallucinations

The most frequent hallucination involves hearing, and often includes hearing voices which tell the person to do something (known as command hallucinations). You may recognize that the person is suffering from auditory (hearing) hallucinations when he or she appears preoccupied and unaware of their surroundings, talks to him or herself, has difficulty understanding or following conversations, and misinterprets the words and actions of others. The person may also isolate themselves or use radio or other sounds to tune out the voices.

A person experiencing other types of hallucination (visual, tactile, smell, taste) are usually identifiable by the person's interaction with the hallucination: visual focus on something you cannot see, touching, scratching or brushing things off themselves, sniffing or holding their nose, spitting out food, etc., when there is no apparent reason to do so.

## Responding to Hallucinations

A person experiencing hallucinations may be very frightened by them and needs your help in establishing a calm environment. Do not invade personal space or touch them without permission. Speak slowly, calmly and quietly, using simple concrete language. Be patient – it may take the person longer to process information. Reduce stimuli: turn off radios, televisions, bright lights, or anything else that may cause stress. Address the person by name or, if you don't know it, ask them how they would like to be addressed.

The immediate goal of your response should be to help the person focus on reality rather than the hallucination. Do not pretend you also experience the hallucination, but do not try to convince the person that the hallucination does not exist: it does exist to them. Ask questions such as: "Are you hearing voices other than mine? What are they telling you? What do you see/feel/taste/smell?" Tell the person: "I don't hear the voices (see what you see, etc.), but I believe that you do." Instruct the person to listen to your voice and not the other voice(s), or to look at you rather than whatever else they are seeing.

A person experiencing hallucinations needs treatment, and should be taken to a hospital or mental health service provider. Reassure the person that you want to help them, and explain who you are, what you are doing and why. If other people arrive, explain who they are, that they are there to help, and how they are going to help. The person needs to understand what is going on in order to reduce stress and confusion, which can increase hallucinations.

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## Recognizing and Understanding Delusions

Some delusions may seem relatively harmless in the short term, such as delusions of being a rock star, royalty, or a religious figure. These delusions can be potentially harmful, however, if they include or lead to delusions of having special abilities or characteristics such as flying, walking on water, or invincibility. Most common, however, are paranoid delusions: the belief that someone or something is going to harm the person in some way.

Paranoid delusions are usually evidenced by extreme suspicion, fear, isolation, insomnia (for fear of being harmed while asleep), avoidance of food and/or medication (for fear of poisoning), and sometimes violent actions. A person experiencing paranoid delusions has extreme difficulty trusting others, will frequently misinterpret others' words and actions, and experience ordinary things in his or her environment as a threat.

## Responding to Delusions

Until you know the content and context of the delusion, it is important to keep yourself safe from potentially violent reactions, and provide a comfort zone for the person experiencing delusions. Keep a safe distance or some barrier (such as a piece of furniture) between the two of you. Do not touch the person without permission. Position yourself at the person's level if it is safe to do so. Do not whisper or laugh, as this may be misunderstood and may increase paranoia. Remember that someone experiencing delusions may not always be honest about what they think or believe; especially if their delusions are paranoid, the person may not trust you enough to be honest.

Ask questions about what the delusion is all about, particularly any elements which indicate the potential for harming self or others (e.g. "Are you having any thoughts about hurting yourself or others?") Do not attack delusions or try to argue or convince the person that the thoughts are wrong or not real. Nor should you indicate that you believe in the delusion; instead explain "I believe you are telling me this is as you see it." Do not smile or shake your head when the person speaks – this may lead to misunderstanding.

Ask whether there is anything you can do to make the person feel more comfortable, and explain your intentions before you act. Police officers and other persons in uniform must realize the potentially intimidating impact of the uniform on someone suffering from paranoid delusions. It is important to assure the person that they are safe, that you are not going to harm them, that the uniform and equipment you carry are for protecting them and that is what you want to do – protect them. Earning trust in order to help the person get treatment is the goal, while at the same time maintaining safety for all.

