Effective Community-based Responses to Mental Health Crises: A National Curriculum for Law Enforcement

Based on Best Practices from CIT Programs Nationwide

BJA
Bureau of Justice Assistance
U.S. Department of Justice

CNA
ANALYSIS & SOLUTIONS

Module 1: Welcome

Course Overview and Administrative Tasks

Pre-Course Survey

- Please complete the **Pre-course survey.**
- Label your survey with a unique and memorable identifier (e.g., your badge number, the street where you live).

EFFECTIVE COMMUNITY-BASED RESPONSES
TO MENTAL HEALTH CRISES

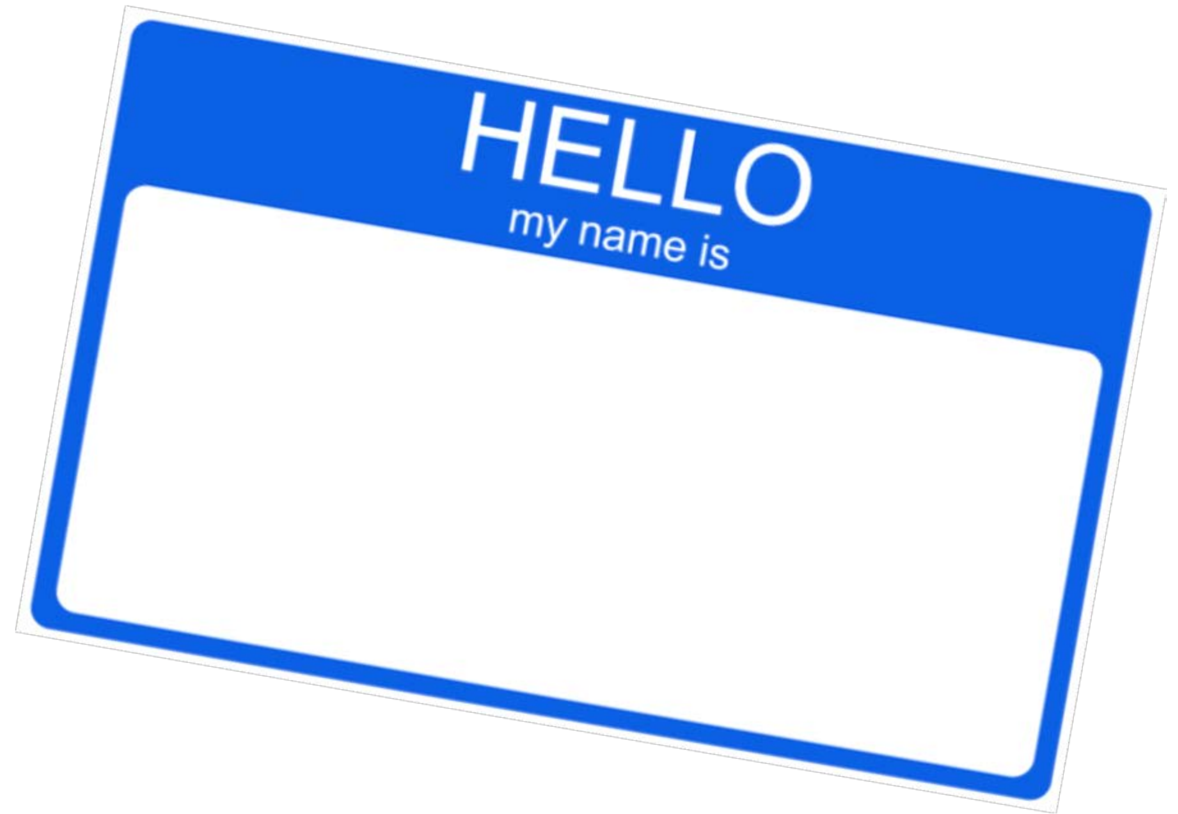
PRE-COURSE SURVEY

Please answer the following questions on a scale of one to five. ***1: Strongly disagree*** ***5: Strongly agree***

	1	2	3	4	5
1. I feel comfortable working with people with mental illness.	☐	☐	☐	☐	☐
2. I believe I have an understanding of what people with mental illness face in their everyday lives.	☐	☐	☐	☐	☐
3. I believe that empathy and rapport building are necessary components of de-escalation in law enforcement.	☐	☐	☐	☐	☐
4. Recovery from mental illness is possible.	☐	☐	☐	☐	☐
5. I see the symptoms of the mental illness separate from the person who has the illness.	☐	☐	☐	☐	☐
6. I am able to tell if a person is psychotic.	☐	☐	☐	☐	☐
7. I know how to interact with a person with serious mental illness.	☐	☐	☐	☐	☐
8. Jail is a safe place for people with mental illness.	☐	☐	☐	☐	☐
9. I am able to tell if a person has autism.	☐	☐	☐	☐	☐
10. Mental illness does not get better with treatment.	☐	☐	☐	☐	☐
11. People with severe mental illness do not respond to de-escalation techniques.	☐	☐	☐	☐	☐
12. I believe that people with mental illness can be contributing members of society.	☐	☐	☐	☐	☐
13. People with severe mental illness often require the use of force to maintain officer safety.	☐	☐	☐	☐	☐
14. I can identify resources in my community for people with mental illness.	☐	☐	☐	☐	☐

Introductions and Activity

- Instructors
- Participants



What to expect this week

- New concepts
- New terminology
- Clear learning objectives
- Hands-on work and exercises
- Site visits and visits from key partners
- Development of skills

What to expect this week, continued

- 25 modules, varying in length from ½ hour to 4 hours
- Varied learning locations
- A variety of instructors, with diverse credentials
- Lively interactions, open discussions, and learning from each other

Logistics

- Breaks
- Cell phones
- Respectful conversations
- Privacy and shared stories
- Restrooms
- Lunch
- Locations

A note about terminology

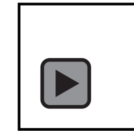
People with mental illness will be referred to as such throughout this curriculum. We have chosen this “people first” approach purposely, because we believe this reflects the priorities of CIT. In like fashion, we will avoid terms like "the criminally insane.”

Other terms exist to refer to people with mental illness, including “clients,” “patients,” “consumers,” and “peers.” While these terms may be acceptable to some, they may not be acceptable to all. Please make an effort to educate yourself about your community’s local and lived perspectives on terminology.

