

Colorado Mental Health Training Course for Law Enforcement and Corrections Officers

Instructor's Guide

This Instructor's Guide was designed to assist the instructors in developing an appropriate training plan to accomplish the course goal and teach the learning objectives and information.

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(NIC Technical Assistance No. 01 A1011)

Richard K. Sherman, MS prepared this training guide, with the assistance of the Mental Health Center of Boulder County, Inc. and the Boulder Police Department

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U. S. Department of Justice

National Institute of Corrections

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Longmont, Colorado 80501*

Re: NIC TA 01A1011

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The resource person who provided the on-site technical assistance did so through a cooperative agreement, at the request of the Twentieth Judicial District of Colorado, and through the coordination of the National Institute of Corrections. The direct on-site assistance and this subsequent report are intended to assist the Twentieth Judicial District of Colorado in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Richard Sherman. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

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**Portions of this training manual curriculum were obtained and adopted
from the following sources:**

Police Recruit Mental Health Training Program, 1990.
New York State

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Law Enforcement Training Liability Issues

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Goal of Course: This course was designed to educate law enforcement and corrections officers about issues related to interactions with persons who suffer from mental disorders. It is intended to help officers develop an understanding of mental disorders and skills to identify and provide the most safe, effective, and compassionate response possible to police situations involving people in a mental health crises.

Target Population: Colorado law enforcement and corrections officers.

Length of Course: Eight hours.

Materials Required: Overhead projector or computer projector, Powerpoint slides, VCR and television, participant manual.

Instructor Qualifications: Instructors for this course should be knowledgeable about human behavior and have good communication skills. A thorough knowledge about mental disorders, mental health laws, as well as an understanding of the mental health and the criminal justice systems is anticipated. Because of the scope and nature of this course it is recommended that it be team taught by persons with law enforcement, mental health, and legal training..

Training Format: The format for this training is based on the principle that it is most effectively presented by a combination of law enforcement, mental health, and legal professionals, and persons with mental illness and their family members. The training is designed to be taught by a team of professional trainers for each of those respective fields and lay persons who have experienced mental illness. Given the limitations of the length of time this curriculum is designed for, it is presented in mostly a didactic fashion. It is important for participants to have plenty of opportunity to ask questions and interact with the instructors. Instructors should contribute their own knowledge and experience whenever appropriate. Identifying misperceptions, fears, and biases regarding persons who have mental disorders is important to the learning experience.

Training Content: The content of this training is based upon the fundamental principle that trained officers with an understanding of mental disorders, assessment, and intervention techniques can significantly reduce the level of danger to officers and others. The content recognizes that officers will often be the first, and sometimes the only, responders to a crisis situation involving a person with a mental disorder. A coordinated law enforcement and mental health approach to managing these situations will enhance safety for everyone involved and result in better outcomes.

Instructor Preparation for Training: This manual has been designed to facilitate the delivery of this training. It is, however, critical that instructors prepare for its implementation in several ways. Instructors are encouraged to use their own experience, knowledge, teaching style, and creativity in the delivery of this curriculum. Some of the tasks required before hand include:

1. Meeting with the instructor team to develop a plan for conducting the training. This includes establishing a training schedule and responsibilities for each section. Interaction between the instructors during the training, drawing on their own experiences and knowledge to provide examples is most effective.
2. The training requires instructors to adapt the content, especially in terms of procedures and community resources, to their local jurisdiction.
3. A thorough review of the manual and accompanying audio-visual aids prior to the training is important.
4. Instructors should be familiar with the Powerpoint slide presentation that is designed to accompany this manual.

Disclaimer: This training is for department use only and does not apply in any civil or criminal proceedings. Nothing in this training should be construed as a creation of a higher legal standard of safety or care in an evidentiary sense with respect to third party claims. Violations of the activities or behaviors recommended in this training might form the basis of departmental administrative sanctions. Violations of law will form the basis for civil or criminal sanctions in a recognized judicial setting.

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SECTION I

INTRODUCTION

I. Introductions:

The instructors should begin the class by introducing themselves to the class. It is important for the instructors to provide a brief description of their professional background, education, and experience.

If time permits class members should be asked to introduce themselves as well. Each may be asked to provide a brief background that includes:

1. Name
2. Rank
3. Department
4. Years of service
5. Experience or education
6. Special duties and assignments

II. Background

The instructors should provide the background and context for the training. This may vary from one community to the next. Some general information related to law enforcement and persons with mental disorders is listed below.

- A. Law Enforcement and Corrections Officers frequently come into contact with persons who suffer from mental disorders.
 1. Studies have shown that people with mental disorders are at a greater risk of arrest than the general population.
 2. 7% of police contacts involve persons with mental illness who are in crises as reported by major police departments.
 3. A survey of 450 police officers in three U.S. cities noted that within the month prior to the survey police responded to an average of six calls involving persons with mental illness in crises.
 4. Most national studies show that between 6 and 15 percent of the population who book into a jail have a diagnosable major mental disorder including:
 - a. Schizophrenia
 - b. Bipolar disorder

- c. Major depression
 - d. Delusional disorder
5. The criminal justice system as a whole has continued to increase with increasing numbers of persons under some sort of criminal justice supervision as a result of an arrest and subsequent conviction. Average daily populations of jails, including juveniles, grew from 227,541 in 1983 to 607,978 in 1999. A growth of 167 %.
6. Concurrently the mental health system has downsized in-patient facilities:
- a. Mid 1950's there were about 500,000 people in state mental hospital nationwide in the United States.
 - b. In the year 2000 there were about 62,000 people in state hospitals nationwide.
7. Some theories propose and some research supports the concept of "trans-institutionalization": As you decrease the number of beds in one system, you will increase the number of beds in the other system.
- a. A lot of research has supported the theory that less hospital beds result in persons with mental disorders coming into more contact with law enforcement and the criminal justice system.
 - b. Independent of this, more community based treatment means that persons with mental illness will have more opportunity to come into contact with law enforcement.
8. There are a number of reasons why persons with mental illness come into contact with law enforcement. These include:
- a. The symptoms of their illnesses, which sometimes cause them to act in bizarre and socially unacceptable ways.
 - b. The stigma associated with the illnesses that sometimes cause others to be fearful of them.
 - c. Lack of Police training
 - d. Public safety initiatives targeting nuisance crimes
- B. Most law enforcement and correctional officers receive minimal training in interacting with and managing situations involving persons with mental disorders.

(ASK MEMBERS OF THE CLASS HOW MUCH TRAINING THEY HAVE RECEIVED IN THIS AREA.)

III. The GOAL of this course is:

- A. To help educate law enforcement and corrections officers about issues related to interactions with persons who suffer from mental disorders.
- B. It is intended to help officers develop an understanding of mental disorders.
- C. It is intended to help officers develop skills to identify and provide the most safe, effective, and compassionate response possible to police situations involving people in a mental health crises.

IV. Overview of Training

- A. The content of this training:
 - 1. Is based upon the fundamental principle that trained officers, with an understanding of
 - a. Mental disorders
 - b. Assessment
 - c. Intervention techniques
 - d. Results in significant reduction of the level of danger to officers and others.
 - 2. The content recognizes that officers will often be the first, and sometimes the only, responders to a crisis situation involving a person with a mental disorder.
 - 3. A coordinated law enforcement and mental health approach to managing these situations will enhance safety for everyone involved and result in better outcomes.
- B. The information presented will include:
 - 1. Important facts about mental illness.
 - 2. Help identify the behavioral indicators of mental illness.
 - 3. Provide information about the mental health law, including situations when you must transport a person with mental illness to a hospital.

4. Provide information to help you assess the level of dangerousness in a situation involving a person with a mental illness.
5. Help you to intervene in these situations in a manner that enhances safety.

V. Disclaimer

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SECTION II

MENTAL DISORDERS

I. Definition and Causes of Mental Illness

A. Mental illness is a number of disorders which:

1. Is primarily a brain disorder.
2. Creates problems with feeling, thinking and perception.
3. Affects a person's behavior by involuntarily causing bizarre and/or inappropriate behavior.
4. Can be short term (acute) or long term (chronic).
5. Can occur at anytime in a person's life.

B. Mental disorders are conceptualized as:

1. Clinically significant behavioral or psychological syndrome or pattern
2. Associated with distress (e.g., a painful symptom), or
3. With significant increased risk of suffering death, pain, disability, or an important loss of freedom.
4. Not an expectable and culturally sanctioned response to a particular event (e.g., death of a spouse).
5. Whatever original cause must currently be a manifestation of a behavioral, psychological, or biological dysfunction in the individual.

C. The cause of mental illnesses is believed to be rooted in:

1. Biology or genetics, which heavily influences predisposition to the development of a disorder.
2. Psychology, which impacts the onset of a disorder.
3. Sociology, which significantly influences the course of the illness.
4. This Bio-Psycho-Social Model can be illustrated like this:

	Predisposition	Onset	Course
Biological	X		
Psychological		X	
Sociological			X

D. The result of this interplay of multiple influences on mental illness is that there is no clear boundary between actions based on

1. Personal choice
2. Social difficulties
3. Psychological distress
4. Biological disease

E. Multiple actions simultaneously influence the actions of an individual.

II. Categories of Mental Disorders

A. Mental disorders are categorized based upon a number of factors including:

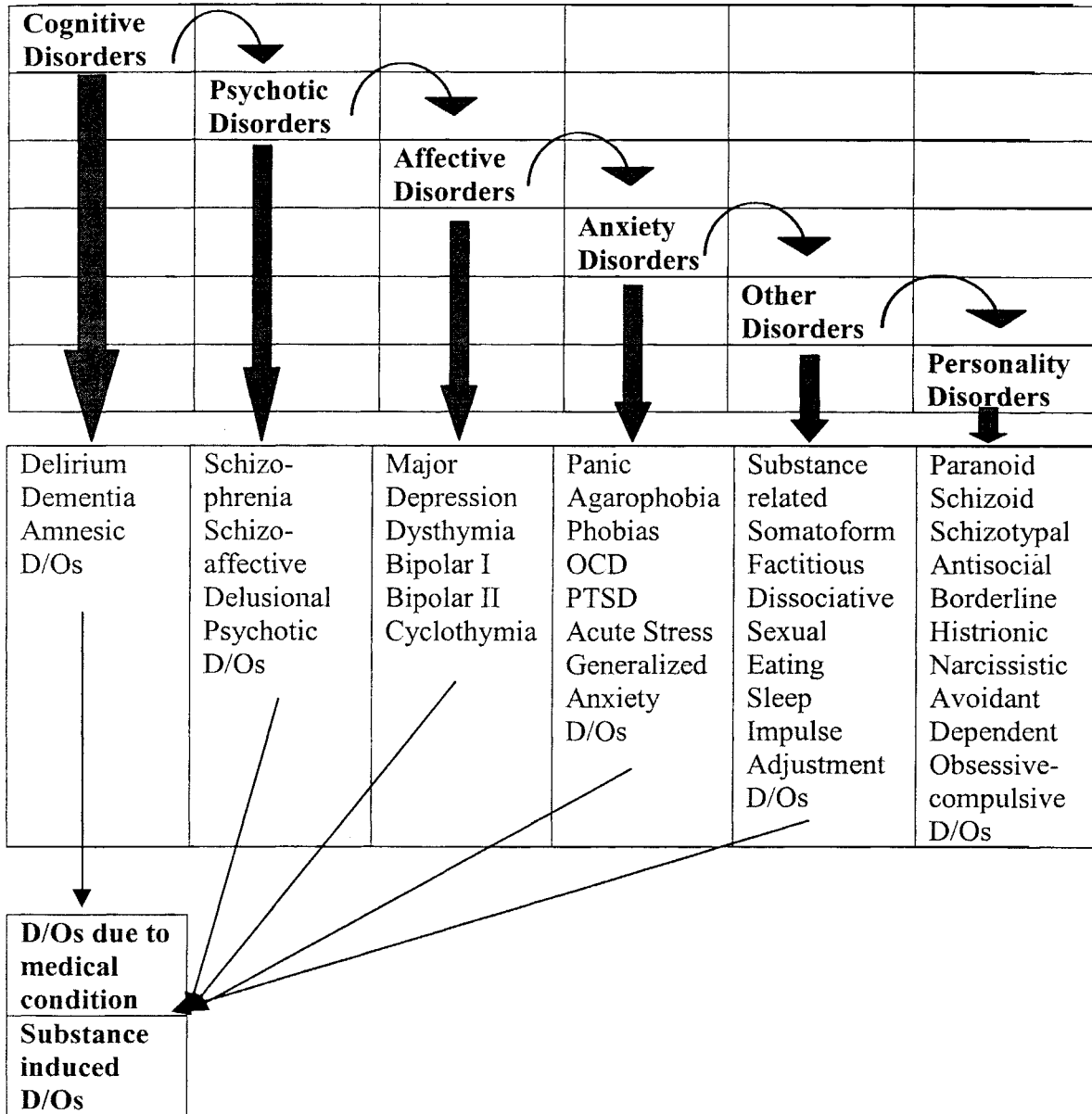
1. Distress;
2. Dyscontrol;
3. Disability;
4. Inflexibility;
5. Irrationality;
6. Syndromal pattern;
7. Etiology;
8. Statistical deviation.

B. Mental disorders are categorized into diagnosis with very specific criteria

1. DSM-IV
2. Show example of specific criteria for Schizophrenia, paranoid type.

- C. The DSM-IV diagnostic system lends itself to hierarchy for consideration of which disorders take precedence over others for the purposes of diagnosis and treatment. This hierarchy's categories creates a cascade of broad diagnostic categories that looks like this:

Diagram of diagnostic cascade (Adapted from Basic Psychiatric Life Support, Portland Police Version, July 10, 1995. Written by Rupert Goetz, MD. Used with permission of the author):



1. Generally, the hierarchy implies that treatment must be directed towards diagnoses higher in the model first.
2. The more “biological” or “organic” a disorder, the more likely it is to be found on the left.
3. The more “psychological” or “functional” a disorder, the more likely it is to be found on the right.

D. Diagnostic Categories

1. Cognitive disorders

a. All Cognitive disorders affect the brain's ability to function. Can be considered "hardware" problems in that they involve physical changes to the nervous system.

b. Delirium

1) A medical emergency.

2) Characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention.

3) Indicated by disorientation and severely disorganized thought process.

4) Can look like intoxication.

5) Generally caused by a toxin or substance in the body or not enough oxygen to the brain. Commonly associated with organ failure.

6) Risk Factors for delirium:

a) Age over 70

b) Prior history of depression

c) Prior history of dementia

d) History of stroke, epilepsy

e) Alcohol abuse within a month

f) Withdrawal from alcohol

g) Use of psychoactive medications

h) Drug overdose or illicit drug abuse within a week

i) Renal failure (creatinine > 2.0 mg/dl)

j) Liver disease (bilirubin > 2.0 mg/dl)

k) History of Congestive heart failure

- l) Cardiogenic or septic shock
- m) Malnutrition
- n) Visual or hearing impairment
- o) Hypothermia or fever

7) Substances that can cause delirium through intoxication or withdrawal:

Drugs of Abuse	Medications	Toxins
Alcohol	Anesthetics	Anticholinesterase
Cannabis	Analgesics	Organophosphate insecticides
Cocaine	Antiasthmatic agents	Carbon monoxide
Hallucinogens	Anticonvulsants	Carbon dioxide
Inhalants	Antihypertensives and Cardiovascular	Volatile substances (e.g. fuel)
Opioids	Antimicrobials	Organic solvents
Phencyclidine	Antiparkinsonian medication	
Sedatives	Corticosteroids	
Hypnotics	Gastrointestinal medications (e.g. H ₂ blockers)	
Other	Muscle relaxants	
	Immunosuppressive agents	
	Lithium and psychotropic medications with anticholinergic properties	

American Psychiatric Association. Practice Guidelines for the Treatment of Patients with Delirium. Am J Psychiatry 1999; 156(5 suppl): 1-20.

c. Dementia

- 1) Characterized by loss of memory PLUS one or more of these:
 - a) Aphasia – loss of language.
 - b) Apraxia – loss of knowledge of how to do things (i.e. tie shoes)..
 - c) Agnosia – loss of ability to recognize things and what you do with them

- d) Loss of higher executive functioning - ability to plan and organize (one of the first things to go).
- 2) Some memory loss is normal part of aging process, usually occurring in the forties with word finding or retrieval difficulties.
 - 3) The “pathogenesis” or cause of all dementia is abnormal loss of brain tissue.
 - a) Most Common cause is Alzheimer Disease thought to be caused by an abnormal building up of a protein, Beta-amyloid, in neuron that kills the cell.
 - b) Second most common cause is vascular dementia or multi-infarct dementia, or mini-strokes. Possibly due to bleeds at the very small capillary level.
 - c) Other possible causes can be:
 - i. Drugs and toxins
 - ii. Brain masses (tumors)
 - iii. Hypoxia
 - iv. Trauma
 - v. Neurodegenerative disorders (Parkinson’s disease)
 - vi. Infections
 - vii. Nutritional disorders (i.e. thiamin, B12, folate)
 - viii. Metabolic disease (i.e. thyroid)
 - ix. Inflammatory disease (i.e. Lupus)
 - x. Pseudo dementia – secondary to depression
 - d. Amnesic disorders
 - 1) Characterized by loss of memory
 - 2) Typically caused by something organic or physical (i.e. intoxication).