Hallucinations and delusions can be frightening for both the person experiencing them and for those who come in contact with that person, including police officers. Maintaining safety for everyone, and providing a calm, clear and persistent message that you want to help the person in need, while at the same time giving that person the time and space to hear and respond to that message, is the best response you can give as first responder.



CANADIAN MENTAL  
HEALTH ASSOCIATION  
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POUR LA SANTÉ MENTALE  
**BC DIVISION**

# Mental Illness and Substance Use Disorders: Key Issues

## Concurrent Disorders/Dual Diagnosis

The term 'concurrent disorders' – also known as 'dual diagnosis' – refers to the combination of a mental illness and substance use disorder. The issue of substance abuse is complex because the substance itself is not the problem so much as a person's relation to it: drinking a glass of wine or taking a painkiller on occasion can be beneficial or at least unproblematic. It is when the substance use creates life problems and/or becomes compulsive that it becomes an identifiable disorder – it is a matter of degree.

Concurrent disorders is much more widespread than many people realize: studies show that over 50% of persons with mental illness abuse illegal drugs or alcohol, compared to 15% of the general population. The relationship can be complex. Mental health problems can be a risk factor for substance use problems, and substance abuse can be a risk factor for mental illness. In the first case, a person may self-medicate with alcohol or drugs to temporarily relieve symptoms (e.g. insomnia, anxiety, racing thought patterns, etc.) of depression, anxiety disorder or other mental illness. In the second case, substance misuse or withdrawal can induce or worsen psychiatric symptoms such as depression, hallucinations or paranoid thought patterns.

There are also common risk factors for mental illness and substance abuse: poverty or unstable income, problems at work or school, lack of decent housing, family history, past trauma or abuse, and biological or genetic factors.

## Impact of Concurrent Disorders

The combination of these life issues, mental illness, and substance abuse has a devastating effect as each contributes to the occurrence of the others in a vicious cycle. Persons with concurrent disorders tend to become marginalized members of society, often homeless and penniless.

At the same time, persons with concurrent disorders are more likely to come to the attention of police because of poverty, homelessness and behavioural issues. The substance abuse is often much more visible and identifiable, and may mask the presence of mental illness. Because the substance being abused may be illegal, or the behaviour resulting from concurrent disorders may be illegal and attributed to substance abuse, a person with concurrent disorders is more likely to receive criminal sanctions than treatment. Once the person has been criminalized in this way, law enforcement and the criminal justice system are more likely to look only at the criminality of behaviour rather than consider the possibility of mental illness as a contributing factor. In this way, persons with concurrent disorders may be labelled as 'bad' (criminals) and requiring punishment rather than 'ill' (suffering from disorders) and requiring treatment.

## Treatment of Concurrent Disorders

Persons with mental illness usually have some access to treatment if they are willing and able to seek help. There are also a wide range of treatment and support options for people with substance use problems. Access to treatment for persons with concurrent disorders is much more complicated, both in terms of diagnosis and effective treatment. Concurrent disorders may be misdiagnosed as a single disorder due to the commonality of symptoms between mental illness and substance abuse.

Even a correct diagnosis of concurrent disorders presents a hurdle for treatment. Treatment programs for mental illness may refuse admission to a person with an active drug or alcohol problem, and vice versa. At the same time, the treatment for one may not be appropriate in relation to the other: for example, a confrontational approach sometimes used in substance abuse treatment can be traumatic for a person with mental illness.

This can leave a person with concurrent disorders out in the cold if specific concurrent disorder treatment is not readily available, and there are still relatively few such specialized programs.

For police officers, who often come into contact with persons with mental illness and substance abuse disorders, it is important to recognize that a person may have a mental illness as well as substance use disorder, that the person needs treatment rather than punishment, and that accessing appropriate treatment for concurrent disorders is a challenge for those who need it. Increased awareness about concurrent disorders and the unique challenges in recognizing, diagnosing and treating them – as well as the multitude of problems faced by those suffering from them – is a first step to better and more appropriate responses and support.