What do you know about CIT?

- Do you know CIT-trained officers?
- Have you heard their stories?
- Have you seen news articles about CIT?
- Have you seen things on social media about CIT programs or CIT officer interactions with people with mental illness?
- Are you aware of some of the benefits of successful CIT programs?

Recent News Story: National Public Radio



What is CIT?

Crisis Intervention Teams (CITs) are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises.

They are built on strong partnerships between law enforcement, mental health provider agencies, and individuals and families affected by mental illness.

What are the goals of CIT?

- Improve officer and community safety
  - Immediacy of response
  - In-depth training
  - Team approach
  - Change police procedures
- Redirect people with mental illness from the judicial system to the health care system
  - Single point of entry
  - No clinical barriers
  - Minimal officer turnaround time

CIT is about…

CIT is about *systems* and *infrastructure of services*

CIT is about *relationships*

CIT is about *community engagement*

CIT is about *partnerships*

CIT is about *advocacy*

CIT is about *leadership*

CIT is about *empathy*

CIT is about *you*

Module 2: Research and Systems

CIT Overview

Background: Problem Statement

- Number of people with mental illness in jails and prisons (2006)
  - 479,000 people in local jails
  - 705,600 people in state prisons
  - 78,800 people in federal prisons
- Number of fatal police contacts
  - 246 people with mental illness being shot and/or killed by police nationwide (2017)
  - People with mental illness are 16 times more likely to be killed during a police encounter
- Number of people with mental illness who are homeless: 216,000

Background: U.S. History

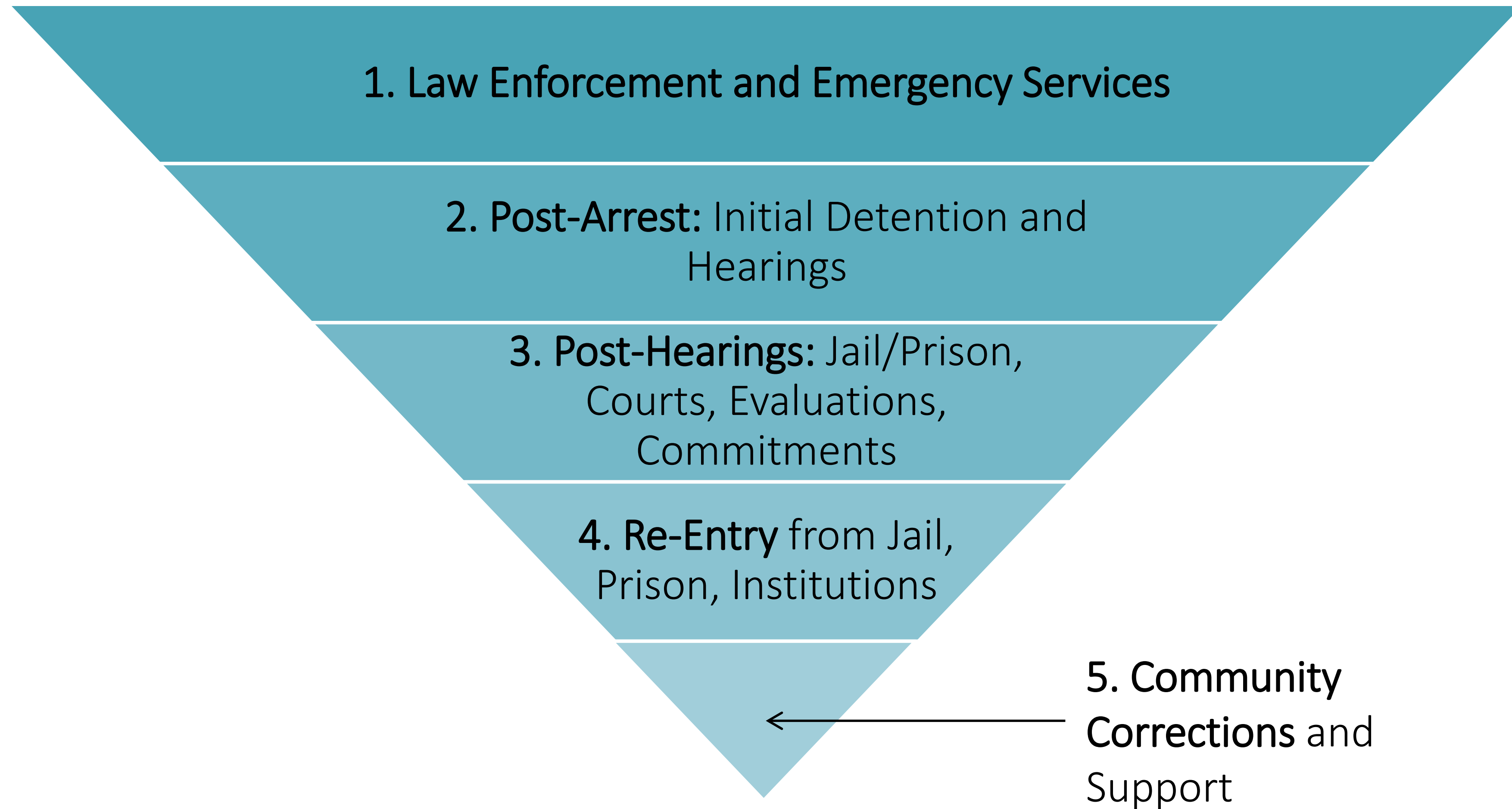
Deinstitutionalization

- Deinstitutionalization refers to the policy of moving people with severe mental illnesses out of large state institutions and then closing part or all of those institutions; it has been a major contributing factor to the mental illness crisis we face in America today.

Today's broken mental health system

- We have not solved the problem created by deinstitutionalization; America suffers from a severe lack of mental health resources and options today.

Criminal Justice Approaches: Sequential Intercept Model



Criminal Justice Approaches

- There are a number of mental health and criminal justice innovations around the nation:
  - Mental health courts
  - Jail and prison mental health evaluations
  - Continuity of care: from arrest to re-entry
  - Community corrections

CIT Background

- CIT grew out of an incident in Memphis in 1987.
- The Mayor of Memphis turned to the National Alliance on Mental Illness (NAMI), Memphis chapter for assistance.
- Together, NAMI, the Memphis Police Department, university leaders at the University of Memphis, mental health professionals and community leaders developed the CIT training model.
- Since 1987, CIT has been steadily adopted by law enforcement agencies throughout the country and the world.