2. Psychotic Disorders

- a. Illnesses which affect the individuals ability to distinguish real from not real or a “break from reality”.
- b. Characterized by:

- 1) Thought process disturbances such as “loosening of associations” and “flight of ideas”.
 - 2) Thought content disturbances such as delusions or false beliefs.
 - 3) Perceptual disturbances such as hallucinations (hearing voices, seeing things that are not there).
- c. Treatment regime:
- 1) Usually involves the use of medications to alter the neurotransmitters in the brain. These medications are called neuroleptic or antipsychotic medication.
 - 2) Supportive therapy.
 - 3) Hospitalization during acute periods of illness.
 - 4) Outpatient follow-up to administer and monitor medication.
 - 5) Day treatment or group home programs for residential care.
 - 6) Psychiatric rehabilitation programs involving recreation, group, and vocational training and support.
- d. These disorders are considered to be biological brain diseases.
- e. Substance use or exposure to toxins can induce some psychotic symptoms.
3. Affective disorders
- a. Illnesses that affect the mood which may be:
- 1) Depressed
 - 2) Elevated (Manic)
 - 3) Irritable
- b. Mood changes may be accompanied by psychotic symptoms as well.
- c. Treatment regime:
- 1) Involves the use of medication to stabilize the mood and treat the psychotic symptoms if present. These medications are referred to as “antidepressants” or “mood stabilizers”.

- 2) Hospitalization may be necessary during acute phases of the illness especially if risk of suicide is present.
 - 3) Antipsychotic medication may also be necessary if psychotic symptoms occur.
 - 4) Supportive psychotherapy is often used in conjunction with medication.
 - 5) Outpatient follow-up, day treatment, group homes, and psychiatric rehabilitation programs may also be used.
4. Anxiety disorders:
- a. Characterized by excessive and inappropriate worry, anxiety, and panic.
 - b. Examples include phobias, panic disorders, post traumatic stress disorder, obsessive compulsive disorder, and generalized anxiety disorder.
 - c. Treatment regime:
 - 1) Involves the use of medications such as antianxiety or antidepressant agents.
 - 2) Insight oriented psychotherapy and behavioral therapy are often used as well.
5. Other disorders:
- a. Includes substance abuse disorders including substance dependence, impulse related, and adjustment disorders.
 - b. Also includes disorders associated with sexual functioning.
 - c. These disorders can progress to crises and even emergency levels.
 - d. Treatment regimes:
 - 1) May involve the use of medications.
 - 2) Individual and group insight oriented, cognitive (focusing on thought process), and behavioral psychotherapy approaches used as well.
6. Personality disorders:
- a. Characterized by problems associated with a persons overall coping abilities.

- b. Characterized by long-standing (since adolescence) and pervasive (affecting all aspects of the persons life) pattern of maladaptive (causing personal distress or impaired functioning) behavior.
 - c. These disorders are divided into three groups or clusters:
 - 1) Cluster A: Characterized by odd or eccentric behavior.
 - 2) Cluster B: Characterized by dramatic, moody, and erratic behavior.
 - 3) Cluster C: Characterized by anxious and fearful behavior.
 - d. The DSM IV considers these more functional or psychological disorders “Axis II” disorders, to distinguish them from the Axis I disorders described above.
 - e. Treatment regime:
 - 1) Usually involves coordinated psychotherapeutic and social interventions.
 - 2) May involve the use of medication to treat concurrent symptoms such as anti anxiety agents for Cluster C disorders or antipsychotic medication during acute episodes involving psychotic symptoms.
7. One can think of the disorders on several continuums that interact with each other:
- a. Axis I and Axis II disorders:
 - 1) Axis I disorders are the major psychiatric disorders that most people associate with mental illness.
 - 2) Axis II disorders are personality disorders and mental retardation.
 - b. Thought, Mood, and Anxiety continuum.
 - c. Biological to Psychological (or organic to functional) continuum.
 - d. Chart of the various continuums:

	Thought Disorders	Mood Disorders	Anxiety Disorders	
Axis I Disorders	Schizophrenia Delusional D/O Schizo-	Depression Bipolar D/O Affective D/O	GAD PTSD Panic/Phobias	Biological
Axis II Disorders	Cluster A P/D Paranoid Schizotypal Schizoid	Cluster B P/D Antisocial Borderline Histrionic Narcissistic	Cluster C P/D Avoidant Dependent OCD	Functional or Psychological

- e. As the arrows in the chart illustrates, many of the disorders or individual patients will demonstrate symptoms in more than one category (i.e. Schizoaffective disorder.).

III. Severe Mental Disorders of Childhood

A. Attention deficit hyperactivity disorder (ADHD)

1. Previously referred to as Attention deficit disorder (ADD).
2. Three types defined in DSM IV:
 - a. Hyperactive/impulsive type
 - b. Inattentive type
 - c. Combined type
3. Prevalence:
 - a. 5% of children in United States have ADHD.
 - b. Boys have it more frequently than girls by a ratio of 3:1. Although female population may be under diagnosed due to propensity for type of ADHD that they develop.
 - 1) Boys more likely to have the Hyperactive/impulsive type.

- 2) Girls more likely to have the inattentive type, may not be seen as a problem.
4. Frequently co-morbid (occurring along with) behavior disorders, such as:
 - a. Oppositional defiant disorder (ODD)
 - b. Conduct disorder
 - c. Substance abuse
 - d. Impulse control disorders
5. Characterized by:
 - a. Impulsiveness
 - b. Hyperactivity
 - c. Difficulty concentrating and inattention
 - d. Distractibility
 - e. Forgetfulness
 - f. Poor school performance
 - g. Over-talkativeness
 - h. High stimulation, risky behaviors
6. Treatment regime:
 - a. No cure, can only manage symptoms with medications.
 - b. Medications are generally short acting stimulants (i.e. Ritalin). As the medication metabolizes, symptoms reoccur until another dose is taken.
 - c. Three newer medications are longer acting stimulants due to their delivery or release system once in the body:
 - 1) Adderall
 - 2) Metadate
 - 3) Concerta

- d. Paradox of stimulant helping to “slow down” hyperactivity probably explained by stimulation of an inhibitory dopamine system and the stimulation of the Frontal cortex which helps with executive functions such as concentration and organization.
- e. Treatment with stimulants has been shown to decrease propensity towards substance abuse. This effect is likely the result of decreased impulsivity and self-medication.

7. Prognosis (Outcomes)

- a. About 30 % grow out of it, although this number may be lower.
- b. 30 % grow out of some of the symptoms or accommodate to them by picking jobs, careers, and life styles that tolerate the symptoms.
- c. 40% continue to develop symptoms and co-morbid disorders such as substance abuse.
- d. Close to a quarter may go on to develop Bipolar disorder.

B. Oppositional defiant disorder (ODD)

1. Two Types:

- a. Childhood onset – poorer prognosis. Symptoms usually start by age 8.
- b. Adolescent onset –

2. Characterized by characteristics you would expect from the name of the disorder:

- a. Oppositional and defiant;
- b. Tells lies;
- c. Cheats;
- d. Vindictive;
- e. Spiteful;
- f. Loses temper;
- g. Talks back;

- h. May be good in one setting (i.e. home) and bad in another (i.e. school). Or may be the same in all settings.
- i. Usually starts off with mild symptoms, as children grow older they may develop more severe symptoms.

4. Treatment- Best approach is prevention/early intervention:

- 1) Target kids and families at risk early.
- 2) Treat co-morbid symptoms.

5. Etiology (cause) is unclear. May have both biological and social causes.

- a. Parenting problems may be associated with inconsistent limit setting and affect regulation.
- b. Above problem with parenting may also be the result of the difficulty of raising these kids. Kids may be biologically “hard wired” for the disorder.

5. Prognosis:

- a. Majority of kids grow out of it.
- b. 2% to 16% develop Conduct disorder.

C. Conduct Disorder

1. Two types:

- a. Childhood –Onset type – symptoms occur prior to age 10. Poorer prognosis.
- b. Adolescent-Onset type – symptoms occur after age 10.

2. Prevalence –

- a. Appears to have increased over last decade.
- b. May be higher in urban than in rural settings.
- c. Males under age of 18 – rates range from 6% to 16%.
- d. Females under the age of 18 – rates range from 2% to 9%.

3. Frequently co-morbid with:
 - a. ADHD
 - b. Mood disorders – sometimes symptoms of ODD abate with treatment of mood disorder symptoms.
 - c. Substance abuse.
 - d. PTSD.
4. Characteristics –Essential feature is a repetitive and persistent pattern of behavior in which the basics rights of others or major age-appropriate societal norms and rules are violated. Four main grouping of behavior:
 - a. Aggressive conduct that causes or threatens physical harm to other people or animals. Males more aggressive then females
 - b. In adolescence may see fighting, forced sex, stealing, vandalism, truancy, and confrontational behavior. More common in males.
 - c. Non-aggressive conduct that causes property loss or damage.
 - d. Deceitfulness or theft.
 - e. Serious violations of rules.
5. Treatment is difficult. Generally involves “multi-systemic therapy” – all facets of life addressed in coordinated fashion (i.e. P.O., school, mental health, parents, social services, etc.).
 - a. High level of coordination required is very difficult particularly if parents are not cooperative as they may resent “system” involvement.
 - b. Can medicate some of the co-morbid symptoms such as ADHD, depression and aggression in some cases.
 - c. Controversy exists regarding incarcerating children with conduct disorder, as they do not adjust their behavior in an incarcerated setting so it is not rehabilitative. Removal from home may be more a deterrent than treatment.
6. Prognosis –
 - a. In majority of cases the disorder remits by adulthood.

- b. Many grow up to develop Antisocial personality disorder.
7. Etiology unclear. May have both biological and social causes.
- a. Kids may require high stimulation due to low levels of dopamine.
 - b. May lack system for feelings of empathy and anxiousness so they are not deterred from disordered activity.
- D. Mood disorders:
1. Includes Depression and Bipolar disorders.
 2. Prevalence:
 - a. Depression: About 1% in childhood raising to adult rates in teen years.
 - b. Bipolar: Rare in childhood, reaching adult rates in teen years.
 3. Co-morbid with Conduct disorders, substance abuse, etc.
 4. Characteristics of Depression:
 - a. Irritability;
 - b. Depressed mood;
 - c. Socially isolative;
 - d. Problems with sleep or appetite;
 - e. Death wishes and suicidality:
 - 1) High mortality rate in adolescence.
 - 2) Suicide is the second leading cause of death in adolescents (motor vehicle accidents is first leading cause of death).
 - 3) Suicide attempts by boys are more lethal attempts. More boys complete suicide than girls do.
 - 4) Girls attempt more often.
 - 5) Suicide rare in prepubescent children.
 - 6) 10% of people with depression commit suicide.

- 7) 15% of people with bipolar disorder commit suicide.
 - 8) Adolescent levels of suicide are higher. They approach adult levels, as the child grows older.
- f. Poor grades in school.
 - g. Loss of interest in sports, friends, and hobbies.
5. Etiology:
- a. Bipolar disorder is difficult to diagnosis in children because many of the symptoms resemble other disorders (i.e. ADHD). For example three symptoms shared with ADHD are:
 - 1) Hyperactivity;
 - 2) Impulsivity;
 - 3) Talkativeness.
 - b. More likely biological in nature.
6. Treatment is aimed ad symptoms of mood disorder first as the stimulants that treat ADHD, for example, can make mood disorder symptoms worse.
- E. Post Traumatic Stress Disorder (PTSD):
1. Relatively common in children who present for treatment. Studies show a wide variation in prevalence rates.
 2. Disorder may be the result of sexual abuse, physical abuse, witnessing domestic violence, even exposure to violence in the media and the movies.
 3. Exposure to trauma leading to PTSD can be auditory and does not require that the child be present in the room where the traumatic event actually occurred. For example, a child hearing his mother being beaten in the next room can be traumatized.
 4. Symptoms include:
 - a. Re-experiencing traumatic event;
 - b. Avoidance of stimuli associated with traumatic event;

- c. Persistent symptoms of increased arousal;
 - d. Sometimes irritability;
 - e. Sometimes Anxiety;
 - f. Intrusive memories or flashbacks;
 - g. Possibly hypervigilant behaviors;
 - h. Sometimes dissociation occurs;
 - i. Avoidance behaviors;
 - j. Feeling like one has no future.
- F. Officer response to child crisis, out of control child, abuse or neglect:
1. Police officers are required to report suspected or known abuse or neglect to Social Services if it involves a family member such as a parent.
 2. If abuse or neglect involve an unrelated third party it is investigated by police as a criminal matter.
 3. If presenting child at the emergency department for mental health intervention it is important to have the parents or other person who is knowledgeable about the child also present to provide mental health professionals with necessary information.
 4. In less severe cases officers can refer parents to the community mental health centers child program. **NOTE:** Instructors should provide class with the phone number and referral procedure of the local community mental health center.
 5. **NOTE:** Instructor to provide the name and phone number of the Child Protective Social Service Agency in the community.

VI. Severe Disorders of Adulthood

(NOTE: IN THE INTEREST OF TIME, INSTRUCTORS MAY WANT TO SKIP THIS PORTION OF THE TRAINING, AS IT IS A MORE DETAILED SECTION OF MATERIAL COVERED ABOVE)

1. Schizophrenia

A. Five types recognized in diagnostic manual:

- 1) Catatonic type;
- 2) Disorganized type
- 3) Paranoid type
- 4) Undifferentiated type
- 5) Residual type

B. General characteristics:

- 1) Psychotic symptoms (1,2, or 3, below) present for at least one week while in the active phase:
 - a. Two of the following:
 - i. Delusions
 - ii. Hallucinations
 - iii. Incoherence or disorganized speech
 - iv. Catatonic behavior
 - v. Flat or grossly inappropriate affect
 - vi. Disorganized speech
 - b. Bizarre delusions
 - c. Prominent hallucinations of voice or voices.
- 2) During course of disturbance ability to work, interact with others, and take care of self is markedly below previous levels.
- 3) Signs of disturbance persist for at least six months.
- 4) Associated features include:
 - a. Perplexed and disheveled appearance;
 - b. Abnormal psychomotor activity, such as rocking and pacing;
 - c. Poverty of speech: brief unelaborated responses;
 - d. Depression, anger, or anxiety;

- e. Depersonalization or derealization: feeling that self or world is not real;
- f. Ritualistic or stereotypical behavior;
- g. Excessive or bizarre concerns with physical health (e.g. limbs are artificial, body fluids are poisoned, etc).

C. Phases of Schizophrenia

- 1) Prodromal phase: a clear deterioration in functioning before the active phase of the illness that is not due to a mood disorder or substance abuse and that involves at least two of the symptoms listed below.
- 2) Active phase: When the psychotic symptoms described above are present and active.
- 3) Residual phase: following the active phase persistence of at least two of the symptoms listed below which are also not due to a mood disorder or to substance abuse.
- 4) Prodromal and residual symptoms:
 - a. Marked isolation and withdrawal;
 - b. Impairment in role functioning as wage-earner, student, homemaker, etc.;
 - c. Peculiar behavior;
 - d. Marked impairment in personal hygiene and grooming;
 - e. Blunted or inappropriate affect;
 - f. Digressive, vague, over elaborate, or circumstantial speech; poverty of speech, or content of speech;
 - g. Odd beliefs or magical thinking that influences behavior and is inconsistent with cultural norms;
 - h. Unusual perceptual experiences, such as recurrent illusions;
 - i. Marked lack of initiative, interests, or energy.

D. Prevalence – occurs in between .2% and 2% of the United States population.

2. Major Depression

A. Characterized by:

- 1) A sustained period (at least two weeks) during which an individual experiences a depressed mood or a loss of interest or pleasure in most or all activities.
- 2) At least five of the following symptoms must be present everyday over the two week time period:
 - a. Depressed mood;
 - b. Disinterest or lack of enjoyment in usual activities;
 - c. Significant weight loss or weight gain when not dieting;
 - d. Insomnia or increased need for sleep (hypersomnia);
 - e. Psychomotor agitation or psychomotor retardation;
 - f. Fatigue or loss of energy;
 - g. Feelings of worthlessness or excessive or inappropriate guilt;
 - h. Diminished concentration or ability to think clearly;
 - i. Recurrent thoughts of death, suicidal thoughts, attempts, or plans.
- 3) Associated features of depression:
 - a. Tearfulness;
 - b. Anxiety;
 - c. Irritability;
 - d. Brooding or obsessive rumination;
 - e. Excessive concern with physical health;
 - f. Phobias or panic attacks.

B. Prevalence

- 1) Lifetime risk has varied between 10% and 25% for women and between 5% and 12% for men.
- 2) Point prevalence in adults in the community has varied from 5% to 9% for woman and from 2% to 3% for men.
- 3) Twice as many women as men are diagnosed with depression. May be under diagnosed in men due to social pressures for men to not complain about symptoms.

3. Bipolar Disorder

A. Characterized by:

- 1) One or more manic episodes usually accompanied by one or more major depressive episodes.
- 2) Manic episodes are distinct periods of abnormally and persistently elevated, expansive, or irritable mood lasting for at least a week. During this episode at least three of the following symptoms have persisted and been present to a significant degree:
 - a. Grandiosity, inflated self esteem;
 - b. Decreased need for sleep;
 - c. Increased talkativeness;
 - d. Flights of ideas or racing thoughts;
 - e. Distractibility (i.e. attention is easily drawn to unimportant or irrelevant stimuli);
 - f. Increased goal oriented activity (either socially, at work, at school, or sexually), or psychomotor agitation;
 - g. Excessive involvement in pleasurable activities, with lack of concern for the high potential for painful consequences, such as buying sprees, foolish business ventures, reckless driving, or casual sex.
- 3) Mood disturbances are severe enough to cause marked impairment in occupational or social functioning or to necessitate hospitalization to prevent harm to others.