Building Capacity: Mental Health and Police Project (BC:MHAPP) is a project of the Canadian Mental Health Association's BC Division, with a goal of improving interactions between police, emergency services, and people with mental illness. This fact sheet is produced as part of the BC:MHAPP Project. These fact sheets have been supported by gaming revenue from the Province of British Columbia. This project is supported by the Vancouver Foundation and the Provincial Health Services Authority. This fact sheet is one in a series of eight:

- Police and Mental Illness: Increased Interactions
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- Mental Health Crises: Frequently Asked Questions
- Hallucinations and Delusions: How to Respond
- Mental Illness and Substance Use Disorders: Key Issues
- Suicidal Behaviour: How to Respond

For more information on this project, please contact Camia Weaver, Provincial Co-ordinator for BC:MHAPP, CMHA BC Division, at [info@cmha-bc.org](mailto:info@cmha-bc.org) or 604-688-3234.



# Suicidal Behaviour: How to Respond

## Overview

One of the most traumatic experiences anyone can experience is witnessing the unnatural death of another person, especially by suicide. An even more traumatic experience for a police officer is when that person commits suicide by doing something that causes a lethal threat to someone, forcing the officer to shoot him or her: this is known as 'suicide by cop,' or victim-precipitated homicide.

Suicide by cop is a controversial topic in our society, but whereas it is clear that in some cases a fatal police shooting is in fact suicide, the questions go beyond whether lethal force was necessary. The first questions are "Did that person really mean to die? Could their death have been prevented?" Whatever the means of achieving suicide, the issue really is: how do you prevent it?

Suicide is the last resort for a person who feels there are no other alternatives in their life to escape the pain they feel. The best way of preventing suicide is for all to understand risk indicators for suicide, as well as the signs of, and the best responses to, suicidal behaviour.

High-risk indicators for suicide include:

- being single or divorced, and without strong family ties
- history or family history of suicidal behaviour or psychiatric illness
- substance abuse
- age (elderly or youth)

The signs of suicidal behaviour include:

- depression, expressions of hopelessness or negative self-image
- preoccupation with death
- talking or joking about suicide; talking about what it would be like to die
- black and white thinking
- self-harming (e.g. cutting oneself) or risk-taking behaviour
- self neglect (hygiene)
- withdrawal from relationships or commitments followed by positive behaviour
- preparations for the end, as in 'tidying up of loose ends'
- hearing voices instructing them to do something dangerous

## What to do if someone you know or have contact with shows signs of being suicidal

Don't be afraid to ask directly: "Are you feeling like you want to kill yourself?" If the answer is yes, ask questions such as: "How would you do it? When and where were you planning to do it? Have you made preparations (such as saving pills)? Have you tried to kill yourself before? Are voices telling you to kill yourself?"

If the person gives indications of suicidal behaviour or thoughts, take it seriously. It is important to know that people who talk about suicide DO commit suicide. Up to 90% of people who have committed suicide were suffering from depression, a substance use disorder, and/or another mental illness at the time. Suicide is often the last choice when a person is no longer able to cope with the effects of these illnesses.

Say to the person “It’s reasonable to feel as you feel, but I can help you find other solutions.” A suicidal person feels hopeless and needs to have a sense of hope, and believe that there is a way to be helped. Affirm the person’s sense of self-worth, which is at a low point – tell them that they are important, and you do not want them to die.

Most importantly, do not leave the person alone. Phone your local emergency number or crisis line, or take them to the hospital – even if you have promised to keep confidential their statements to you: this is a matter of life and death.

When police officers encounter a suicidal person, it is usually in circumstances where the threat is self-directed rather than outwardly directed. In those cases where a person seems to be trying to instigate violence against themselves by threatening to harm others, it can be difficult to identify the suicidal nature of their actions.

In either case, engaging the person in talking about what they are experiencing is the best way to deal with the situation, although this may not be possible when the person is in a state of high anxiety or psychosis. In such cases, some degree of force may be necessary to prevent harm. The use of non-lethal but incapacitating force – such as mace, tear gas, beanbag shotgun, rubber bullets or taser – is the preferred response of police when negotiation fails. Unfortunately, these tools are not always immediately available to all officers who find themselves in this situation.

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