CIT Background

NAMI

The Nation's Voice on Mental Illness

CIT Background

- National prevalence of crisis intervention teams: 47 states, approximately 2,700 programs (source: University of Memphis)

- Legislation by state: At present, there are only three states that *mandate* a 40-hour CIT training course for officers (Virginia, Illinois, and New Mexico). Other states, however, have taken legislative steps to support CIT or other specialized police training. (source: NAMI)

The Memphis Model

- Key characteristics of the Memphis Model:
  - Community partnerships
  - Specialized officer training
  - Emphasis on de-escalating crisis situations
  - Focus on routing to mental health care facilities, rather than jail

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Department of Criminology
and Criminal Justice

CIT Training for Officers

Police officer training in selected topics, including:

- Mental health diagnoses
- Signs and symptoms of mental illnesses
- Psychiatric medications
- Substance use and misuse
- Specialized skills such as crisis resolution and communication
- Mental health and disability law
- Cultural sensitivity

CIT trainers are mental health professionals, criminal justice professionals, and NAMI educators who often volunteer their time.

Jail Diversion and Alternatives to Arrest

- Referral to appropriate health care services such as:
  - Community mental health centers
  - Local hospitals
  - Veterans Administration (VA) facilities

Community-based Model

- CIT steering groups and CIT coordinators:
  - Seek funding
  - Lead community coordination
  - Coordinates training and outreach

CIT Core Elements

The CIT Model has *10 Core Elements* divided into three categories:

- Ongoing elements (3)
- Operational elements (3)
- Sustaining elements (4)

CIT Ongoing Elements

The ongoing elements include:

- **Partnerships**: law enforcement, advocacy, and mental health
- **Community ownership**: planning, implementation, and networking
- **Policies and procedures**

CIT Ongoing Elements

Partnerships

Law enforcement community

- Police department
- Sheriff's department
- Corrections (Probation, Parole)
- Judiciary (Public Defender, State's Attorney, Judges)
- Law enforcement training staff
- Training and standards board or POST

CIT Ongoing Elements

Partnerships

Advocacy community

- Consumers and individuals with mental illness
- Family members of people with mental illness
- Advocacy groups (NAMI, NMHA)

CIT Ongoing Elements

Partnerships

Mental health community

- Providers, educators, practitioners, and trainers
- Professionals (psychologists, psychiatrists, physicians, social workers, counselors, substance use treatment counselors, criminologists)
- Public and non-profit agencies (universities, hospitals, mental health centers, medical schools)

CIT Ongoing Elements

Community Ownership

Planning

- Advocates
- Community members
- Consumers and family members
- Government / Judiciary
- Law enforcement community
- Mental health community

CIT Ongoing Elements

Community Ownership

Implementation

- Leadership from law enforcement, mental health community, advocacy community
- Training curriculum and trainers

CIT Ongoing Elements

Community Ownership

Networking

- Feedback
- Problem solving

CIT Ongoing Elements

Policies and Procedures

CIT training

- Inter-agency agreements
- Size and scope

CIT Ongoing Elements

Policies and Procedures

Law enforcement agency policies and procedures

- Dispatch
- Patrol

CIT Ongoing Elements

Policies and Procedures

Mental health emergency policies and procedures

- Law enforcement referral policies

CIT Operational Elements

The operational elements include:

- Crisis Intervention Team: Law enforcement officers, dispatchers, CIT coordinators, community partners, mental health community, advocacy community
- Curriculum: CIT training
- Mental health receiving facility and emergency services, first responders

CIT Operational Elements

Crisis Intervention Team: Officer, Dispatcher, Coordinators

- CIT officer
- Dispatcher
- CIT law enforcement coordinator
- Mental health coordinator
- Advocacy coordinator
- Program coordinator

CIT Operational Elements

Curriculum: CIT Training

- Patrol officer training, 40 hours, comprehensive
- Dispatch training

CIT Operational Elements

Mental Health Receiving Facility and Emergency Services

- Specialized mental health emergency care

CIT Sustaining Elements

The sustaining elements include:

- Evaluation and research
- In-service training
- Recognition and honors
- Outreach: Developing CIT in other communities

CIT Sustaining Elements

Evaluation and research

- Research on a wide variety of issues

CIT Sustaining Elements

In-Service Training

- Extended and/or advanced training

CIT Sustaining Elements

Recognition and Honors

- Awards (i.e. CIT Officer of the Year)
- Certificates of recognition
- Annual banquets

CIT Sustaining Elements

Outreach: Developing CIT in other communities

- Outreach efforts – regional or statewide
- Legislative efforts

A Model for the Nation

- **Advantages of CIT:**
  - Provides excellent immediacy of response (Deane et al, 1997)
  - Changes nature of intervention
  - Reduces injuries to officers, use of force (Dupont and Cochran, 2000)
  - Changes attitudes/perception (Borum, et al., 1998)
  - Lowers arrest rates (Steadman, et al., 2000)
  - Increases health care referrals (Dupont and Cochran, 2000)
  - Clarifies lines of responsibility

CIT Components

Models of Implementation

For more information, please refer to the following video:

Seattle Police Partner up with Mental Health Expert —
https://youtube.com/watch?v=R-MmPVSGcnM