- 4) Associated features of manic episode include:
 - a. Inability to recognize presence of an illness. Resistance to treatment;
 - b. Rapid shift to depression or anger;
 - c. Hallucinations or delusions;
 - d. Euphoric, elevated, expansive, or irritable mood.

B. Prevalence of Bipolar disorder:

- 1) Lifetime prevalence of Bipolar I disorder in community samples has varied from .4% to 1.6%.
- 2) Equally prevalent in men and women.

VII. Severe Disorders of the Elderly

1. Delirium

- A. As previously described, a medical emergency.
- B. Characterized by an acute and fluctuating change in brain function.

2. Dementia:

- A. As described above, a chronic change in brain function.
- B. Prevalence:

- 1) 5 % of people age 65, increasing by 8% every 5 years.
- 2) Over half the cases of dementia are due to Alzheimer disease.

3. Alzheimer disease:

- A. Characterized by multiple cognitive defects that include impairment in memory without impairment in consciousness. The cognitive functions that can be affected include:
 - 1) General intelligence;
 - 2) Learning and memory;

- 3) Language;
- 4) Problem solving;
- 5) Orientation;
- 6) Perception;
- 7) Attention and concentration;
- 8) Judgement;
- 9) Social abilities.

B. Prevalence and other statistics:

- 1) 4 million people suffer from Alzheimer's disease.
- 2) 20 million people have a family member with it.
- 3) 40 million people know someone with it.
- 4) By the year 2025, 22 million people will have it.
- 5) 7 out of 10 people with it live at home.
- 6) One half of all nursing home patients have it.

C. Warning Signs:

- 1) Memory loss that affects job skills;
- 2) Difficulty performing familiar tasks;
- 3) Problems with language;
- 4) Disorientation to time and place;
- 5) Poor or decreased judgement;
- 6) Problems with abstract thinking;
- 7) Misplacing things;
- 8) Change in mood or behavior;

9) Change in personality;

10) Loss of initiative.

D. Course:

1) Gradual deterioration;

2) Average survival of three to four years from time of diagnosis.

E. Treatment:

1) Supportive care for person and family.

2) Address specific problems such as:

a. Disruptive behavior;

b. Agitation;

c. Delusions or hallucinations;

d. Anxiety or mood problems;

e. Insomnia;

f. Bathing difficulties.

g. Wandering;

h. Inappropriate sexuality;

i. Hoarding.

4. Handling an elderly crises:

A. Remain calm;

B. Reassure caregivers;

C. Remember the patient may not be ABLE to follow directions;

D. Transport to hospital:

- 1) Bring both caretaker and the patient, as the patient will not be able to provide history of problem;
 - 2) Bring all the medications and substances that the patient may have taken, including those of the caregiver as they may have been taken by mistake;
 - 3) Find out whom the Primary Care Physician is while still at home so as to not forget in the Emergency room.
5. Report suspected elderly abuse or neglect to the Senior Protective Services agency in your community.

VIII. Alcohol and Other Drug Abuse

1. Substance abuse and substance dependence are both defined as mental disorders in the DSM IV.
 - A. Substance abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period:
 - 1) Recurrent use resulting in failure to fulfill major role obligations at work, home, or school;
 - 2) Recurrent use in situations where it is physically hazardous;
 - 3) Recurrent substance related legal problems;
 - 4) Continued use despite persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.
 - B. Substance dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:
 - 1) Tolerance to the substance;
 - 2) Withdrawal from the substance;
 - 3) Substance taken in larger amounts or over longer time than was intended;
 - 4) Persistent desire or unsuccessful attempts to control use;

- 5) Great deal of time spent in obtaining, using, and recovering from the substance;
 - 6) Important social, occupational, or recreational activities are given up or reduced due to use of the substance;
 - 7) Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use.
- C. Incidence of substance abuse among individuals with chronic mental illness has been shown to be higher than that of the general population. More functional general population may be under diagnosed.
- 1) Use and abuse of substances do not generally cause many of the disorders that we have been talking about (i.e. schizophrenia or bipolar disorder) in an otherwise un-predisposed individual.
 - 2) Use and abuse of substances can exacerbate the symptoms of a mental disorder in a person already predisposed to a mental illness.
 - 3) Long term use and abuse of substances can also cause physical changes to the nervous system and result in deteriorated functioning and other mental disorders, such as:
 - a. Depression;
 - b. Dementia;
 - c. Anxiety.
- D. Substances of abuse can cause persons to have acute symptoms very similar to those seen in persons with mental illnesses such as hallucinations and delusions. This is true both for persons under the influence of these substances or as a result of withdrawing from them as can be the case with alcohol withdrawal after long term chronic use (i.e. Delirium Tremors or D.T.'s).
- E. Addiction is a chronic, progressive, and terminal illness.
2. “Dual Diagnosis” or “Co-occurring disorders” are terms used to describe persons who suffer from both a mental illness and another disorder such as substance abuse or dependence.
- A. Research shows that as many as 75% of persons with a mental disorder who come into contact with the criminal justice system also have a substance abuse or dependence problem.

- B. This does not mean that they caused their own mental illness by using substances. In many cases the mental illness predated the abuse of substances.
- C. Reasons for use of substance by persons with mental disorders can include social, self medication and addiction:
 - 1) Social reasons include:
 - a. Wanting to be like non-mentally ill peers;
 - b. Opportunity to be around others without high social demands;
 - c. Creates sense of belonging to a social group.
 - 2) Self Medication - some persons with mental illness, abuse substances to self medicate with illegal substances to ease the symptoms of their mental illness. For example:
 - a. Anxiety reduction;
 - b. Improved concentration;
 - c. Improved energy level;
 - d. Increased sense of ability to function and of well being;
 - e. Improved mood (short term).
 - 3) Addiction:
 - a. Physical and psychological dependence;
 - b. Altered brain function.
- D. Treatment of persons who suffer from both a mental illness and a substance abuse disorder must address both problems in an integrated and coordinated fashion to be effective.
 - 1) Many treatment providers are not qualified to treat both types of disorders.
 - 2) Treatment programs that treat one type of disorder frequently do not recognize, or if they do recognize the presence of the other type of disorder, do not treat it.

- a) They may not be licensed to provide that type of treatment.
 - b) They are frequently not funded to treat the other type of disorder.
- 3) Many people with co-occurring mental illness and substance abuse disorders do not get adequate treatment for their disorders.
 - 4) Research has shown that persons with a mental illness are no more dangerous than their non-mentally disordered neighbors. But those who are mentally ill and abusing substances have a higher incidence of violence and criminal behavior. (See Steadman, et.al. 1998).

VII. Psychotropic Medication

1. Psychotropic medications are those that affect the nervous system and behavior.
 - A. They are used to treat the symptoms of mental illness.
 - B. They do not cure the illness. They can only treat symptoms. This is similar to medications that treat other chronic disorders, such as insulin for diabetes or antihistamines for allergies.
2. Psychotropic medications work by altering the neurochemicals in the brain. These are the chemicals that allow nerve cells to communicate with each other.
 - A. They are diffuse in their action on the nervous system, affecting the transmitters in many parts of the brain.
 - B. This diffuse impact on the chemicals in the brain produces unwanted side effects in addition to the desired effects on the symptoms of the illness.
 - C. These side effects can be uncomfortable, intolerable, dehumanizing, dangerous, and even irreversible.
 - D. Side effects include:
 - 1) Uncomfortable side effects include dry mouth, constipation, muscle tension, dizziness, flushed face, and sexual dysfunction.
 - 2) Intolerable and more dangerous side effects include:

- a. Dystonia – Fixed muscle spasms such as a stiff neck with protruding tongue and eyes rolled back in head (ocular-gyric crises).
 - b. Akathisia – Restlessness with constant moving of legs, even when sitting down.
 - c. Parkinsonism – Tremors of the hands and limbs.
 - d. Tardive Dyskinesia – Irreversible side effect resulting in uncoordinated, twisting movement of the limbs, grimacing and protruding tongue.
- 3) Side effects can sometimes be controlled or reversed by stopping the medication or introducing another medication to counter the side effect.
- 4) Some medications are so dangerous at the wrong dose that the amount in the blood system must be carefully monitored by regular blood tests.
- 5) New medications that are less likely to produce these side effects are being developed all the time.
- a. These new medications may have other side effects.
 - b. These new medications may not be as effective.
 - c. New medications are VERY expensive.
3. Patients may stop taking the medications, called “non-compliance with treatment”, for a variety of reasons:
- A. Uncomfortable, intolerable, or dangerous side effects;
 - B. They feel better on the medications and decide they do not need them anymore;
 - C. They may like the symptoms of their illness (i.e. mania);
 - D. Nobody likes to be sick and feel they are different from other people. The medication reminds them of their illness.
 - E. Many people with serious mental illness do not recognize that they have an illness and that they require medication.

4. **NOTE:** Instructors should now discuss issues of medication non-compliance. For example ask participants:
- A. Did you ever not finish a medication that was prescribed for you? Like an antibiotic for a upper respiratory infection because you felt better before all the pills were finished? Why did you not take them all as directed?
 - B. Did you ever have medications that made you feel sick to your stomach? Or made you tired and groggy? Did you take them anyway?
 - C. Were you ever prescribed medications that you did not feel really helped you feel better? What did you do? How would you have felt if others insisted that you take the medications anyway?

VIII. Mental Retardation and Learning Disorders

- 1. Mental Retardation defines a condition characterized by:
 - A. Below average intellectual functioning;
 - B. Impairment began before the age of 18 and is usually present at birth;
 - C. General impaired social-living adaptation and functioning. Areas affected include:
 - 1) Personal care and hygiene;
 - 2) Money management;
 - 3) Leisure time activities;
 - 4) Social relationships.
 - D. These persons often demonstrate the following traits:
 - 1) Lack of basic knowledge;
 - 2) Short attention span;
 - 3) Easily distracted;
 - 4) Difficulty understanding questions;
 - 5) Difficulty expressing themselves;

- 6) Appear inappropriate;
 - 7) Apparent inability to understand the consequences of their actions;
 - 8) Fear of unfamiliar places, persons, or situations;
 - 9) Eagerness to please others.
2. Learning disorders are conditions which are characterized by an individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially lower than expected for age, schooling, and level of intelligence.
 3. Mental retardation and learning disorders are unrelated to mental illness.
 - A. Intelligence is unrelated to mental illness.
 - B. Mental illness and retardation or developmental disabilities can co-exist in the same person just like any other two illnesses.

IX. Myths and Facts About Mental Illness

1. Persons with mental illness are dangerous, violent, likely to participate in criminal behavior, and should be locked up in hospitals. True or False?
 - A. False
 - B. The majority of persons with mental illness do not belong in hospitals and can function very well in the community. They may require brief hospital stays during acute periods of their illness.
 - C. Research indicates that persons with mental disorders are not more dangerous than other persons, unless they are also abusing drugs or alcohol.
2. Persons with mental illness are "crazy" because of their upbringing and bad parenting. True or False?
 - A. False
 - B. Mental illness is not a product of bad parenting.
 - C. Research has shown that many mental illnesses are associated with congenital or hereditary causes.

- D. Many mental illnesses are disorders of the brain with a biochemical problem causing misperceptions and bizarre ideas, emotions, and behavior.
3. Persons with mental illnesses are just lazy, unproductive and have a weak will. True or False?
- A. False.
- B. As with other chronic illnesses, it takes energy to manage the illness, which at times becomes overwhelming to the person.
- C. For many persons mental illness is a lifelong condition. It is possible to help the people with mental illness manage their illness, improve their coping abilities, and care for themselves. However some of the behavioral symptoms may be permanent.
- D. Many mental illnesses cannot be cured but medication can help control the symptoms. Many persons with mental illness are working, productive members of the community.
4. Persons with mental illness do not have the same feelings and emotions as “the rest of us”. True or False?
- A. False.
- B. Persons with mental disorders have the same emotional responses as everyone else. They may be more confused than others, they may perceive things differently, they may have trouble expressing themselves as well as others. But they are feeling human beings and, just like the rest of us, to treat them so can be an enormous help.
5. How are persons with mental disorders portrayed in popular books, newspaper articles, television programs, and movies? They are portrayed as being:
- A. Deviant. A social group decides what characteristics it will accept. Those that have other characteristics become “deviant”. As a social group we reward people who are like us and punish those who are deviant from us. We fear those who are deviant (different) from us.
- B. Unpredictable.
- C. Dangerous.
- D. Evil.

6. What words have you heard or even used to describe persons with mental disorders?
 - A. Words like: crazy, nuts, wacko, psycho, lunatic, demented, loony-toons, mental, etc.
 - B. Such words are demeaning of course and they reinforce the stereotypes, myths, and fears that we all have about persons with these disorders.
 - C. Referring to “persons with mental illness” is preferable to “the mentally ill”, which depersonalizes and highlights the illness instead of the person. People are NOT their illness.

7. Mental illness is not an uncommon phenomenon:

- A. Schizophrenia is six times more common than insulin dependent diabetes and is sixty times more common than muscular dystrophy.
- B. Prevalence of mental Illness in the United States Adult Population:

	<u>Number of Persons</u> <u>Percent of Population</u>
Severe and Persistent Mental Illness	5.4 million 2.7%
Serious Mental Illness (functional impairment limiting life activity)	11.4 million 5.7%
Diagnosable Mental Disorder (Within one year period)	48.2 million 24.1%

[Estimates by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. United States Government. February 1996.]

8. Are all persons who are emotionally disturbed are mentally ill?
 - A. No.
 - B. Persons who are emotionally disturbed may exhibit exaggerated behavior, feelings, thinking, or perceptions.

C. Emotional disturbance and its resulting behavior may be caused by numerous factors:

- 1) Mental illness.
- 2) Substance intoxication or withdrawal.
- 3) Medical conditions.
- 4) Situational stress.

D. When dealing with an emotionally disturbed person, remember, "Things are not always as they appear to be".

SECTION III

OFFICER INTERACTIONS WITH PERSONS WHO HAVE A MENTAL ILLNESS

I. Indicators and Behaviors Suggestive of Mental Illness

- A. Behaviors associated with mental disorders will depend on a number of factors, including:
1. The nature of the disorder.
 2. The severity of the affliction.
 3. The personality of the individual.
 4. Other influences (i.e. intoxication).
- B. Some general characteristic symptoms associated with mental disorders are:
1. Behaviors and moods that are inappropriate.
 2. Behavior tends to be inflexible.
 3. Behavior tends to be impulsive.
 4. Persons with mental disorders tend to have a lower tolerance of stress. May respond in an exaggerated fashion to stressful situations.
 5. Behaviors are often unusual and upsetting to others.
 6. Behavior is generally not an immediate threat to themselves or others.
- C. Not unlike physical illnesses, psychiatric symptoms can be grouped according to “systems” that they affect. These are psychological rather than physical symptoms.
- D. When observing human behavior we look at these systems to determine how a person is functioning. These observations will assist you in trying to differentiate if:
1. The person suffers from a mental disorder.
 2. The person is emotionally disturbed absent a mental disorder.

3. The person is under the influence of intoxicants.
 4. The person has a medical problem.
 5. Or the person has some combination of two or more of these.
- E. Note that no one indicator is going to tell the nature of the problem that the person is experiencing. It is a combination of the totality of your observations that is important. This is just a tool to use in making and recording your observations about people.
- F. The mnemonic “CAST-A-MOP” will assist you in remembering these systems for observation. Each letter stands for one of these systems as follows:
1. C – Consciousness;
 2. A – Activity;
 3. S – Speech;
 4. T – Thought;
 5. A – Affect;
 6. M- Memory;
 7. O – Orientation;
 8. P – Perception.
- G. We shall now talk about each of these “systems” individually.
1. Consciousness is the degree to which a person is aware of, attentive and responsive to the world around him or her.
 - a. Delirium, stupor, and coma indicate the least or no awareness or responsiveness to the environment. This state of consciousness is usually indicative of an organic or physical problem and is a medical emergency.
 - b. Inattention – on the continuum of consciousness, this state is indicated by difficulty gaining and maintaining the person's attention.

- c. Distractibility is a state of consciousness in which a person's attention is easily diverted by other stimuli.
 - d. Confusion is an impaired understanding of one's surroundings.
 - 2. Activity refers to "motor activity" or movement of the muscles. It may be increased, decreased, or unusual.
 - a. Restlessness is a state of constant movement, an inability to sit still. Remember that this might be associated with a side-effect of medication or may be indicative of other concerns
 - b. Agitation is restlessness associated with extreme anxiety.
 - c. Retardation is very slow movements common in depressed persons or those under the influence of sedating substances.
 - d. Stereotyped activity is repetition of movements that do not seem to serve a useful purpose.
 - e. Compulsive activity is characterized by repetitive actions carried out to relieve the anxiety of obsessive thoughts.
 - 3. Speech refers to both the content of the speech and the process of the speech.
 - a. Speech process refers to how a person speaks.
 - 1) Speech may be accelerated or pressured as seen in persons who are manic.
 - 2) Speech may be slowed or retarded as seen in persons who are depressed.
 - 3) Speech may be markedly unusual in rate, volume or tone.
 - b. Speech content is what a person actually says. Unusual content might include:
 - 1) Neologisms or words that the person makes up that have no real meaning in our language.
 - 2) Note content for themes such as paranoia or other delusional content.