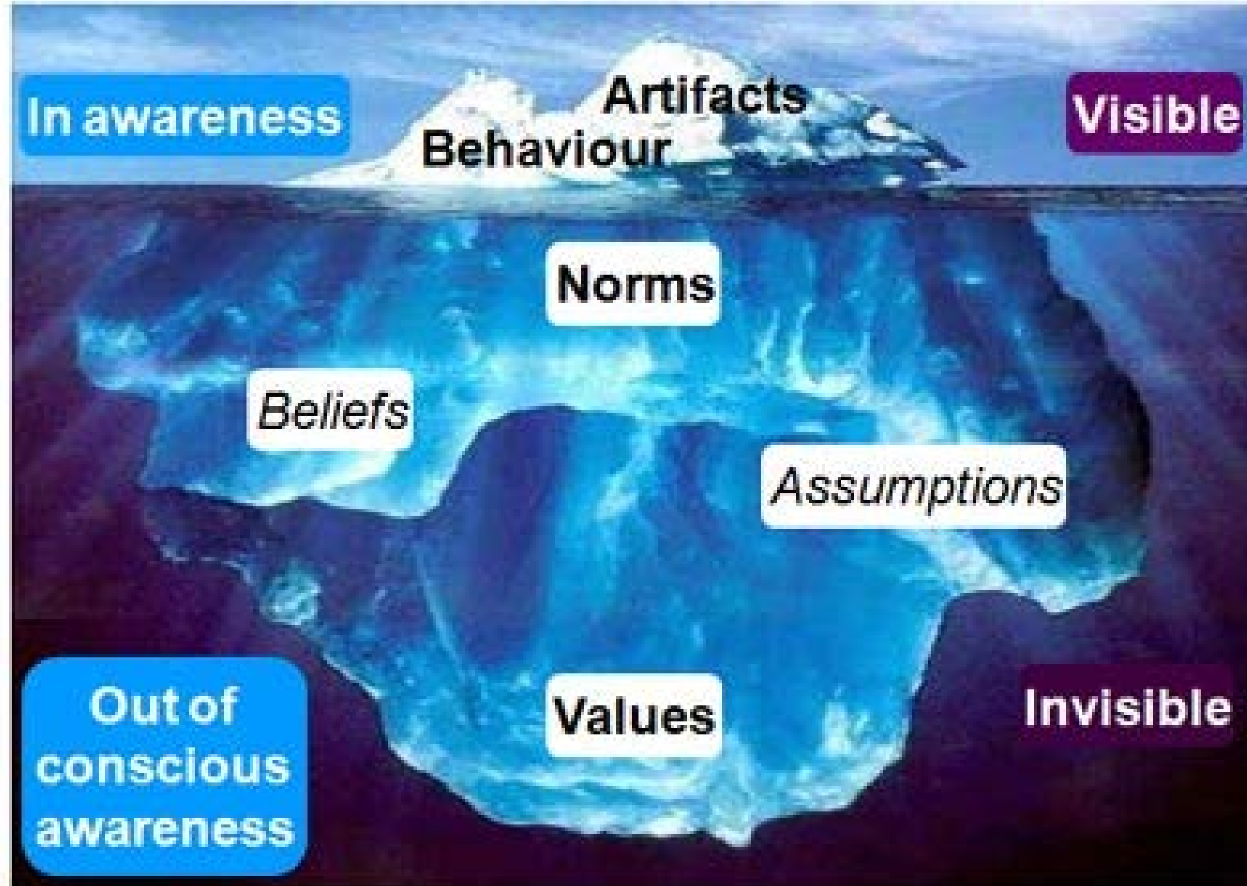
Module 3: Community Support

Cultural Awareness and Mental Health

How would you describe culture?

Meaning, values, and behavioral norms that are learned and transmitted in society and within social groups.

What is culture?



- Why is cultural awareness important in the context of CIT?
- Consider your local community: how does the iceberg apply?
  - What about culture in people who have mental health issues?
  - What about your departmental culture?

What is cultural awareness?

- Understanding people different from you
- Learning new patterns of behavior
- Effectively applying your understanding in the appropriate settings

Cultural Awareness

- Consider our experiences with different cultures, and their impact on you. How have those experiences shaped us?
- What are our assumptions and perceptions?
- Where do they come from?
- How do they affect us as we work with others?
- Why do we need to set them aside when working with others?

Cultural Considerations

Culture influences language, communication, and engagement:

- Directness
- Gestures
- Facial expressions
- Distance
- Touch
- Degree of formality
- Forms of address
- Pace and pitch

Culture may also influence beliefs about mental health and coping strategies:

- Preference to seek therapy with a professional vs. talking things out with family
- Disinclination to take medications for mental illness
- The level and way in which families support a family member struggling with mental illness
- Ability (or inability) to see strengths in a person's experience, regardless of diagnosis

What is diversity?

The understanding that each individual is unique, recognizing our individual differences. These can be along dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, experiences, and other ideologies.

The Bottom Line

Treat everyone with ***respect***.