- 3) A person echoing the words of the observer/examiner demonstrates echolalia.
 - 4) Speech content may also tell you about the next system, thought process.
4. Thinking, like speech, may be disordered in either or both it's content and it's progression. Thought being the highest of mental functions it requires an integration of knowledge, perception and memory.
- a. Progression of thought, like motor activity and speech, may be speeded up or slowed down.
 - b. "Thought Process" refers to the logical or illogical flow of thoughts as indicated by each of the following:
 - 1) Sequential thought process is the normal flow of thought in which ideas logically connect from one to the next in an organized and consistent pattern.
 - 2) Circumstantial thought process occurs when ideas are logically connected but do not flow directly from one to the next in an organized fashion. The person eventually gets from one point to the next, but takes a round about way of getting there. The listener frequently finds himself saying "come on get to the point".
 - 3) Tangential thought process occurs when ideas appear logically connected but lose their logical association as the speaker moves on to a different tangent. The listener finds himself wondering: "huh, what was my last question? How did we get onto this topic"?
 - 4) Thought blocking is when ideas are logically connected but the thinker is unable to move on to the next logical idea.
 - 5) Loose associations refer to a process where two ideas may be logically connected, but they are not connected with the next idea in a logical way. The listener finds himself saying: "huh? Where did that come from"?
 - 6) Flight of ideas refers to accelerated thinking in which none of the ideas appear to the listener to be connected with each other in any kind of logical way.

- 7) Perseveration is a repetition of the same idea over and over again.
- c. Abnormal thought content indicative of a mental disorder includes the following:
- 1) Delusions which are false and fixed beliefs that one cannot be persuaded to change. Delusions may have various themes such as:
 - a) Paranoia
 - b) Grandiosity
 - c) Religiosity
 - 2) Thought broadcasting is the belief that others can hear ones thoughts.
 - 3) Ideas of reference refer to the belief that events, objects, or other people in the person's immediate environment have a particular and unusual meaning specifically for him or her.
 - 4) Thought control is the belief that outside forces are controlling ones thoughts.
 - 5) Obsessions are fixated thoughts that will not go away despite attempts to stop them.
 - 6) Homicidal and suicidal ideations are thoughts of wanting to kill other or oneself. Examiners must ask specific questions about such thoughts.
5. Affect and mood refers to the outward expression (affect) of the subjective feeling state (mood).
- a. Mood refers to a person's sustained, pervasive, subjective emotional state.
 - 1) Person's with mental disorders have the same feeling states as everyone else, including happiness, sadness, fear, etc.

- 2) Moods differ in their extremeness, appropriateness to the situation, or in their rapid fluctuation.
 - b. Affect refers to the outward expression of one's mood.
 - 1) Affect may be incongruent with the situation, mood, and expressed ideas.
 - 2) Labile affect refers to the rapid shifting from one state to another.
 - 3) Flat affect refers to the lack of expression of any feeling state as seen in depression.
6. Memory is a complex process consisting of four separate functions:
- a. Registration is the ability to add new information to the cerebral data bank.
 - b. Retention is the ability to retain or store information for later retrieval
 - c. Recall is the ability to retrieve information on demand.
 - d. Recognition is the ability to identify information that one has encountered before.
 - e. Any one or some combination of all of these functions may be impaired.
7. Orientation refers to a person's sense of:
- a. Who they are (Person);
 - b. Where they are (Place);
 - c. And at what point of time it is (Time)
 - d. Disorientation is usually associated with organic, physical impairments, which may be medical emergencies.
 - e. Delusional persons may be disoriented as to person, believing they are someone else.
8. Perception refers to the manner in which a person processes data provided by the five senses.

- a. Hallucinations are perceptions that have no basis in reality. That is no stimuli coming to the sense organ.
- b. Hallucination may occur in any of the five senses.
- c. Auditory hallucination most common for persons with mental disorders.
- d. Hallucinations in other sense modalities may be indicative of more organic or physical problems such as drug intoxication or withdrawal.

H. Physical symptoms may also help you to identify the nature of a person's difficulty, particularly if the problem is organic, medical, or intoxication related. Some things to look for include:

1. Examine the skin. Be aware of temperature, moisture, needle marks, etc.
2. Be aware of the pupils. Check for size, equality and reaction to light. Pupillary abnormalities may be indicative of toxic ingestion or an intracranial process as the cause of the behavior. This may well be a medical emergency.
3. Note the rate of breathing and unusual odors on the breath.
4. Be aware of the extremities; look for needle marks, tremors, unilateral weakness, or loss of sensation, which would indicate a medical problem.

I. Use these observations in your report.

II. Obtaining Information

A. In addition to your own observations based on the above indicators, it is important to obtain information from other sources including witnesses and family members. Questions you might ask of them are:

1. Is the individual in treatment for a mental disorder? If so, where and when did he/she last go to treatment? What is the treatment for?
2. Has the individual ever been in treatment for a mental disorder? Where? For what?

3. Has the individual ever been hospitalized for a mental disorder? If so when was the last time?
4. Has the individual been taking his prescribed medication?
5. What is his prescribed medication?
6. Has the individual been using alcohol or other substances to your knowledge?
7. Has the individual threatened or attempted to use violence, or acted dangerously towards self or others?
8. Does the individual own or have access to weapons?
9. Has the individual been neglecting personal care or bodily functions, such as eating or sleeping?
10. Has there been a recent traumatic event in the individuals life?

B. Question to consider asking of the disturbed person include:

1. What is your name?
2. Where do you live? Where have you been sleeping?
3. Can you tell me where you are right now?
4. What is the date, month, day of week, time of day?
5. When did you last eat?
6. When did you last sleep and for how long?
7. Have you been using any substance? What? How much? When did you last use?
8. Do you hear voices that other people cannot hear? What do the voices say to you?
9. Do the voices tell you to hurt yourself or other people?
10. Are you thinking about hurting or killing yourself?
11. What kind of problems are you experiencing?

12. Are you supposed to be taking any kind of medication?
 13. When was the last time you took your medication?
 14. Do you see a doctor or other professional for treatment? Who do you see? When did you last see this professional?
 15. How do you support your self? Are you on SSI? If so what for?
 16. What are you afraid of?
 17. Do you suffer from a mental disorder?
 18. What do you think would be helpful to you right now?
 19. Are you able to control yourself at this time?
- C. Be aware of the surroundings; gather what information you can from your observations of the environment.

III. Helpful and Unhelpful Types of Interactions

A. Interaction Basics

1. Personal safety first!
2. Be aware of the environment:
 - a. Weapons, things that could be used as weapons.
 - b. Other people.
 - c. Escape routes.
3. Use proper positioning:
 - a. Keep your distance, at least a legs length.
 - b. Use a non-threatening, safe stance (Bladed).
 - c. Maintain calm, low voice.
 - 1) Command presence is not likely to work.

2) A person with a brain disorder is acutely sensitive to stimuli.

d. Hands out, palms up.

4. Be strategic:

a. Reach for small concrete goals.

b. Assume the persons concerns are real.

c. Meet reasonable demands or requests when possible.

d. Re-focus their attention (keep their focus on you no others).

e. Reduce anxiety (control physical symptoms and movements).

f. Attempt to reduce excessive stimuli

g. Move to a safe place ASAP.

5. Rely on verbal intervention initially:

a. Use the person's name.

b. Introduce yourself.

c. Be polite in requests and statements.

d. Use I statements (I understand what you are saying).

e. Listen to what they are saying or requesting.

f. Validate their feelings or concerns.

g. Clarify the problem (reframe it, reduce it to basics).

h. Restore the person's problem solving capacity.

i. Give the person as many choice points as the situation permits.

j. i.e., "Would you like to come out here to talk to us or would you like us to come in there".

k. Provide information and support

1. Give firm, simple, clear directions.
6. Try not to:
- a. Take anything that is said personally.
 - b. Make promises you cannot keep.
 - c. Demand obedience.
 - d. Get into a power struggle.
 - e. Act afraid or angry.
 - f. Laugh inappropriately.
 - g. Speak in patronizing tone.
 - h. Ask too many questions.
 - i. Engage in their psychosis by agreeing or arguing about delusions or hallucinations.

IV. Assessing Dangerousness and Communication

A. Crisis Escalation Cycle:

1. As people move into a crises they go through fairly predictable stages, unless they are acutely psychotic and responding to internal stimuli, or intoxicated, or both. Under these circumstances their behavior will be erratic and tend to not follow progressive patterns.
2. The Crisis cycle shows how people generally move through a crisis.
 - a. At the onset they are behaving normally. Something happens to cause them to become:
 - 1) Excited, or
 - 2) Active, or
 - 3) Upset, or
 - 4) Physically uncomfortable.

- b. The cause or stimulus can be:
 - 1) External:
 - a) The words of another person.
 - b) The behavior of another person.
 - c) The environment:
 - i. Crowded.
 - ii. Hot.
 - iii. Cold.
 - 2) Internal:
 - a) Physical illness or pain.
 - b) Emotional upset.
 - c) Mental illness (internal stimuli).
 - 3) Regardless of the source of their anxiety, their capacity to comprehend verbal information decreases between 50 to 75 percent of normal.
- c. The next stage is continued escalation and anger:
 - 1) Obvious signs of distress.
 - 2) Observable changes physically and in behavior.
 - a) Red Face.
 - b) Tense muscles – tight face, clenched fists.
 - c) Talking more and /or louder.
 - d) Some people get quiet and withdrawn.
 - e) Increased activity – pacing, rocking, etc.
 - 3) During this phase their ability to comprehend verbal information decreases to 25 to 50 percent of normal.

- 4) As the move from anger to hostility their ability to comprehend drops to between 5 and 25% of normal.
- d. During the actual crises stage they get out of control:
 - 1) Aggression
 - 2) Screaming and yelling.
 - 3) May throw or hit things.
 - 4) May become assaultive.
 - 5) Comprehension now diminishes to between 0 and 5 percent of normal. They are no longer able to follow directions.
 - e. As they de-escalate from the crises, comprehension remains impaired. If provoked they can quickly re-escalate back to a crises.

B. Communication

1. Communication is an interactive phenomenon, which involves words, behaviors, and context.
 - a. Verbal components consist of:
 - 1) Content of speech.
 - 2) Process of speech, including:
 - a) Rate.
 - b) Tone.
 - c) Volume.
 - d) Congruency with other messages.
 - b. Non-verbal components consist of:
 - 1) Stance.
 - 2) Gestures – transient movements of the body and face.

- 3) Eye movements.
- 4) Facial expressions.
- 5) Personal attire.
- 6) Motor movements.

c. Other factors that influence communication are:

- 1) Culture.
- 2) Religion.
- 3) Sex/gender roles.
- 4) Social economic class.
- 5) Perceptions or internal experiences.
- 6) Values.

2. When highly stressed, non-verbal communication becomes dominate.
 - a. Verbal communication, when stressed account for only 7% of the information that is communicated.
 - b. Tone and volume account for another 38%.
 - c. Body language accounts for a full 55% of that which is communicated under these circumstances.
3. As anxiety increases, thought process becomes more concrete.
4. Like the crisis cycle, the violence curve shows how people generally move through predictable stages as they move towards aggression and violence. Your response to each stage is also predictable and provides a tool for you to understand the where the other person is on the violence curve and how you should conduct yourself.

a. Escalation of violence chart:

SUSPECT/PERSON	OFFICER
LEVEL 4: VIOLENCE	ANGER/ FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

- b. Chart describes the interaction and dynamic between the subject and the officer.
- c. During calm state, subject is at ease it is relatively easy to interact with them. This is true even if they are experiencing perceptual distortions such as hallucinations.
- d. At level 1 it remains relatively easy to engage the person with a degree of empathy.
- e. At level 2, as the subject begins to exhibit signs of anger, officer will normally begin to exhibit signs of anxiety.
- f. At level 3, with hostility most begin to exhibit increased signs of anxiety, anger, and even fear.
- g. At the highest level, with open aggression and abuse, officers exhibit clear signs of anger and fear.
- h. As we saw before, the problem is that as we move up the scale, our ability to effectively communicate diminishes.
 - 1) Tunnel vision.
 - 2) Concrete thinking.
 - 3) Increased stress level.
 - 4) Fight or flight response (blood flow leaves the head).
 - 5) Officers with additional disadvantage of having to suspend emotional response in order to perform well. Separating out feeling and increasing cerebral activity to perform a technical function is common amongst emergency service workers. It is what we are trained to do.

j. These responses are counter productive to the task and process of communicating, especially with an emotionally charged person.

k. The goals of the officer are to:

- 1) Bridge paradox between suspending emotions temporarily while listening for emotional cues in an effort to be effective.
- 2) Pace and guide the emotionally disturbed person into levels more conducive to mutual communication and interchange.
- 3) Communication skills are like any other technical skill requiring training and experience to access the skill, especially under emergent conditions.

5. Response and Skills required at each level:

a. Level 1: Anxiety

- 1) A subjective and uncomfortable emotion, which results from perceived threats to the person. Associated feelings are dread and helplessness.
- 2) Goal: Provide support to restore the person's sense of control. Negotiate an alternative action to the impending crisis.
- 3) Physical attending skills:
 - a) Face the person squarely.
 - b) Adopt an open posture.
 - c) Lean towards the person.
 - d) Maintain direct eye contact.
 - e) Retain a relaxed posture.
 - f) Promote a relaxing environment.
- 4) Responding skills:

- a) Emotional labeling.
 - b) Paraphrasing.
 - c) "I" statements.
 - d) Reflection and mirroring.
 - e) Minimal reassurance.
 - f) Effective silence.
 - g) Open statements,
- 5) Psychological attending skills:
- a) Level of agitation being displayed.
 - b) Central theme of concern?
 - c) Evidence of intoxication, which would interfere with predictability.
- 6) Intervention:
- a) Active listening.
 - b) Negotiate.
 - c) Consider backing off from person and giving person more room.

b. Level 2: Anger

- 1) Feeling state that serves to reduce the helplessness and dread of anxiety. Serves to give one a sense of power or control.
- 2) Can quickly escalate into physical expression of violence.
- 3) Thought process changes:

- a) More concrete.
 - b) Less flexible.
 - c) Non-verbal, visual information becomes more important.
- 4) Goal: Keep subject talking to you, utilize time to de-escalate agitation.
- 5) Three primary techniques:
- a) Diffuse adversarial interaction by acknowledging the anger. Acknowledging how they feel does not mean you agree with their position.
 - b) Provide guidance in choosing a new course of action or assuming a new role.
 - c) Provide choices. Offer a different option.
 - i) Choose A or B.
 - ii) Choose A or not A.
- 6) Physical attending skills:
- a) Face the person at a 45 degree angle, bladed stance.
 - b) Adopt an open posture.
 - c) Lean in to listen.
 - d) Maintain direct eye contact.
 - e) Retain a relaxed posture.
 - f) Promote a relaxing environment.
- 7) Responding Skills:
- a) Be respectful.
 - b) Be empathetic.

- c) Be genuine.
 - d) Keep your voice calm.
 - e) Keep your volume low.
 - f) Keep dialogue simple.
 - g) Keep focused on the immediate issues.
 - h) Pace your speech to slow the person's agitated tempo.
- 8) Psychological attending skills:
- a) Analyze the situation and identify the primary concerns.
 - b) Monitor the level of agitation.
- 9) Intervention:
- a) Diffuse adversarial momentum by affirming the anger.
 - b) Advice giving. Direct to follow your good plan.
 - c) Provide choices. Either A or B, or A or not A.
 - d) Consider backing off from angry person a few feet while maintaining observation and officer safety.

c. Level 3: Hostility

- 1) Hostility is anger with a focused recipient .
- 2) Easy to detect:
 - a) Irritable.
 - b) Demanding.
 - c) Argumentative.

- d) Antagonistic.
 - e) Oppositional.
 - f) Loud and threatening.
- 3) Next stage to violence:
- a) Exercise caution.
 - b) Potentially quick transition time to violence.
 - c) Subject is concrete, non-verbal communication is important here.
- 4) Goals:
- a) Obtain immediate control of situation.
 - b) Diffuse to less agitated and more manageable stage.
- 5) Each intervention attempts should be quick, less than 60 seconds in duration.
- 6) Four techniques:
- a) Limit setting:
 - i) Clearly state the boundaries of behaviors that you will allow.
 - ii) Keep non-verbals serious, professional and authoritative
 - iii) Use hand signals to communicate.
 - iv) Verbal tone and volume consistent with serious message.
 - v) Sentences less than 5 words, repeated rather than elaborated.
 - b) Diffuse the adversarial stance by acknowledging the anger:

- i) Timing is critical
- ii) Upon acceptance (“your damn right I’m angry”) continue to dialogue, moving to more manageable stage.
- iii) If person does not accept acknowledgement, despite repeated tries, be prepared for violence.
- c) Provide directives: firmly tell the person what you want them to do.
- d) Give warning: Clearly state as neutrally as possible the likely consequences of a given course of action.