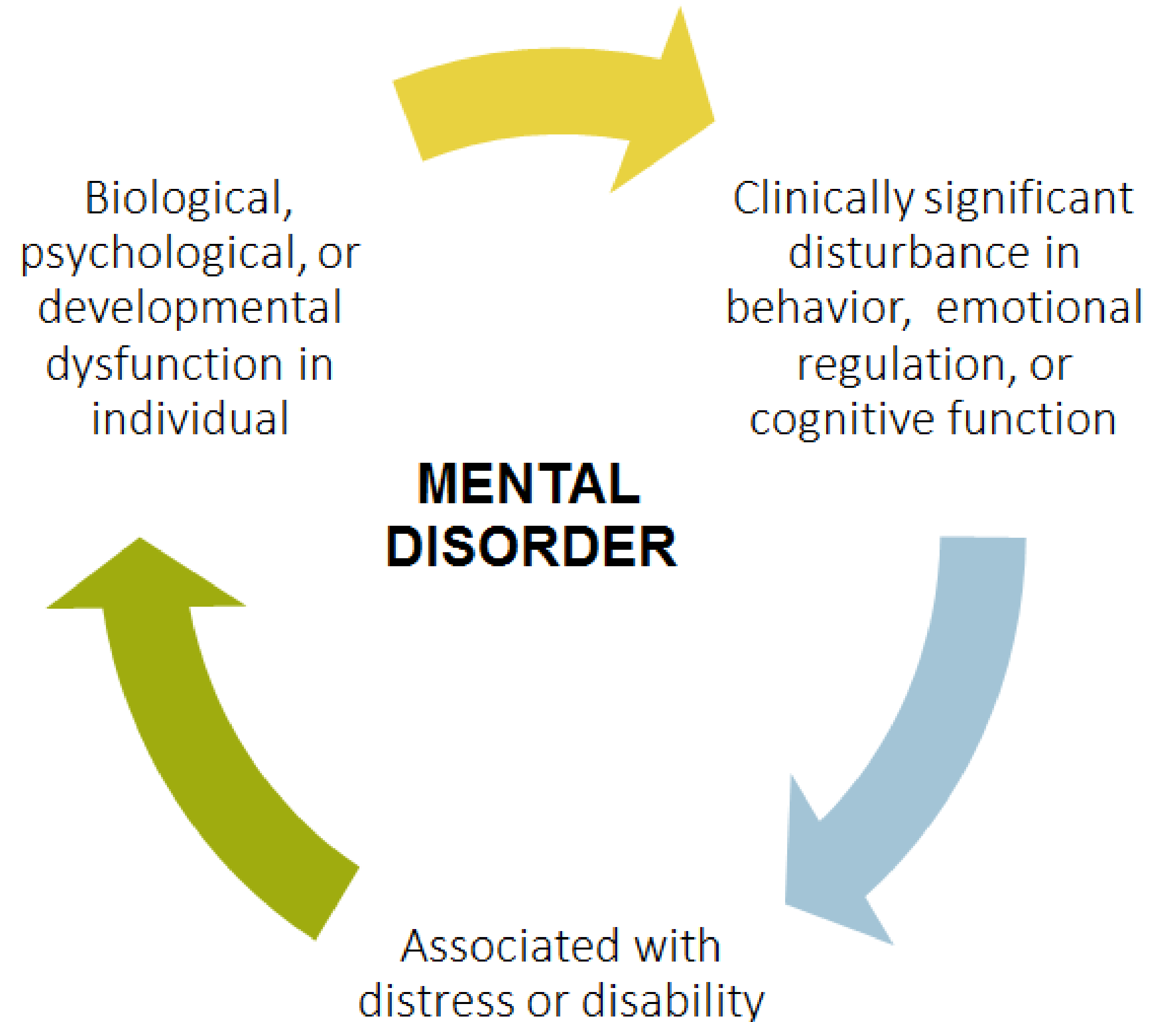
People from differing cultures show respect to others in different ways. Differences may be particularly relevant to authority figures like law enforcement and emergency personnel. Make efforts to understand your community and help them to understand you.

Module 4: Mental Health Basics

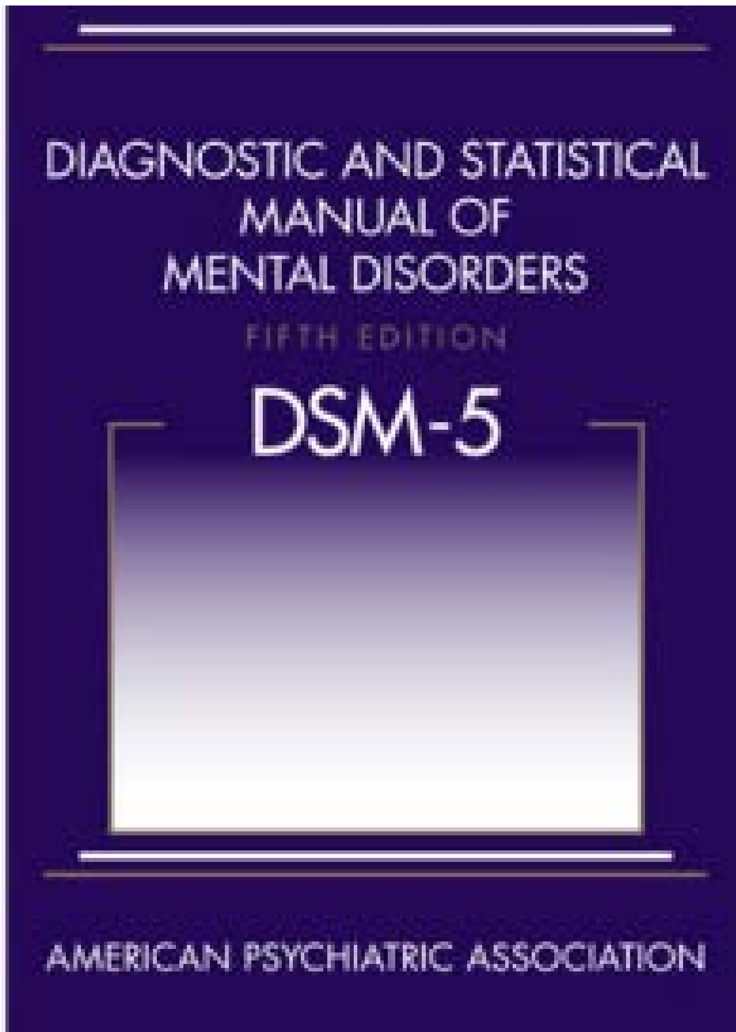
Depressive Disorders

Severe, Persistent Mental Illnesses

- How do you differentiate between a mental illness and stress?
- How might signs or symptoms differ?



General Psychiatric Diagnosis and Symptoms



- Mental health disorders are laid out by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5).*
  - List of diagnoses
  - List of criteria to be met
  - Description of symptoms
  - Description of impairments
- The DSM-5 is meant to only be used by trained professionals to diagnose clients.

Recognizing Signs and Symptoms of Mental Illnesses

- Excessive feelings of fear or worry
- Feeling excessively sad or low
- Extreme changes in mood
- Confused thinking
- Irritability or anger
- Avoiding friends and/or social activities
- Change in eating habits
- Inability to carry out daily activities; difficulties perceiving realities (delusions or hallucinations)
- Lack of insight; inability to perceive changes in one's own feelings
- Abuse of substances
- Physical symptoms, without obvious causes (aches and pains)
- Thoughts about suicide

Depressive Disorders

Depressive Disorders include the presence of sad, empty, or irritable moods. These disorders also include changes in the way people think and behave.

- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

Mood disorders, including major depression and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.

Major Depressive Disorder: Living with Depression

For more information, please refer to the following video:

Living with Depression –

https://youtube.com/watch?v=EJ_S5Rjt_iI

Major Depressive Disorder

Signs and symptoms include:

- Depressed mood most of the day
- Diminished interest or pleasure in activities
- Changes in appetite, leading to significant weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation or slow movements
- Sleep disruptions
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death, suicidal ideation/thoughts, suicide attempt

Depression

Important notes:

- Not everyone who has depression becomes suicidal.
- Major depressive disorder (MDD) impacts social and occupational functioning.
  - MDD is frequently characterized by insomnia and agitation.
- Many people experience depression.
  - One in five Americans may experience a severe depressive episode at any point in time.
  - The ratio of women to men with depression is 2:1. It is believed that depression among men is underreported.
  - It is estimated that about 20 million people in America suffer from a depression severe enough to interfere with their life each year.
    - Depression may lead to substance misuse and eating disorders.
    - The economic impact of depression exceeds $210 billion a year.

Major Depressive Disorder: Depression Isn’t Always Obvious

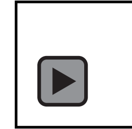
For more information, please refer to the following video:

> Depression Isn’t Always Obvious —
> https://youtube.com/watch?v=1Yq6W7YAHM4

Persistent Depressive Disorder (Dysthymia)

- **Persistent Depressive Disorder (dysthymia)** involves depression symptoms that are present for most days over a ***two-year time period.***
- Cognitive symptoms are more prevalent with individuals with dysthymia.
- Symptoms include:
  - ✓ Poor appetite
  - ✓ Insomnia or hypersomnia
  - ✓ Low self-esteem
  - ✓ Hopelessness
  - ✓ Low energy

Depressed Teen's Struggle to Find Mental Health Care in Rural California



Depressive Disorders: SARAH | *A Case Study*

Sarah is a 16-year-old female. She has recently become withdrawn from her family and friends. She has become less interested in her appearance. She got caught shoplifting and seems intoxicated.

Module 5: Mental Health Basics

Bipolar Disorders, Schizophrenia, and Psychotic Disorders

Bipolar Disorder

- About 1 in 100 people suffers from bipolar disorder, which is similar to the rate of schizophrenia but far lower than the incidence of major depression.
- Men and women are equally likely to develop bipolar disorder.
- There is a **higher likelihood of attempted and completed suicides** among those with bipolar disorder than any other behavioral disorder.

Bipolar and Related Disorders

- Bipolar disorder is a disorder that causes unusual shifts in mood, energy, and activity levels.
- Bipolar disorders may include both manic and depressive symptoms, which may last days to months.

Three Types of Bipolar Disorders	Bipolar I Disorder	Bipolar II Disorder	Cyclothymic Disorder

Bipolar and Related Disorders

Mania/Manic Symptoms	Depression/Depressive Symptoms
Mood Changes	**Mood Changes**
▪ Feeling “high” or extremely happy/outgoing ▪ Extreme irritability	▪ Feeling sad or hopeless ▪ Loss of interest in activities previously enjoyed
Behavior Changes	**Behavior Changes**
▪ Fast talking; jumping between ideas/conversations ▪ Racing thoughts ▪ Easily distracted ▪ Taking on new tasks ▪ Extremely restless ▪ Not tired/little sleep ▪ Increase in impulsive and high risk behaviors	▪ Feeling tired ▪ Difficulties concentrating, remembering, or making decisions ▪ Feeling restless or irritable ▪ Changing eating or sleeping habits ▪ Thoughts of death, suicide, or attempting suicide

Bipolar Disorder DSM-5 Criteria

Mania (Bipolar I)	Hypomania (Bipolar II)
▪ At least **one week** of abnormally and persistently elevated, expansive or irritable mood. ▪ Presence of 3 or more out of 7 specific symptoms listed in the DSM-5. ▪ **Severe enough** to cause significant impairment in social, occupational, or interpersonal functioning – or warrant hospitalization. ▪ Psychotic features can be present.	▪ At least **4 days** of a persistently elevated, expansive or irritable mood clearly different from the non-depressed mood state. ▪ Presence of 3 or more out of 7 specific symptoms listed in the DSM-5. ▪ Not severe enough to cause marked impairment in social, occupational, or interpersonal functioning, or necessitate hospitalization. ▪ No psychotic features.

Bipolar Disorder: Rapid Speech Example

For more information, please refer to the following video:

Bipolar I Disorder - Hypomania!/Rapid Speech —
https://www.youtube.com/watch?v=kiEUibfC47o

Bipolar and Related Disorders: JANE | *A Case Study*

Jane is a 20-year-old female. She has recently had contact with local police because she was found outside a coffee shop loudly initiating a conversation with people passing by the shop.

Psychosis

- **Psychosis is a state defined by a loss of contact with reality.**
  - The ability to perceive and respond to the environment is significantly disturbed; functioning is impaired.
  - Symptoms may include hallucinations (false sensory perceptions) and/or delusions (false beliefs).
- Psychosis is a symptom, not a disorder.
- Psychosis may be experienced for a wide range of reasons such as a result of a physiological disorder, a psychological disorder, or drug or alcohol withdrawal.

Psychotic Disorders: Schizophrenia Spectrum

Schizophrenia Spectrum disorders have symptoms and abnormalities in one or more of the following areas:

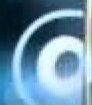
- Delusions
- Hallucinations: Disorganized thinking
- Grossly disorganized or abnormal motor behavior (e.g., too much or too little body movement)
- Positive symptoms (e.g., hallucinations, delusions, racing thoughts)
- Negative symptoms (e.g., apathy, lack of emotion, poor or lack of social functioning)

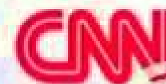
Delusions

- Delusions are fixed beliefs that do not change.
- The content of delusions has a variety of themes – persecutory, referential, somatic, religious, grandiose.
- Bizarre delusions usually express a loss of control over mind or body:
  - Thoughts have been put into one's mind (thought insertion)
  - Thoughts removed from outside force (thought withdrawal)
  - Thoughts that one's body or actions are being acted on or manipulated by some outside force (delusions of control)

Hallucinations

- Hallucinations are perception-like experiences that occur without an external stimulus. Hallucinations are usually vivid and clear, and not under voluntary control.
- Auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices (familiar or unfamiliar) and are perceived as distinct from the individual's own thoughts.
- Voices may be derogatory (e.g., "You are worthless").
- Keep cultural and religious/spiritual considerations in mind.
- Disturbed perception may include changes in how the body feels or a feeling of depersonalization that makes a person feel detached from their body.
- Some schizophrenics are unable to filter out irrelevant information.