7) Approaching the subject:

- a) Monitor your own response. Maintain control by purposely taking deep breaths. Since you are going to be trying to regain control of the situation by communication you will need the air.
- b) Approach the subject squarely from the side to avoid direct kicks. Keep an open posture, to avoid being seen as attacking.
- c) Keep approximately two arms length away from the person.
- d) Do not attempt to communicate by touch.
- e) Maintain eye contact and an upright posture to convey control.
- f) Communication is continuous. The eyes coupled with facial gestures may provide advance warning of an attack.

8) Interaction:

- a) Do not engage in accusations, arguments, and demands for justification from the person. This

will result in a power struggle, which will prove futile. Do not succumb to baiting.

- b) Work as a team. May be part of pre-arranged set of actions for dealing with emergent situations. Don't be maneuvered into being split apart as good guy, bad guy. (i.e. I can't talk to this jerk. Can we talk privately?).
- c) Keep verbalizations short and simple. Repeat Short requests as opposed to paraphrasing. Subject is very concrete and will only hear a portion of what is said.
- d) Define clear expectations and communicate these firmly and positively.
- e) Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.
- f) Confine the limits only to those that can be carried out. Empty limits only reinforce the notion that you cannot be relied upon. Don't promise what you cannot deliver, you will only be setting the next guy up for potential violence.
- g) Practice pat phrases and have them available. Timing your responses is important in disarming an aggressor.

9) Physical attending skills:

- a) Face person squarely but approach at 45 degree angle.
- b) Open posture. Hands out of pockets.
- c) Upright posture to convey seriousness and control.
- d) Relaxed posture to convey lack of intimidation.
- e) Do not communicate by touch.

- f) Maintain eye contact – look for advance warning of attack. Do not look away.
- g) Remain two arms lengths away from subject.

10) Responding skills:

- a) Be genuine.
- b) Be respectful.
- c) Speech volume: Avoid shouting.
- d) Speech tone: convey confidence, assurance, and seriousness. Avoid challenging and condescending inflections.
- e) Speech rate; purposely slow to de-escalate.
- f) Speech productivity: keep sentences short and simple. Repeat rather than elaborate.
- g) Speech content: keep it here and now. Focus on your directive.
- h) Do not succumb to being baited into an argument or justification.
- i) Avoid discussions leading to splitting.
- j) Confine warnings and promises to those that can be carried out.

11) Psychological attending skills:

- a) Evaluate and analyze.
- b) What level of agitation?
- c) Is the person intoxicated?
- d) What themes are being presented?
- e) Any “baiting” or key words?

f) What level did you leave the person?

12) Intervention:

- g) Set limits. Clearly state the boundaries of the behavior you will tolerate.
- h) Acknowledge the anger.
- i) Provide directives, firmly telling the subject what you want them to do.
- j) Warning as clearly and neutrally as possible what the consequences of the persons's behavior will be.

d. Level 4: Violence

- 1) Violence is aggression with a focus on destruction.
- 2) The goal of violence is injury.
- 3) Violence may be verbal (if disruptive or hurtful enough) or physical.
- 4) Goal: Officer Safety. Protect yourself and others.

5) Interaction:

- a) Let face drain of gesture.
- b) Drop your shoulders indicating relinquishment.
- c) Remain at 45 degrees to the person.
- d) Don't make sudden moves.
- e) Don't take insults and taunting personally.
- f) Don't be baited.
- g) Do not take your eyes off of the subject.

- h) Clearly indicate that you intend to disengage and withdraw (e.g. “I quit” or “I’m out of here”).
- i) Start moving away towards your escape.
- j) Move slowly and methodically.
- k) Continue your verbal and non-verbal communication to indicate retreat.
- l) You can remain at bay waiting for backup to arrive or totally withdraw.

SECTION IV

UNDERSTANDING THE EXPERIENCE OF MENTAL ILLNESS

I. The Perspective of People with Mental Disorders

For this section of the training instructors are encouraged to ask a person with a mental disorder to come speak to the trainees about their experience with mental illness and with law enforcement officers. The person presenting should be articulate and should be able to describe their experience in a non-defensive manner. The goal is to help trainees understand the experience of having a mental disorder from the perspective of one who does. It is important to sensitize officers to the fact that persons with mental illness have lives, feelings, and thoughts, just like they do when they are not in an acute state of psychosis. It is also important to identify the elements of a constructive response by peace officer.

In lieu of a person with a mental disorder presenting a video may be used. The following videos are recommended:

- 1) “Mental Illness First Hand Account (David and Kathy’s Story)” Police Recruit E.D.P. Training Video. Available from the Bureau of Forensic Services, NYS Office of Mental Health. 44 Holland Avenue, Albany, NY 12229. Phone: (518) 474-7275.

- 2) “When the Music Stops: The Reality of Serious Mental Illness”. Available from the Delaware Alliance for Mental Illness: NAMI – DE 2500 West 4th Street, Suite 5, Wilmington, DE 19805. Phone (888) 427-2643.

II. The Perspective of Family Members

For this section of the training instructors are encouraged to invite family members of a person with a mental disorder to come and speak to the class about their experience with mental illness and with law enforcement officers. Again, the person or persons speaking should be articulate and be able to describe their experience in a non-defensive manner. The goal is to sensitize the trainees to the experience and difficulties that families face and to identify elements of a constructive response by the peace officer from a family members perspective. Speakers can be obtained by contacting the local office of the Alliance for the Mentally Ill (AMI). Local AMI offices can be found in the phone book or by contacting the Colorado State office of the National Alliance for the Mentally Ill at (303) 321-3104.

In lieu of speakers a video may be used. The following videos are recommended:

- A. "The Bonnie Tapes": (1) "Mental Illness in the Family"; (2) "Recovering from Mental Illness"; (3) "My Sister is Mentally Ill". These tapes present an articulate young woman with schizophrenia in discussions with her family and with mental health professionals. She and her family talk together about the illness and how it has affected them. The discussion examines important questions such as: What happens when mental illness enters the life of a family? How does the person struck by the illness feel? What are some of the steps on the road to recovery. The tapes are available from The Mental Illness Education Project, 22-D Hollywood Avenue, Hohokus, NJ 07423. Phone (800)343-5540. Tapes may also be ordered on line at www.miepvideos.org.
- B. "Families Coping With Mental Illness". Ten parents and siblings share their experiences of having a family member with schizophrenia or bipolar disorder, with lengths of illness ranging from three to 40 years. Also available from The Mental Illness Education Project at the addresses and phone numbers listed above.

SECTION V

LEGAL AND LIABILITY ISSUES

I. Commitment

A. Civil Commitment

6. Legislative declaration at beginning of civil commitment laws says laws are designed to:
 - a. Secure humane treatment;
 - b. Maximize personal dignity and rights;
 - c. Minimize deprivation of liberty;
 - d. Encourage family involvement;
 - e. Encourage voluntary treatment.
7. Mental Illness and “Gravely disabled” defined as legal concept, not clinical one, in state statute:
 - a. Mental illness (CRS 27-10-102(7)): A substantial disorder of the cognitive, volitional, or emotional processes that grossly impairs judgement or capacity to recognize reality or to control behavior.
 - b. Gravely disabled (CRS 27-10-102(5)): If THE mental illness causes him to be unable to care for himself so that he is in danger of serious physical harm *or*, causes a lack of judgement and understanding in managing life’s resources and relationships significant enough to endanger his health and safety, *or* shows a deteriorating course leading towards danger to self or others.
8. Raising the Issue of Mental Illness and Gravely Disabled:
 - a. 72 hour mental health hold (CRS 27-10-105(1)(a)): If mental illness causes a person to be an imminent danger to self or others *or* renders him gravely disabled then he MAY be taken into custody for a 72 hour mental health hold.

- b. Note that the statute says “MAY be taken into custody” it say you have to take him into custody.
 - c. 72 hour hold authority (CRS 27-10-105(1)(b)): Peace officers and mental health workers (psychiatrists, psychologists, psychiatric nurses, licensed counselors and therapists, licensed social workers) MAY take or order the mentally ill person taken in to custody for a 72-hour hold.
 - 2) Officers may be served with a protective order (EMIR) by one of these professionals asking that a specific individual be taken into custody for care and treatment.
 - 3) Officers should be certain that the protective order (EMIR) was signed within the last 72 hours before picking the person up.
 - 4) Although taking a person into protective custody is not considered an arrest, search and seizure under the 4th amendment applies. Officer may act in a reasonable and prudent fashion to keep the person and others safe.
 - 5) Officers may rely on a third party who is reliable and has an interest in the case for determining if the person meets the criteria for initiating a 72 hour hold.
 - d. Citizen initiated hold (CRS 27-10-106(1)(b): Any other person may swear out an affidavit establishing facts showing imminent danger or grave disability and present it to a district court judge, not County or Municipal court judges. Judge can authorize 72-hour hold based on affidavit.
 - e. District court judge may authorize hold without affidavit if he/she observes behavior directly
9. Effect of Hold and Place of Confinement:
- a. Hold results in period of confinement for evaluation.
 - b. Place of confinement and evaluation should be at an approved facility, preferably a hospital (CRS 27-10-102(4.5) and 27-10-105(1)(b)).

- c. Jail should be used to confine person on 72-hour hold only as a last resort if there is no other suitable place of confinement (i.e. in remote or rural area) (CRS 27-10-105(1.1)).
 - 1) Person may be held in jail no longer than 24 hours.
 - 2) Person must be kept separate from criminals.
- d. At conclusion of 72-hour hold period one of the following must occur:
 - 1) Person must be released as no longer dangerous or gravely disabled;
 - 2) Person may enter treatment on a voluntary bases;
 - 3) Person must be certified for involuntary treatment (CRS 27-10-105(4)).

10. Certification and Hearings:

- a. Certification is made by a Medical Doctor or a Licensed Psychologist (CRS 27-10-102(11) and 27-10-107 (2)).
- b. Court appoints an attorney for the certified person and a review hearing is held within 10 days if requested (CRS 27-10-102(6)).
 - 1). Hearing may be to Judge or Jury.
 - 2) Burden of proof is by clear and convincing evidence (e.g. 100%) on party seeking to detain person (CRS 27-10-111(1)).
- c. Short term certification is 3 months, can be repeated two times (CRS 27-10-109).
- d. Long term certification is 6 months, may be repeated infinite number of times.

11. Local Alternatives:

(NOTE: INSTRUCTORS SHOULD PROVIDE OFFICERS WITH AN OVERVIEW OF THEIR SPECIFIC DEPARTMENT POLICY REGARDING 72 HOUR HOLDS AND SPECIFIC LOCAL PROCEDURES FOR INSTITUTING SUCH HOLDS INCLUDING:

- a. NECESSARY FORMS AND PAPERWORK
- b. WHERE TO PRESENT THE PERSON FOR EVALUATION).
- c. Other Local Alternatives: (INSTRUCTORS SHOULD REVIEW LOCAL ALTERNATIVES FOR PERSONS WHO DO NOT MEET THE CRITERIA FOR A 72 HOUR HOLD BUT ARE CLEARLY IN NEED OF MENTAL HEALTH TREATMENT. FOR EXAMPLE:
 - 1) PHONE NUMBERS OF COMMUNITY MENTAL HEALTH CENTERS AND PROGRAMS.
 - 2) REFERRAL PROCESS TO LOCAL PROGRAMS.

B. Emergency Commitment – Alcohol (CRS 25-1-310)

- 1. When a person is intoxicated or incapacitated by alcohol and clearly dangerous to the health and safety of himself or others, he SHALL be taken into custody by law enforcement authorities or an emergency service patrol (CRS 25-1-310 (1)).
- 2. Unlike the 72 hour hold statute this one says the person “shall” or must be taken into custody if intoxicated and dangerous. This creates liability if you fail to take into custody and damage occurs.
- 3. Officer must have probable cause of intoxication and dangerousness.
- 4. Person may only be held in an approved holding facility. If there is no approved holding facility person may be held:
 - a. In an emergency medical facility or jail.
 - b. May only be held in these other facilities for so long as may be necessary to prevent injury to self or others or to prevent a breach of peace (CRS 25-1-310 (1)).
- 5. If intoxicated but not dangerous, may be assisted home or other like location.
- 6. Considered protective custody and not an arrest.
 - a. Resistive persons are not resisting arrest.

- b. Resistive persons may be obstructing a peace officer (CRS 18-8-104).
 - c. Although taking a person into protective custody is not considered an arrest, search and seizure under the 4th amendment applies
 - d. Detaining officers may protect themselves by “reasonable methods”.
- 7. Officers acting in course of official duties in compliance with the above are not liable criminally or civilly (CRS 25-1-310 (1)).
- 8. Officers (and others) may make a written application for emergency commitment directed to the administrator of the approved treatment facility (CRS 25-1-310(2)).
 - a. Application shall state circumstances requiring emergency commitment.
 - b. Include personal observations and statements of others relied upon.
 - c. Copy of application must be furnished to person committed.
- 9. Upon approval of application person committed, evaluated and treated for a period not to exceed five days. May be held for 10 days if a petition for involuntary commitment is filed with court CRS 25-1-310 (6)).
- 10. If application is not approved, person shall be immediately released and encouraged to seek voluntary treatment if appropriate.
- 11. Court order may be issued to the police upon petition of interested person, to pick up and transport an intoxicated person to a approved facility.
 - a. Before you pick up and transport a person under these circumstances you should verify that the facility director or authorized designee has signed the written application.
 - b. Signed application is valid legal authority to pick up and transport a person to a facility.

C. Criminal Commitment:

1. Incompetent to Proceed:

a. Defined as suffering from a mental disease or defect that renders person incapable (CRS 16-8-102(3):

- 1) Of understanding the nature and course of the criminal proceedings; *or*
- 2) Of participating or assisting in defense; *or*
- 3) Of cooperating with attorney.

b. Grounded in common law and due process.

- 1) Mid 1600's in England, Blackstone wrote: "Defendant who becomes mad should not be arraigned for how can he make his defense"?
- 2) Ban also arose from difficulties that the English courts encountered when defendants frustrated the ritual of the common law by remaining mute instead of pleading to charges. Without a plea, trial could not go forward.
- 3) Courts had to determine if "mute by visitation of God" or "mute of malice".
 - a) Mute of malice resulted in defendant having increasingly heavier weights placed on chest in effort to compel a plea.
 - b) Mute by visitation of God included deaf and dumb and then its scope gradually expanded to include "lunatics".

c. No person shall be tried, sentenced, or executed if incompetent (CRS 16-8-11-(1)(b)).

d. Raising the Issue of Incompetence:

- 1) May be raised by the court, prosecution, or the defense.
- 2) “Reason to Believe” is standard for the court (CRS 16-8-110(2)(a)).
- 3) Presumption of competence without reason to believe otherwise.
- 4) Once there is a reason to believe incompetence, “duty to suspend the proceedings and determine” the issue (CRS 16-8-110(2)(a)).

e. Evaluations

- 1) Court may order evaluation if more information is needed (CRS 16-8-111(1)).
- 2) Evaluation may be in-patient or out-patient (CRS 16-8-106(1)):
 - a) In-patient evaluations must be at Pueblo State Hospital or other public facility.
 - b) Defendant out of custody on bond or summons may be taken into custody for purpose of in-patient evaluation or evaluated out of custody.
 - c) If defendant is in jail, exam at the jail is preferred by statute.
- 3) Court, DA, or defense can request further evaluation “for good cause shown.
- 4) A defendant with means may hire own evaluator and need not show cause. Defendant’s evaluator must be given reasonable opportunity to conduct exam (CRS 16-8-108(1)).
- 5) Court must advise defendant of reason for evaluation, and rights with regard to the evaluation and subsequent hearings, including right (CRS 16-8-117):
 - a) To read reports;

- b) Cross examine witnesses if there is a hearing;
- c) Call own witnesses;
- d) Consult with counsel before the evaluation;
- e) Remain silent. (CRS 16-8-102(2)(b)). Silence during evaluation may be used as a factor at a competency hearing but not as proof of guilt at a trial.

f. Preliminary Findings and Hearings:

- 1) Court reviews report of examination and makes finding.
- 2) Court must notify DA and defense counsel of finding and set date by which they must request hearing if desired.
- 3) Either side may request a hearing before another judge (CRS 16-8-111(2)).
- 4) If no hearing is requested the preliminary findings become the final determination by default (CRS 16-8-111(2)).
- 5) If hearing is requested:
 - a) Party asserting incompetence has the burden of proof by a preponderance of the evidence (e.g. 51%) (CRS 16-8-111(2)).
 - b) Experts may testify. They must be reported to the other side and their reports provided even if they are not endorsed (CRS 16-8-103.6(2)(a)).
 - c) Lay witnesses may testify (CRS 16-8-109).

- d) Final determination is made at conclusion of hearing.
- e) If competent the suspended proceedings resume (CRS 16-8-112(1)).
- f) If incompetent defendant must be committed to the Department of Human Services or if amenable to out-patient treatment and he is charged with a non-violent offense, he may be ordered to out-patient treatment (CRS 16-8-112(2)).

g. Incompetent Defendant's rights:

- 1) Defendant has right to remain silent at evaluation (CRS 16-8-106(2)(b)).
- 2) Any evidence acquired either directly or indirectly from defendant's statements or mental processes while being evaluated or treated can only be used:
 - a) At a competency hearing;
 - b) For or against mitigation at a capital sentencing;
 - c) To impeach or rebut a defendant's trial testimony if the evidence was given voluntarily (CRS 16-8-107 (1.5)).
- 3) Right to bond. Fact of incompetence can be considered and if not appropriate for out-patient treatment court must presume defendant is unlikely to appear and set bond accordingly (CRS 16-8-112(3)).
- 4) Right to preliminary hearings and motions in his absence if the court decides they may be fairly heard. May be reopened if new evidence is presented once defendant is restored to competency (CRS 16-8-112(4)).
- 5) Right to treatment (Jackson v. Indiana 406 U.S. 715 (1972)).

- a) Director of Department of Human Services designates which facility if defendant is committed for in-patient treatment (CRS16-8-105.5(4)).
 - b) The committing court retains jurisdiction but may not micro-manage treatment (Kort v. Carlson, 723 P.2d 143 (Colo. 1986)).
 - 6) Right to regular review with regard to the probability that the defendant will eventually be restored to competency and with regard to the justification for continued commitment or confinement (CRS 16-8-114.5(2)).
 - 7) Right to Restoration of Competence hearing. Burden of proof is on the party asserting that competence has been restored (CRS 16-8-113(2)).
 - 8) Right to be released when time equivalent to the maximum possible sentence has elapsed while confined (CRS16-8-114.5(1)). Civil commitment process may be initiated.
 - 9) Right to have all time spent committed, credited against any sentence (CRS 16-8-114(1)).
 - 10) Right to speedy trial is tolled while defendant is incompetent (CRS 18-1-405(6)(a)). When deemed competent speedy trial clock resumes and proceedings resume where they left off.
2. Not Guilty by Reason of Insanity or Impaired Mental Condition:
- a. A person who is insane is not responsible for his or her criminal conduct under Colorado law (CRS 18-1-802).
 - b. “Insanity” is legal concept, not clinical one. Defined as:
 - 1) “So diseased or defective in mind...as to be incapable of distinguishing right from wrong”.

- 2) Does not include “moral obliquity, mental depravity, or passion growing out of anger, revenge, hatred ,or other motives and kindered evil conditions...”. (CRS 16-8-101.5)
 - 3) Impaired mental condition: A person who suffers from “a condition of the mind caused by mental disease or defect that prevented the person from forming a culpable mental state that is an element of a crime...” (i.e. intent). (CRS 16-8-101.5).
 - 4) Also excludes “abnormality manifested only by repeated criminal or otherwise antisocial conduct”.
 - 5) Includes “only those severely abnormal mental conditions that grossly and demonstrably impairs a person’s perception or understanding of reality and that are not attributable to the voluntary ingestion of alcohol or other psychoactive substance...” (CRS 16-8-101.5).
- c. Not guilty by reason of insanity or impaired mental condition as a defense must be raised by defendant. If attorney believes it should be entered and defendant refuses, the court shall order an examination by psychiatrist and may enter the plea on behalf of the defendant if it is necessary for a just determination of the charge. (CRS 16-8-103).
- d. Affirmative defense: defendant must prove his insanity.
- e. Defendant loses claim to confidentiality with examining psychiatrist when defense is raised (CRS 16-8-103.6).
- f. If found to be not guilty by reason of insanity or by reason of impaired mental condition the court shall commit the defendant to the custody of the department of human services until eligible for release.
- 1) Court can order a release hearing at any time.
 - 2) Court orders a release hearing upon receiving report from hospital that the defendant no longer required hospitalization.
 - 3) Defendant may ask for a release hearing 180 days after commitment, and thereafter every one year after the last hearing if he has evidence from a medical expert

in mental disorders that he is no longer in need of hospitalization.

- 4) Victims and immediate family members are notified of release hearings.
- 5) Defendant has burden to prove restoration of sanity and that he or she has no abnormal mental condition which would likely cause him or her to be dangerous in the reasonable future. (CRS 16-8-115).
- 6) Burden of proof is by a preponderance of evidence.
- 7) Court may impose terms and conditions that it determines are in the best interests of the defendant and the community.
- 8) Upon conditional release defendant is ordered to cooperate with treatment at community mental health center. The director of the center makes written reports every three months to the director of human services and to the district attorney regarding the defendant's treatment and status of the defendant including any known violations of conditions or change in mental status.
- 9) Failure to remain under supervision or leaving the state without the courts permission constitutes the crime of escape.
- 10) Conditions imposed on conditional release and mental status of defendant reviewed at least every 12 months.
- 11) Superintendent of Colorado mental health institute at Pueblo may notify court that the defendant has become ineligible for conditional release.
 - a) Court issues a warrant to have defendant picked up and brought to hospital at Pueblo.
 - b) District attorney may petition court for a revocation of conditional release hearing.

3. General Information

- a. Length of hospitalization:

- 1) If Unfit to proceed maximum time in hospital is statutory maximum of crime charged.
 - 2) If Not Guilty By Reason of Insanity no limit on maximum hospitalization.
 - 3) Persons exposed to possibly serving life in hospital as opposed to maximum sentence in prison.
- b. Not Guilty by Reason of Insanity does NOT get defendant “off the hook”. In many cases defendant will do more time and be under more stringent supervision.
- c. Number of cases handled this way is relatively small:
- 1) Fiscal year 1999-2000 there were only 15 Not Guilty by Reason of Insanity Cases in the state of Colorado.
 - 2) Average number of persons in forensic ward of Pueblo State hospital is 293 including NGRI and persons unfit to proceed.
 - 3) 198 of the person in the Forensic Ward are NGRI cases.

II. Use of Force in Protective Custody Situations

A. The courts have said that the Fourth Amendment protection against the use of excessive force includes the right to be free from being “hog-tied” when one has an apparent impairment creating special susceptibility to positional asphyxia (Cruz v. Laramie, Wyo., 10th Cir., No. 99-8045, 2/15/01).

1. Hog-tied defined as binding the ankles to the wrists, behind the back, with 12 inches or less of separation. Binding ankles to wrists with more than 12 inches of separation is not considered a hog-tie by this court.
2. Court focused on use of hog-tie on persons of obvious diminished capacity, declining to address the validity of the procedure in general.
3. Obvious diminished capacity could result from intoxication by alcohol or drugs, a discernible mental condition, or any other condition.

- B. The peace officer exercising any use of force when taking a person into protective custody due to their mental condition or intoxicated state, must keep into perspective the goal of obtaining care and treatment for the person.
- C. The officer's use of force should be comparable to what would be justified in performing any other legal duty against another person.
- D. The use of force should be "reasonable", and what is reasonable is determined by the goal of obtaining care and treatment.

III. Liability

- A. Right to Liberty – All persons have a right to freedom under our constitution unless statutory authority deprives them of that right.
- B. The commitment laws provide for such statutory authority in cases where persons have a mental disorder and meet the law's criteria for involuntary or emergency holds. Remember that the laws place an emphasis on "imminent danger".
- C. It is important to follow the procedures outlined in the commitment laws as well as department policy and to know the criteria for detaining someone under these civil procedures. Otherwise a peace officer risks being held liable for a false arrest and a violation of various constitutional rights.
- D. Custody vs. Arrest/Detention
 - 1. Protective custody is not as intrusive as arrest.
 - 2. The difference between protective custody and arrest is the degree to which liberty can be restricted; the degree of restriction depends on the purpose of the detention.
 - 3. Limited statutory purposes for taking a person into custody:
 - a. To transport a person to a facility to receive evaluation, care and treatment
 - b. To prevent a mentally ill person from harming himself or others.
 - 4. Persons taken into custody for these purposes cannot be treated like others who are arrested:

- a. Cannot be housed in jails or lock-ups (except under special circumstances and only after assuring certain conditions).
 - b. They cannot be subjected to disciplinary procedures.
 - c. They cannot have their visiting restricted.
 - d. They cannot be “hog-tied” with separation of wrists to ankles 12 inches or less
5. If you charge the person with a crime, write a citation for example, you cannot institute the 72 hour hold process (CRS 27-10-103). Generally, charge and arrest for violent felonies. Use protective custody when no felony is involved. You can always charge the person with a crime later, after the commitment process has been completed.
6. Custodial Responsibility
 - a. While a person is in an officer’s custody, the officer is responsible for the safety, care, and well being of that person. It is the duty of the officer to exercise care in accomplishing this responsibility.
 - b. Officers should always keep in mind officer safety considerations.
 - c. The duty of care may be affected by specific facts known to the officer about any particular risk posed by a particular detainee (i.e. suicide risk).
 - d. Peace officers taking a mentally ill person into custody in either a protective custody or arrest situation, must at all times treat the mentally ill person in a reasonable manner to prevent him from having an opportunity to harm himself.
7. Transfer of custody
 - a. Occurs when control over another person’s freedom of movement is turned over to another.
 - b. While you may be obligated to take a person into protective custody, as in emergency commitments due to intoxication, in some cases facilities have refused to

accept the person. You will then need to explore other alternatives.

- c. When peace officers transport a mentally ill person to a facility, in most cases, a transfer of custody occurs when the facility personnel actually take physical control of the person and certainly when he is admitted for treatment.
- d. If asked to assist in controlling a mentally ill person after the transfer of custody has occurred, you may be said to be acting as an agent of the director of that facility. The director has custody at that point and officers should follow the director's reasonable orders.

8. The statutes preclude your having liability as long as you:

- a. Follow Department Policy and the procedure outlined in the statute.
- b. Act within the scope of your responsibility and duty.
- c. Do not demonstrate willful and wanton neglect.
- e. Act as any reasonable and prudent officer would act.

9. Breach of Duty

- a. No "general" duty at large to protect an individual member of the public. If you fail to take someone into custody and they harm themselves or another person, you are not liable. Liability can only attach if a peace officer breaches a "special duty" to a person. A "special duty" can be created by any of the following:
 - 1) Representation by the officer/agency to a person that induces reliance by the person upon the representation. "Induced Reliance" – if you tell someone that you are going to do something to protect him or her you create a "special duty". If you fail to protect him or her, you could be liable if they get hurt. For example, you take a dangerous person into custody and tell potential victims that you will have him hospitalized and they will be safe. If the doctors do not place the

dangerous person in the hospital and he injures the victim, you may be liable.

- 2) If the officer does an act that puts a person in a known zone of danger. Fore example, you pick up a drunk on the side of the road and the detoxification facility refuses to accept him. If you return him to the highway and he gets injured you may be liable.
- 3) The officer does an act that increases the then-existing risk of injury to the person.

b. In limited instances a statue can create a duty.

- 1) CRS 42-4-106 (4) creates a duty of care to innocent third parties during vehicle pursuits.
- 2) CRS 18-9-111 (6) Domestic violence statutes state: "A peace officer shall have a duty to respond as soon as reasonably possible to a report of a stalking and to cooperate with the alleged victim in investigating such report".

**Mental Illness and Law
Enforcement Training**

**Prepared by
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With the assistance of the
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Department.
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SECTION I

Introduction

**Mental Illness and Law
Enforcement Contact:**

Studies have shown that people with mental disorders are at a greater risk of arrest than the general population.



Mental Illness and Law Enforcement Contact:

7% of police contacts involve persons with mental illness who are in crisis as reported by major police departments.



Mental Illness and Law Enforcement Contact:

450 officers in 3 U.S. cities reported responding to 6 calls involving persons with mental illness within the previous month.

Mental Illness and Law Enforcement Contact:

ADP of jails increased 167% between 1983 and 1999.

National surveys report that between 6% and 15% of all jail inmates have a severe and persistent mental disorder.



Decrease in Mental Health Beds:

Mid 1950's - 500,000 people in state hospitals nationwide.

2000 - 62,000 people in state hospitals nationwide.

"Trans-institutionalization".



Mental Illness and Law Enforcement Contact:

Reasons for contact:

- Symptoms of illness,
- Stigma of illness,
- Lack of police training,
- Public safety initiatives,
- Lack of community resources.

Goal of Training Course:

Educate officers about issues related to interactions with persons who suffer from mental illness.



Goal of Training Course:

Develop an understanding of mental illness.

Develop skills to identify and provide the safest, most effective, and compassionate response possible.



Content of Training:

Understanding of:

Mental disorders,

Assessment,

Intervention techniques.



Content of Training:

Results in significant reduction of the level of danger to officers and others.



Content of Training:

Information Presented -
Facts about Mental Illness,
Behavioral Indicators of Mental Illness,
Mental Health Law,
Assessment of Dangerousness,
Enhancement of Safety.

Disclaimer:

This training is for department use only and does not apply in any civil or criminal proceedings. Nothing in this training should be construed as a creation of a higher legal standard of safety or care in an evidentiary sense with respect to third party claims.

Disclaimer:

Violations of the activities or behaviors recommended in this training might form the basis of departmental administrative sanctions. Violations of law will form the basis for civil and criminal sanctions in a recognized judicial setting.

SECTION II

MENTAL DISORDERS

Mental Disorders:

Creates problems with feeling, thinking and perception.

Affects a person's behavior by involuntarily causing bizarre and/or inappropriate behavior.



Mental Disorders:

Are primarily brain disorders.

Can be short term (acute) or long term (chronic).

Can occur at anytime in a person's life.

Mental Disorders Are Conceptualized As:

Associated with distress, or



With significant increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Disorders Are Conceptualized As:

Not an expected response to a particular event (e.g., death of a spouse).



Current manifestation of a behavioral, psychological, or biological dysfunction.

Cause of Mental Illness:

Biology - heavily influences predisposition.

Psychology - impacts onset of disorders.

Sociology - significantly influences course.



Bio-Psycho-Social Model:

Source: [http://www.psychology.com](#)

	Predisposition	Onset	Course
Biological	X		
Psychological		X	
Sociological			X

Behavior Caused By:

Source: [http://www.psychology.com](#)

- Personal choice
- Social difficulties
- Psychological distress
- Biological disease



Categorization of Mental Disorders:

Source: [http://www.psychology.com](#)

- Distress
- Dyscontrol
- Disability
- Inflexibility
- Syndromal pattern
- Etiology
- Statistical deviation



Delirium:

Inability to focus attention.

Disorientation.

Disorganized thought.

May look like intoxication.



Delirium: Risk Factors

Age over 70
Depression
Dementia
Stroke, epilepsy
Alcohol abuse
Alcohol withdrawal
Psychoactive substances
Renal failure

Liver failure
Congestive heart failure
Septic shock
Malnutrition
Visual/hearing impairment
Hypothermia or fever

Delirium: Substances

Substance that can cause delirium:

Drugs of abuse – alcohol & illicit drugs.

Medications – many types.

Toxins – insecticides, carbon monoxide, carbon dioxide, fuels, solvents.



Dementia:

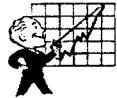
Loss of memory, PLUS

Aphasia – loss of language.

Apraxia – can't do things.

Agnosia – can't recognize things and what to do with them.

Higher executive function – plan and organize.



Dementia: Causes -

Abnormal Loss of Brain Tissue.

Alzheimer disease.

"Mini-strokes."

Other causes:

Drugs, tumors, trauma, neurodegenerative disorders, infections, nutrition, metabolic disease, inflammatory disease, etc.



Amnesic Disorders:

Characterized by loss of memory.

Organic or physical cause -



(e.g., Intoxication)

Psychotic Disorders:

"Break from reality".



Thought disturbances -

Process - loosening of associations, flight of ideas.

Content - false beliefs.

Perceptual disturbances - hallucinations.

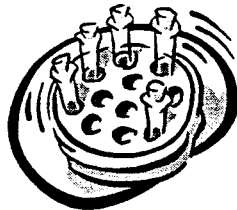
Psychotic Disorders: Treatment

Medications - alter neurotransmitters

Therapy

Hospitalization

Rehabilitation



Affective Disorders:

Affect mood:

Depressed.

Elevated.

Irritable.

Possible psychosis.



**Affective Disorders:
Treatment**

Medications:
Mood stabilizers.
Antidepressants.
Antipsychotics.



Supportive therapy.

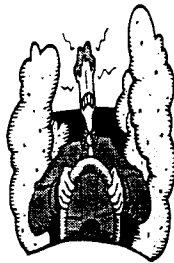
Hospitalization.

Anxiety Disorders:

Excessive anxiety.

Examples:

- Phobias.
- Panic disorders.
- Post traumatic stress disorder.
- Obsessive compulsive disorder.
- Generalized anxiety disorder.



**Anxiety Disorders:
Treatment**

Medications – antianxiety or
antidepressants.

Therapy – insight oriented or behavioral.



Other Disorders:

Substance abuse/dependence.

Impulse control disorders.

Adjustment disorders.

Sexual disorders.



**Other Disorders:
Treatment**

May involve medication.

Psychotherapy:
Individual & group.
Insight oriented.
Cognitive.
Behavioral.



Personality Disorders:

Overall coping abilities.

Longstanding (since adolescence).

Pervasive.

Maladaptive behavior.



Personality Disorders:

Cluster A – odd, eccentric.

Cluster B – dramatic, moody, erratic.

Cluster C – anxious, fearful.



**Personality Disorders:
Treatment**

Coordinated psychotherapy & social interventions.

Medications for concurrent symptoms.



**Continuums of Mental
Disorders:**

DSM IV Axes –

Axis I – major psychiatric disorders.

Axis II – personality disorders & mental retardation.

Continuums of Mental Disorders:

Thought, mood, & anxiety.

Biological (organic) – psychological (functional).



Continuums of Mental Disorders

	Thought Disorders	Mood Disorders	Anxiety Disorders	
Axis I Disorders	Schizophrenia Delusional D/O Schizo	Depression Bipolar D/O Affective D/O	GAD PTSD Panic/Phobias	Biological
Axis II Disorders	Cluster A P/D Paranoid Schizotypal Schizoid	Cluster B P/D Antisocial Borderline Histrionic Narcissistic	Cluster C P/D Avoidant Dependent OCD	Functional or Psychological

Severe Disorders of Childhood:

Attention deficit hyperactivity disorder (ADHD) -

Three types:

- Hyperactive/impulsive type,
- Inattentive type,
- Combined type.

**Attention Deficit
Hyperactivity Disorder:**

Affects 5% of Children in U.S.
More Boys than Girls (3:1).
Co-morbid with Other Disorders.
Oppositional defiant disorder,
Conduct disorder,
Substance abuse,
Impulse control disorders.

ADHD Characteristics:

Impulsiveness	Poor School Performance
Hyperactivity	Over-Talkativeness
Difficulty Concentrating	High Stimulation
Inattention	Risky Behaviors
Distractability	
Forgetfulness	

ADHD Treatment:

No Cure, Manage Symptoms.
Medications - stimulants.
Prognosis:
30% grow out of it.
30% accommodate to symptoms.
40% continue to develop symptoms and co-morbid disorders such as substance abuse.

Oppositional Defiant Disorder (ODD):

Two Types:

Childhood onset - Symptoms by age 8, poorer prognosis.

Adolescent onset.

Characteristics - Oppositional, Defiant, Lies, Cheats, Vindictive, Spiteful, Talks Back, Loss of Temper.

Symptoms more severe over time.

Oppositional Defiant Disorder (ODD):

Best Approach to Treatment is Prevention.
May be Caused by Both Biological and Social Causes.

Prognosis:

Most kids grow out of symptoms.

2% to 16% develop conduct disorder.

Conduct Disorder:

Two Types:

Childhood Onset Type - before age 10, poorer prognosis

Adolescent-Onset Type

Prevalence:

Increase Over Last Decade.

Males under 18: 6% to 16%.

Females under 18: 2% to 9%.

**Conduct Disorder -
Characteristics:**

Aggressive Conduct	Males More
Threatening Behavior	Aggressive
Fighting	Property Loss and Damage
Forced Sex	Deceitfulness
Stealing	Serious Violations of Rules
Vandalism	
Truancy	
Confrontational	

**Conduct Disorder -
Treatment:**

Multi-systemic Therapy - all areas of life
addressed in coordinated fashion.
Medicate Co-morbid Symptoms.
Incarceration Not Rehabilitative.
Prognosis -
Majority remit by adulthood.
Many develop antisocial personality disorder.

**Conduct Disorder -
Treatment:**

Multi-systemic Therapy - all areas of life
addressed in coordinated fashion.
Medicate Co-morbid Symptoms.
Incarceration Not Rehabilitative.
Prognosis -
Majority remit by adulthood.
Many develop antisocial personality disorder.

Childhood Mood Disorders:

Depression - Effect 1% of Children, adult Rates in Adolescence.

Bipolar Disorder - Rare in Childhood, Adult Rates in Teen Years.

Also Co-Morbid with Other Disorders.

Childhood Mood Disorders - Depression:

Characteristics:

- Irritability
- Depressed Mood
- Socially Isolative
- Sleep Disturbance
- Appetite Disturbance
- Poor Grades
- Loss of Interest in Sports, School, Friends.

Childhood Mood Disorders - Depression:

Suicide in Childhood:

- High Mortality in Adolescence - Second Leading Cause of Death.
- Boys More Lethal, Girls More Frequent Attempts.
- Attempts Rare in Prepubescent Children.
- Depression - 10% of People Suicide.
- Bipolar Disorder - 15% of People Suicide.

**Childhood Mood Disorders -
Bipolar Disorder:**

Diagnosis Difficult in Childhood as
Symptoms Resemble Other Disorders, E.g.

Symptoms Shared with ADHD:

- Hyperactivity,
- Impulsivity,
- Talkativeness.

Disorders More Likely Biological in Nature.

**Childhood Mood Disorders -
PTSD:**

Wide Variation in Prevalence Rates
Reported.

Common in Children who Present for
Treatment.

Results from Exposure to Trauma in Any
Form - Sexual, Physical, Exposure in the
Media, Hearing or Watching Violence.

**Childhood Mood Disorders -
PTSD:**

Symptoms -

- | | |
|-------------------------------------|---------------------|
| Re-experiencing
Traumatic Event. | Irritability. |
| Avoidance of
Associated Stimuli. | Anxiety. |
| Persistent Increased
Arousal. | Intrusive Memories. |
| | Hypervigilance. |
| | Dissociation. |
| | Avoidance Behaviors |

Child Crisis, Abuse, or Neglect- Officer Response:

Report Abuse or Neglect Involving Family Member to Social Services.
Abuse or Neglect Involving Non-Relative is Investigated as Criminal Matter.
Children Brought to E.R. Should be Accompanied by Knowledgeable Adult.
Refer to Community Mental Health Center.

Severe Disorders of Adulthood - Schizophrenia:

Five Types.
General Characteristics:
Delusions
Hallucinations
Incoherent or Disorganized Speech
Catatonic (unresponsive) Behavior
Flat or Inappropriate Affect
Symptoms Persistent.

Severe Disorders of Adulthood - Schizophrenia:

Associated Features:
Perplexed & Disheveled Appearance.
Abnormal Psychomotor Activity.
Poverty of Speech.
Depression, Anger, Anxiety.
Depersonalization or Derealization.
Ritualistic or Stereotypical Behavior.
Excessive, Bizarre Concerns with Physical Health.

Severe Disorders of Adulthood - Schizophrenia:

Three Phases of Schizophrenia:

Prodromal Phase - deterioration of functioning before the active phase.

Active Phase - psychotic symptoms present and active.

Residual Phase - persistence of at least two of the symptoms.

Prevalence - Between .2% and 2% in U.S.

Severe Disorders of Adulthood - Schizophrenia:

Prodromal & Residual Symptoms -

Isolation & Withdrawal

Impairment in Life Functioning

Peculiar Behavior

Poor Hygiene

Blunted or

Inappropriate Affect

Speech Disturbances

Odd Beliefs or Magical Thinking

Unusual Perceptual Experiences

Lack of Initiative, Interests, or Energy

Severe Disorders of Adulthood - Depression:

Sustained Period of Depressed Mood

Loss of Interest

Weight Loss or Gain

Insomnia or

Hypersomnia

Psychomotor

Disturbances

Fatigue or Loss of Energy

Feelings or

Worthlessness or

Excessive Guilt

Diminished

Concentration

Thoughts of Death and Suicide

Severe Disorders of Adulthood - Depression:

Associated Features -

- Tearfulness
- Anxiety
- Irritability
- Brooding or Obsessive Rumination
- Excessive Concern with Physical Health
- Phobias or Panic Attacks

Severe Disorders of Adulthood - Depression:

Prevalence -

Lifetime Risk - 10% to 25% for Woman
5% to 12% for Men

Point Prevalence - 5% to 9% for Women
2% to 3% for Men

Severe Disorders of Adulthood - Bipolar Disorder:

Manic Episodes Accompanied by Depressive Episodes

Manic Episodes -

- Elevated, Expansive, or Irritable Mood
- Grandiosity, Inflated Self Esteem
- Decreased Need for Sleep
- Talkativeness
- Flights of Ideas or Racing Thoughts

Severe Disorders of Adulthood - Bipolar Disorder:

Manic Episodes -

- Distractibility
- Increased Goal Oriented Activity
- Psychomotor Agitation
- Excessive Involvement in Pleasurable Activities
- Lack of Concern for Potential Consequences
- Buying Sprees, Reckless Driving, Casual Sex

Severe Disorders of Adulthood - Bipolar Disorder:

Impaired Functioning in Major Life Areas

Associated Features -

- Poor Insight to Illness
- Resistance to Treatment
- Rapid Shift to Depression or Anger
- Hallucinations or Delusions
- Euphoric, Elevated, Expansive, or Irritable Mood

Severe Disorders of Adulthood - Bipolar Disorder:

Prevalence -

Lifetime Prevalence in Community Varies from .4% to 1.6%

Equal Prevalence in Men and Women

Severe Disorders of the Elderly:

Delirium -
A Medical Emergency.
Acute Fluctuations in Brain Functioning.

Dementia -
Chronic Change in Brain Functioning
Prevalence - 5% of People Over 65
Risk Increases by 8% Every 5 years

Severe Disorders of the Elderly - Alzheimer Disease:

Characterized By -

Multiple Cognitive Defects

Impaired Memory Without Impaired
Consciousness

Severe Disorders of the Elderly - Alzheimer Disease:

Cognitive Functions Affected:

General Intelligence	Perception
Learning & Memory	Attention & Concentration
Language	Judgement
Problem Solving	Social Abilities
Orientation	

Severe Disorders of the Elderly - Alzheimer Disease:

Prevalence & Other Statistics -

- 4 Million People Suffer From Alzheimer.
- 20 Million People have Family With It.
- 40 Million People Know Someone With It.
- By Year 2025, 22 Million People Will Have It.
- 7 out of 10 People With It Live At Home.
- 50% of All Nursing Home Patients Have It.

Severe Disorders of the Elderly:

Handling an Elderly Crisis -

- Remain Calm
- Reassure Caregivers
- Patient May NOT Be Able to Follow Directions
- Transport to Hospital
 - Bring Both Caregiver and Patient
 - Bring ALL Medications & Substances
 - Bring Name of Primary Care Physician

Alcohol & Other Drug Abuse:

Abuse and Dependence Both Defined as Mental Disorder in DSM IV.



Alcohol & Other Drug Abuse:

Abuse is Maladaptive Pattern of Use

Resulting in -

- Failure to Fulfill Obligations
- Physical Hazards
- Legal Problems
- Recurrent Social & Interpersonal Problems



Alcohol & Other Drug Abuse:

Dependence is Pattern of Use Causing Impairment or Distress Including -

- Tolerance
- Withdrawal
- Increasing Amounts Over Longer Time
- Unsuccessful Attempts to Control Use
- Time Spent Obtaining, Using, Recovering
- Activities Given Up Due to Use
- Continued Use Despite Problems

Alcohol & Other Drug Abuse:

Incidence of substance abuse higher among persons with chronic mental disorders.

Correlated not generally causal.



Alcohol & Other Drug Abuse:

Long term use can result in deteriorated functioning.

- Can cause:
 - Depression.
 - Dementia.
 - Anxiety disorders.



Alcohol & Other Drug Abuse:

Use and withdrawal can cause acute psychotic symptoms.

Addiction is chronic, progressive, & terminal.



“Dual-diagnosis”:

Co-occurring disorders (e.g., Schizophrenia & Substance Abuse).

Describes 75% of persons with mental disorders in contact with criminal justice system.



“Dual-diagnosis”:

Reasons for Substance Abuse:

- Social.
- Self-medicating.
- Addiction.



**“Dual-diagnosis”:
Treatment -**

Must Address Both Problems in Integrated or Coordinated Fashion to be Effective.
Many Treatment Providers or Agencies Only Treat One of the Disorders ignoring the Other.
Should Focus on Relationship Between the Mental Illness and the Substance Abuse.

**“Dual-diagnosis”:
Dangerousness**

Research Shows Persons with Mental Disorders who are Abusing -Substances have a Higher Incidence of Violence and Criminal Behavior.



Psychotropic Medications:

Affect Nervous System and Behavior.

Do Not Cure, Only Treats Symptoms.



Psychotropic Medications:

Alter Neurotransmitters in the Brain.

Neurotransmitters are Chemicals that Allow Nerve Cells to Communicate.

Diffuse in Effect on Nervous System.

Produce Unwanted "Side-effects".



Psychotropic Medications:

Uncomfortable Side-effects -

- Dry Mouth
- Constipation
- Muscle Tension
- Dizziness
- Flushed Face
- Sexual Dysfunction

**Psychotropic Medications:
Side-effects**

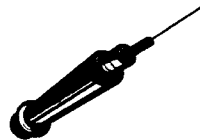
Intolerable & Dangerous Side-effects:

- Dystonia – muscle spasm.
- Akathesia – restlessness of legs.
- Parkinsonianism – tremor.
- Tardive dyskinesia – irreversible twisting, grimacing, protruding.
- Suppression of immune system.

**Psychotropic Medications:
Side-effects**

Can Sometimes be Reversed by Stopping
or Adding Another Medication.

Blood Levels of Some Medications Must be
Monitored Closely.



Psychotropic Medications:

New Generation Drugs Being Developed:

- Less Side-effects.
- Different Side-effects.
- May Not be as Effective.
- Are VERY Expensive.



Psychotropic Medications:

Patients Stop Taking Medication (Non-compliance):

- Side-effects Intolerable.
- Feel Better.
- Prefer Feeling "themselves".
- Do Not Want to be Sick.
- Do Not Recognize They Have an Illness.



Mental Retardation:

- Below Average Intellectual Functioning.
- Begins Before Age 18, Usually Present at Birth.
- Unrelated to Other Mental Illness.



Mental Retardation:

Impaired Social-living Adaptation & Functioning:

- Personal care & hygiene.
- Money management.
- Leisure activities.
- Social relationships.



Mental Retardation:

- Lack Basic Knowledge.
- Short Attention Span.
- Easily Distracted.
- Difficulty Communicating.
- Inappropriate Appearance.
- Difficulty Understanding Consequences.
- Eagerness to Please Others.



Myths & Facts About Mental Illness:

Persons with mental illness are dangerous, violent, and should be locked up?



They are "crazy" because of upbringing and bad parenting?

Myths & Facts About Mental Illness:

Persons with mental illness are lazy, unproductive, and weak.



They do not have the same feelings and emotions as the rest of us?

Myths & Facts About Mental Illness:

Stigma – portrayed by media & culture as:

- Deviant
- Unpredictable
- Dangerous
- Evil



Myths & Facts About Mental Illness:

Words used to describe persons with mental disorders are often demeaning and reinforce stigma.



People are not their illness, they are not "the mentally ill".

Myths & Facts About Mental Illness:

Mental illness is not uncommon:

Schizophrenia is 6 X more common than insulin dependant diabetes, 60 X more common than muscular dystrophy.



Myths & Facts About Mental Illness:

Prevalence of mental illness in U.S. adult population:

	<u>Persons</u>	<u>% of pop.</u>
SPMI	5.4 mil	2.7%
Serious	11.4 mil	5.7%
Dx. Mental Disorder	48.2 mil	24.1%

Estimates by Center for Mental Health Services, US Government. February 1996.

Myths & Facts About Mental Illness:

Emotional Disturbance and Resulting Behaviors may be Caused by Numerous Factors:

- Mental illness.
- Substance intoxication or withdrawal.
- Medical conditions.
- Situational stress.



Myths & Facts About Mental Illness:

When Dealing with an Emotionally Disturbed Person, Remember, "Things are Not Always as They Appear To Be".

Rule Out Medical Problems First.

Remember that People May Not Be ABLE to Respond as You Want Them To.



SECTION III

**OFFICER INTERACTIONS
WITH EMOTIONALLY
DISTURBED PERSONS**

**Indicators of Mental
Illness:**

General characteristics associated with
mental illness:

- Inappropriate
- Inflexible
- Impulsive



**Indicators of Mental
Illness:**

- Lower Tolerance For Stress.
- Unusual and Upsetting Behaviors.
- Generally Not an Immediate Threat.



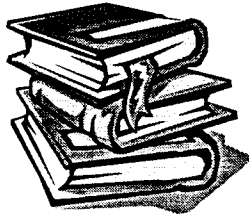
Cause of Behavior:

- Mental Illness?
- Emotional Disturbance?
- Intoxication?
- Medical Condition?
- Some or All of the Above?



“CAST – A – MOP”

- C – Consciousness
- A – Activity
- S – Speech
- T – Thought
- A – Affect
- M – Memory
- O – Orientation
- P – Perception



Consciousness:

- Awareness
- Attention
- Responsiveness



- Coma---Inattention---
- Distraction---Confusion

Activity:

Motor Activity:

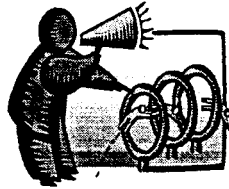
- Increased.
- Decreased.
- Unusual.



Speech:

Process of Speech –
Rate,
Volume,
Tone.

Content of Speech-



Thought Process:

- | | |
|----------------|-----------------|
| Sequential | Loose Associati |
| Circumstantial | Flight of Ideas |
| Tangential | Perseveration |
| Blocking | |



Thought Content:

- Delusions
- Thought Control
- Thought Broadcasting
- Obsessions
- Ideas of Reference
- Homicidal or Suicidal Ideation



Mood and Affect:

- Mood –
- Affect –
- Extreme
- Incongruent
- Inappropriate
- Labile
- Rapid fluctuation
- Flat



Memory:

- Registration
- Retention
- Recall
- Recognition



Orientation:

Person

Place

Time



Perception:

All Five Senses:

- Auditory
- Visual
- Tactile
- Olfactory
- Taste



Hallucinations – Perception Without External Stimulus.

Physical Symptoms:

Skin

Pupils

Breath

Extremities



Witnesses & Families:

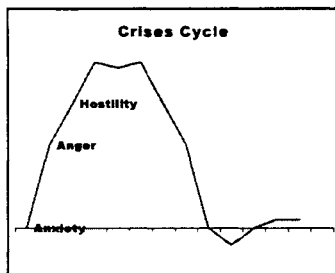
- In treatment?
- History of hospitalization?
- Taking medications?
- Abusing substances?
- Threatening?
- Access to weapons?
- Neglecting personal care?
- Traumatic events?



Questions to Ask:

- | | |
|------------|--------------|
| Name? | Suicidal? |
| Residence? | Homicidal? |
| Oriented? | Medications? |
| Last meal? | Treatment? |
| Sleeping? | SSI? |
| Drug use? | Fearful? |
| Voices? | In control? |

Crises Escalation Cycle:



Crisis Escalation Cycle:

Predictable stages.

Unless psychotic or intoxicated - erratic.



Crisis Escalation Cycle:

Normal Behavior

Stimulus Causing Person to Become:

- Excited,
- Active,
- Upset,
- Physically Uncomfortable.

Crisis Escalation Cycle:

Stimulus Producing Change May Be -

External - Words, Behavior, or Environmental.

Internal - Physical Illness, Pain, Emotional Upset, Internal Stimuli.

Verbal Capacity Decreases by 50% to 75%.

Crisis Escalation Cycle:

Escalation and Anger -

- Red Face,
- Tense Muscles,
- Talkativeness,
- Withdrawal,
- Increased Activity.

Verbal Capacity Decreases to 25% to 50%.

Crisis Escalation Cycle:

Anger to Hostility -

Ability to Comprehend Verbal Communication
Drops to Between 5% and 25% of Normal.

Crisis Stage -

Ability to Comprehend Drops to 0% to 5% of
Normal.

Communication:

Interactive phenomenon involving:

Words;

Behaviors;

Context.



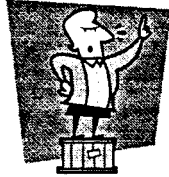
Communication:

Verbal components -

Content of speech.

Process of speech:

- Rate.
- Tone.
- Volume.
- Congruency with other messages.



Communication:

Non-verbal components:

- Stance;
- Gestures;
- Eye movements;
- Facial expressions;
- Personal attire;
- Motor movements.



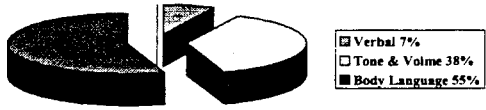
Communication:

Other factors:

- Culture;
- Religion;
- Sex/Gender;
- Social/Economic status;
- Perceptions;
- Values.



Communication: Under Stress -



Violence Curve:

SUSPECT/ PERSON	OFFICER
Level 4: Violence	Anger/Fear
Level 3: Hostility	Fear
Level 2: Anger	Anxiety
Level 1: Anxiety	Empathy
Calm	Supportive

Violence Curve:

As you move up chart towards violence, communication abilities diminishes:

- Tunnel vision;
- Concrete thinking;
- Increased stress level;
- Flight or fight response;
- Officers separate out feelings, increase cerebral activity.



Communication:

Officer Goals:



Bridge paradox between suspending emotion and responding to it.

Pace and guide subject to lower level of arousal.

Develop and use communication skills.

Level 1: Anxiety

Subjective & uncomfortable emotion.

Results from perceived threats.

Associated with dread & helplessness.

Goal:

Provide support to restore sense of control.

Negotiate alternative action to crisis.

Level 1: Anxiety

Techniques:

Open posture;

Direct eye contact;

Promote relaxation;

Acknowledge emotions (labeling);

Paraphrasing;

'I' Statements;

Active listening;

Negotiation.



Level 2: Anger

Serves to reduce sense of helplessness, dread and anxiety.

Gives one a sense of power or control.

Can quickly escalate into violence.

Goal: Keep subject talking, utilize time to de-escalate agitation.

Level 2: Anger

Techniques:

Bladed stance;

Promote relaxation;

Open posture;

Be respectful and genuine;

Use voice in calming way;

Keep it simple;

Acknowledge and affirm emotion;

Direct to follow your good plan.



Level 3: Hostility

Anger with a focused recipient.

Easy to detect.

Potential quick transition to violence.

BE CAREFUL!



Goal: Obtain immediate control, diffuse to more manageable, less agitated stage.

Level 3: Hostility

Techniques:

- Limit setting;
- Diffuse adversarial stance, acknowledge anger;
- Provide directives;
- Warn of consequences.
- Monitor own response;
- Short simple verbalizations, non-verbals more important.

Level 4: Violence

Aggression with focus on destruction.
Goal of violence is injury.

Goal: Protect self and others.



Interaction Basics:

- Personal Safety First!
- Be aware of the environment.
- Proper positioning:
 - At least a leg's length.
 - Non-threatening, safe stance.
 - Calm, low tone of voice.
 - Hands out, palms up.



Interaction Basics:

Use Strategy:

- Small, concrete goals.
- Assume real concern.
- Meet reasonable demands.
- Re-focus attention on you.
- Reduce anxiety.
- Reduce excessive stimuli.



Interaction Basics:

Rely on verbal interventions:

- Use name, introduce yourself.
- Be polite in requests & statements.
- Use I statements.
- Listen.
- Validate feelings & concerns.
- Clarify problem.
- Restore problem-solving capacity.



Interaction Basics:

Try not to:

- Take it personally.
- Make promises you can't keep.
- Demand obedience.
- Get in power struggle.
- Act afraid or angry.
- Laugh inappropriately.



SECTION V

**LEGAL AND LIABILITY
ISSUES**

Civil Commitment:

Civil Commitment Laws Designed To:

- Secure Humane Treatment.
- Maximize Personal Dignity & Rights.
- Minimize Deprivation of Liberty.
- Encourage Family Involvement.
- Encourage Voluntary Treatment.



Civil Commitment:

Mental Illness Defined -

"A substantial disorder of cognitive, volitional, or emotional processes that grossly impairs judgement or capacity to recognize reality or to control behavior."

Civil Commitment:

Gravely Disabled Defined -

"If the mental illness causes him to be unable to care for himself so that he is in danger of serious physical harm **or**, causes a lack of judgement and understanding in managing life's resources and relationships significant enough to endanger his health and safety, **or** shows a deteriorating course leading towards danger to self or others."

Civil Commitment:

72 Hour Hold Criteria:

Mental Illness,
Imminent Danger to Self or Others,
Or Gravely Disabled.

MAY be taken into custody for 72 hour mental health hold.

Civil Commitment:

72 Hour Hold Authority -

Who:

- Peace Officers,
- Psychiatrists,
- Psychologists,
- Psychiatric Nurses,
- Licensed Counselors and Therapists,
- Licensed Social Workers
- Judge.



Civil Commitment:

72 Hour Hold Process -

Authorized Professional May Issue Protective Order to Officers Asking that a Specific Individual be Taken into Custody for Care and Treatment.

Officers Should be Certain Protective Order was Signed Within the Last 72 Hours.

Civil Commitment:

72 Hour Hold Process -

Protective Custody Not an Arrest.

Officer May Act in Reasonable and Prudent Manner to Assure Safety.

Officer May Rely on Reliable and Interested Third Party to Establish Cause for Hold.

Civil Commitment:

72 Hour Hold Effect & Confinement -

Confinement is for Period of Evaluation.
Place of Confinement Should be Approved Facility, Preferably a Hospital.

Jail Used ONLY as Last Resort.

No longer than 24 hours.

Kept separate from criminals.

Civil Commitment:

72 Hour Hold Conclusion -

- Person Released as No Longer Dangerous or Gravely Disabled.
- Person Enters Treatment on Voluntary Basis.
- Person Certified for Involuntary Treatment.



Civil Commitment:

Certification -

- Made by a Medical Doctor or Licensed Psychologist.
- Court Appoints an Attorney.
- Review Hearing Held Within 10 Days Requested.



Civil Commitment:

Certification Review Hearing -

- Hearing by Judge or Jury.
- Burden of Proof by "Clear and Convincing Evidence" on Party Seeking to Detain.
- Short Term Certification is for 3 Months, May be Repeated 2 Times.
- Long Term Certification is 6 Months, May be Repeated Infinitely.

Emergency Commitment - Alcohol:

"When a person is intoxicated or incapacitated by alcohol and clearly a danger to the health and safety of himself or others, he *SHALL* be taken into custody by law enforcement authorities or an emergency service patrol"



Emergency Commitment - Alcohol:

Unlike 72 Hour Hold, this Law Requires Officers to Take a Qualifying Person Into Custody.
Law Creates Liability for Officers if You Fail to Take Qualifying Person into Custody and Damage Occurs.
Must Have Probable Cause of Intoxication and Dangerousness.

Emergency Commitment - Alcohol:

Place of Confinement -

Approved Holding Facility.



Emergency Medical Facility or Jail *Only* if Approved Holding Facility is Unavailable.

Emergency Commitment - Alcohol:

Considered Protective Custody, Not an Arrest.
Resistive Persons Not Resisting Arrest.
Resistive Persons May be Obstructing Officer.
Search and Seizure Applies.
Officers May Protect Themselves by "Reasonable Methods".
No Liability for Acting in Course of Duties in Compliance with Above.

Emergency Commitment - Alcohol:

Process -
Make Written Application to Administrator of Approved Holding Facility:
State Circumstances Requiring Emergency Commitment.
Include Personal Observations and Statements of Others Relied Upon.
Furnish Copy to Person Being Committed.

Emergency Commitment - Alcohol:

Process -
Upon Approval of Application Person Committed, Evaluated, and Treated.
Period Not to Exceed 5 Days.
May Be Held 10 Days if Petition is Filed with the Court.
If Application Not Approved, Immediately Release and Encourage Voluntary Treatment.

Emergency Commitment - Alcohol:

Interested Third Party May Petition Court to Order Police to Pick-up & Transport an Intoxicated Person to an Approved Facility.

Before Picking a Person Up Officers Should -

Verify that Facility Director or Designee has Signed Written Application.

Signed Application is Valid, Legal Authority to Pick-up and Transport.

Criminal Commitment - Incompetent to Proceed:

Criteria -

Mental Disease or Defect that Renders Person Incapable:

Of understanding the nature and course of the criminal proceedings; *or*

Of participating or assisting in defense; *or*

Of cooperating with attorney.

Criminal Commitment - Incompetent to Proceed:

Grounded in Common Law & Due Process -

1600's, England, Blackstone Wrote:

"Defendant who becomes mad should not be arraigned for how can he make his defense?"

English Courts Had Difficulty with Defendants Who Would Not Enter a Plea, Without Plea Trial Could Not Go Forward.

**Criminal Commitment -
Incompetent to Proceed:**

Defendant Refusal to Enter Plea Resulted
in Determination of Reason -

"Mute of Malice" - Weights Placed on Chest in
Effort to Compel Plea.

"Mute by Visitation of God" - Included Deaf
and Dumb, Gradually Expanded to Include
"Lunatics".

**Criminal Commitment -
Incompetent to Proceed:**

Colorado Law -

"No person shall be tried , sentenced, or
executed if incompetent".



CRS 16-8-11(1)(b)

**Criminal Commitment -
Incompetent to Proceed:**

Raising the Issue of Incompetence -
May be Raised by Court, Prosecutor, or
Defense.

Presumption of Competence Without "Reason
to Believe" Otherwise.

With Reason to Believe Comes "Duty to
Suspend Proceeding and Determine the Issue".

**Criminal Commitment -
Incompetent to Proceed:**

Evaluations -

- Court May Order To Make Determination.
- Evaluation May Be In-patient or Out-patient.
- Court, Prosecutor, or Defense May Request Further Evaluation "for Good Cause Shown".
- Defendant May Hire Own Evaluator.
- Court Must Advise Defendant of Reason for Evaluation and Rights.

**Criminal Commitment -
Incompetent to Proceed:**

Defendant's Rights -

- Read Reports of Evaluations.
- Cross Examine Witnesses at Hearing.
- Call own Witnesses.
- Consult With Counsel Before Evaluation.
- Remain Silent. Silence May be Used as a Factor at Competency Hearing, But Not as Proof of Guilt at Trial.

**Criminal Commitment -
Incompetent to Proceed:**

Preliminary Findings & Hearings -

- After Review of Report of Examination Court Makes Preliminary Finding.
- Prosecutor or Defense May Request a Hearing Before Same or Different Judge.
- If No Request for Hearing, Preliminary Findings Become Final Determination.

**Criminal Commitment -
Incompetent to Proceed:**

Hearing on Preliminary Finding -
Burden of Proof is by "Preponderance of
Evidence" on Party Asserting Incompetence.
Experts May Testify.
Lay Witnesses May Testify.
Final Determination Made at Conclusion.
If Competent, Proceedings Resume.
If Incompetent, Committed to Department of
Human Services or Out-patient Treatment.

**Criminal Commitment -
Incompetent to Proceed:**

Incompetent Defendant's Rights -
Remain Silent at Evaluation.
Evidence from Evaluation Can Only Be Used:
At Competency Hearing.
For or Against Mitigation at a Capital Sentencing.
To Impeach or Rebut a Defendants trial Testimony if
Evidence was Given Voluntarily.
Right to Bond
Right to Preliminary Hearings and Motions.
Right to Treatment.

**Not Guilty by Reason of
Insanity:**

A person who is insane is not responsible
for his or her criminal conduct under
Colorado Law (CRS 18-1-802)



Not Guilty by Reason of Insanity:

Insanity = Legal Concept, Not Clinical One

Definition:

"So diseased or defective in mind...as to be incapable of distinguishing right from wrong".

Does not include "moral obliquity, mental depravity, or passion growing out of anger, revenge, hatred, or other motives and kindred evil conditions...".

Impaired Mental Condition:

"A condition of the mind caused by mental disease or defect that prevented the person from forming a culpable mental state that is an element of a crime..." (CRS 16-8-101.5)

Excludes repeated criminal or antisocial conduct.

Excludes voluntary ingestion of alcohol and drugs.

Not Guilty by Reason of Insanity:

Must be raised by defendant or his attorney.

Affirmative Defense: Defendant must prove his insanity.

Defendant loses claim to confidentiality.



Psychiatry

Not Guilty by Reason of Insanity:

If found NGRI or Impaired Mental Condition, the court commits to custody of Department of Human Services until eligible for release.



Not Guilty by Reason of Insanity:

Release:
Court can order hearing at any time.
Hearing ordered if report received that defendant no longer requires hospitalization.
Defendant may request hearing after 180 days and once a year thereafter
Defendant has burden of proof of restoration of sanity.

Not Guilty by Reason of Insanity:

Conditional Release:
Court may impose conditions determined to be in best interest of defendant and the community.
Must cooperate with treatment.
Monitored by the court.

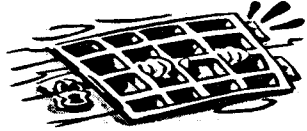


Criminal Commitment:

Length of Hospitalization:

Unfit to Proceed – Statutory Maximum of Crime charged.

NGRI – No Limit on Length of Hospitalization.



**Protective Custody –
Use of Force:**

Fourth amendment protection against use of excessive force includes not being "hog-tied" when susceptible to positional asphyxia.

"Hog-tied" defined as binding ankle to wrists, behind back, with 12 inches or less of separation.



**Protective Custody –
Use of Force:**

Hog-tie ruling applies only to persons of diminished capacity, including:

- Intoxicated persons,
- Discernable mental condition,
- Any other condition.



**Protective Custody –
Use of Force:**

Officer must keep into perspective the goal of obtaining care and treatment.
Use of force should be comparable to what would be justified in performing any other legal duty against a person.
Reasonable use of force determined by goal of obtaining care and treatment.

Liability:

Right to Liberty – all persons have right to freedom, unless statutory authority deprives them of that right.
Commitment laws provide statutory authority if person has mental disorder and meets criteria defined in that law.
Remember the laws place emphasis on “imminent danger”.

Liability:

IMPORTANT –



Follow procedures outlined in commitment laws,
Follow Department Policy and Procedures,
Know the criteria for detaining someone under these civil procedures.

Liability – Protective Custody vs. Arrest:

Protective Custody less intrusive than arrest.
Difference in degree to which liberty can be restricted.
Degree of restriction depends on purpose of detention.

Liability – Protective Custody vs. Arrest:

Limited statutory purposes for custody:

Transport to facility for evaluation, care, and treatment.

Prevent mentally ill person from harming self or others.



Liability – Protective Custody vs. Arrest:

Protective Custody NOT an Arrest:
Cannot be housed in jails or lock-ups,
Cannot be subjected to disciplinary procedures,
Cannot have visiting restricted,
Cannot be "hog-tied".
If you charge with a crime you cannot institute 72-hour hold process.

**Liability – Custodial
Responsibility:**

Officer is responsible for the safety, care, and well being of person in custody. Exercise care in accomplishing this duty.

Always keep in mind officer safety considerations.

Duty of care affected by specific known facts and risks (i.e. suicide).

During arrest or custody take reasonable precautions to prevent harm.

**Liability – Transfer of
Custody:**

Control over another person's freedom of movement is turned over to another.

Officer obligation to take someone into custody may not extend to treatment facility.

Explore other options if facility refuses to accept.

Liability:

Follow Department Policy and Procedure.

Follow procedure outlined in the statutes.

Act within scope of responsibility and duty.

Do not demonstrate willful and wanton neglect.

Act as reasonable and prudent officer.

Liability - Breach of Duty:

No general duty to protect an individual member of the public.
Your failure to act does not create liability.
May have "special duty" to protect an individual



Liability - Breach of Duty:

"Special Duty" created by –
Representation that induces reliance,
Putting a person in a known zone of danger,
Increase existing risk of injury.
Statutes can create a duty –
Vehicle pursuits,
Stalking and domestic violence.