Anderson Cooper: Exercise in Empathy

Psychotic Disorders: Schizophrenia Spectrum

Psychotic disorders include:

- Disorganized thinking (speech): switching from one topic to another, completely unrelated answers to questions (tangential)
- Grossly disorganized or abnormal motor behavior: unpredictable agitation, "silliness," difficulties in daily living
- Catatonic behavior is a marked decrease in reactivity to the environment such as:
  - Negativism – resistance to instructions
  - Mutism – maintaining a rigid, inappropriate, or bizarre posture
  - Stupor – a complete lack of verbal and motor responses
  - Catatonic excitement – purposeless and excessive motor activity without obvious cause

Example of Disorganized Thought

- Why is a fire truck red?
  - *No, no, no, no. Because they have eight wheels and four people on them, and four plus eight makes twelve, and there are twelve inches in a foot, and one foot is a ruler, and Queen Elizabeth was a ruler, and Queen Elizabeth was also a ship, and the ship sailed the seas, and there were fish in the seas, and fish have fins, and the Finns fought the Russians, and the Russians are red, and fire trucks are always "Russian" around, so that's why fire trucks are red*
- Did you know loitering is against the law?
  - *I don't want to go to jail. Jail is for the birds. One time I saw birds flying around in the jail. Birds should be out in the air. The air is dirty in Chicago. All of these big buses. I ride the bus to get my groceries. Jewel is my favorite store.*

Psychotic Disorders: Schizophrenia Spectrum

Schizotypal (Personality) Disorder	Delusional Disorder
▪ Impairments in personality functioning; difficulties with empathy, understanding the impact of one’s behavior	▪ Presence of one or more delusions that happen for at least one month
▪ Odd, bizarre behavior, unusual thought processes	▪ Individuals most likely be able to describe that others see their beliefs as irrational, but unable to accept this themselves
▪ Detached, little reaction to situations, withdrawn	▪ If manic or major depressive episodes occur, they are brief
▪ Suspiciousness	▪ May develop an irritable mood, anger or violent behavior can occur

Psychotic Disorders: Schizophrenia Spectrum

BRIEF PSYCHOTIC DISORDER

- Presence of at least one delusion, hallucination, or disorganized speech
- The episode must last at least one day, but less than one month
- Full functioning will return eventually
- Typically experience emotional turmoil or confusion
- Can result in severe impairment

SCHIZOPHRENIFORM DISORDER

- Presence of two or more delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms
- Episode lasts at least one month, but less than six months
- About one-third of individuals with an initial diagnosis of schizophreniform recover within six months and this remains their final diagnosis

The Development of Schizophrenia

Prodromal stage

- Deterioration of function without being actively psychotic
- Appears in late adolescence or early adulthood
- May last for months or even years

Active stage

- Appearance of major symptoms: disorganized thinking, delusions, hallucinations
- May last for months to a lifetime

Residual stage

- Continued impairment but no severe psychotic symptoms
- Presenting low motivation, blunted affect, and unusual perceptual experiences

Schizophrenia

- Emerges, typically, in early adulthood and is a chronic life-long illness with some periods of remission
- Affects about 1 percent of people worldwide, at any given point
- Estimated that 3 out of every 100 people may experience this disorder throughout their lives
- Presents equally across both sexes.

Schizophrenic Episode

For more information, please refer to the following video:

Schizo Episode 02 27 09 — https://www.youtube.com/watch?v=V521Umt1NjU

Tips and Tools for the Field

Your ability to defuse a mental health crisis is important.

- People experiencing psychotic symptoms may be genuinely terrified.
- People typically fight or flee (“flight) when scared.
- You cannot do either.
- Reasoning with an enraged person is not possible.
- We must reduce the level of arousal so discussion is possible.

Tips and Tools for the Field

Inattention may be due to:

- Anxiety
- Depression
- Irritability
- Psychosis
- Substance-related and addictive disorders mimicking a psychiatric disorder
- And others

Tips and Tools for the Field

Officers should demonstrate:

- **Non-threatening stance** – open, but not vulnerable
- **Eye contact** – Not constant, but brief to show concern
- **Commands** – Brief, slow, only as loud as needed, and repeat as needed
- **Movement** – Not sudden; announce actions when possible
- **Attitude** – Calm, interested, firm, patient, reassuring
- **Acknowledge** – Their delusions/hallucinations or feelings are real to them
- Remove distractions and upsetting influences

Tips and Tools for the Field

- Keep them talking/focused on the here and now
- Ignore rather than argue
- Allow verbal venting within reason
- Be sensitive to personal space/comfort zone
- Set limits as necessary
- Limit interaction to just the contact officer
- Avoid rushing – Slow things down
  - Be patient
  - Display dignity, respect
  - Remember the person may be inattentive due to illness

Tips and Tools for the Field

- Introduce yourself – "Hi, I'm John. I'm with the Waukegan Police Department. Can we talk?"
- "What's your first name?"
- "Bob, what's going on today?"
- "It seems you are upset. I would like to try to help you."
- "Help me understand what is happening to you."
- "I can't hear or see that, but I know you can." *(Redirect, do not feed into psychosis, but do not challenge their perceptions.)*
- "I would like to get you some help, maybe talk with someone."

Tips and Tools for the Field

For more information, please refer to the following video:

Officers Get Training to Help People with Mental Illness — https://www.youtube.com/watch?v=xDpdl6rgY1s

Note the use of:

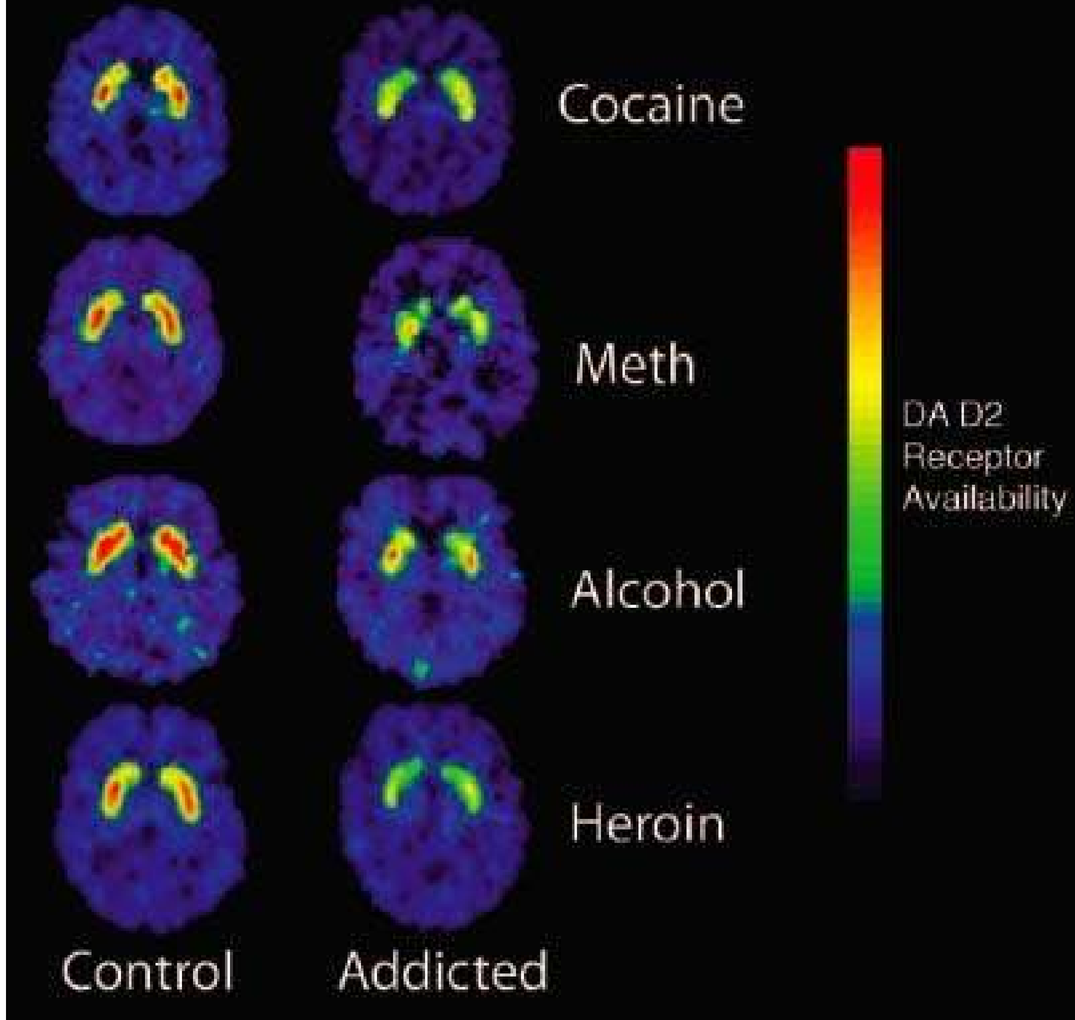
- Distance, space
- Being calm, patient, reassuring
- Planning action once additional units arrive
- TASER
- Calling for medics

Module 6: Mental Health Basics

Substance-Related and Addictive Disorders

Substance-Related and Addictive Disorders

- A substance use disorder is categorized as a single disorder measured on a continuum from mild to severe.
- A diagnosis of a mild substance use disorder in *DSM-5* requires 2 to 3 symptoms from a list of 11.
- Substance use disorders occur when the recurrent use of alcohol and/or drugs causes significant impairment.



Addiction as a Brain Disease

Effects on Dopamine Receptors

Drug Use and the Criminal Justice System

- 53% of people in state prisons and 45% of people in federal prisons meet the criteria for substance use disorder (SUD).
- 16.6% of people in state prisons and 18.4% in federal prisons reported committing their crimes to obtain money for drugs.
- One in three people in state prisons reported using drugs at the time of their crime.
- 64% of people in state prisons who committed a property offense reported drug use in the month prior to arrest.

ADDICTION IN AMERICA

By the Numbers

#ABC2020

DSM-5 Changes: Substance Use and Addictive Disorders

- No longer distinguishes between “abuse” and “dependence.” Instead, it is described on a single spectrum
- The spectrum has 11 criteria—from mild to severe
- New disorders were added for caffeine and cannabis withdrawal
- Also of note, pathological gambling was listed as a behavioral addiction

10 separate classes of drugs

1. Alcohol
2. Caffeine
3. Cannabis
4. Hallucinogens
5. Inhalants
6. Opioids
7. Sedatives
8. Stimulants
9. Tobacco
10. Other or unknown

Substance-related and Addictive Disorders

- Alcohol Use Disorder
- Tobacco Use Disorder
- Cannabis Use Disorder
- Stimulant Use Disorder
- Hallucinogen Use Disorder
- Opioid Use Disorder

11 Criteria for Substance Use Disorders

Impaired Control

1. Taken in larger amounts, over a longer period than intended
2. Persistent desire/unsuccessful efforts to cut down or control use
3. Great deal of time spent to obtain, use, recover
4. Craving, strong desire or urge to use

Social Impairment

5. Recurrent use resulting in failure to fulfill obligations at work, school, or home
6. Continued use despite persistent social or interpersonal problems caused by use at home
7. Important social, occupational, or recreational activities given up because of use

11 Criteria for Substance Use Disorders

Risky Use

8. Recurrent use in physically hazardous situations
9. Continued use despite physical or psychological problems exacerbated by use

Physiological Changes

10. Tolerance
11. Withdrawal

Substance-Related and Addictive Disorders

<u>Diagnosis of Severity</u>:

- Mild: The presence of 2 to 3 symptoms
- Moderate: The presence of 4 to 5 symptoms
- Severe: The presence of 6 or more symptoms

Substance-related and Addictive Disorders

Alcohol Use Disorder	Cannabis use disorder
Questioning how often one drinks	Impairment or distress (within a 12-month period)
Questioning the interference in daily functioning	Cannabis taken in larger amounts over a longer period of time
Continuing to use substances even while knowing the consequences	Inability to stop using; craving, strong urge to use cannabis
Increased tolerance	Increased tolerance
Interfering with functioning at school, work, etc.	Interfering with functioning at school, work, etc.

Alcohol: Basic Facts

Description: Alcohol or ethylalcohol (ethanol) is present in varying amounts in beer, wine, and liquors

Route of administration: Oral

Acute Effects: Sedation, euphoria, lower heart rate and respiration, slowed reaction time, impaired coordination, coma, death

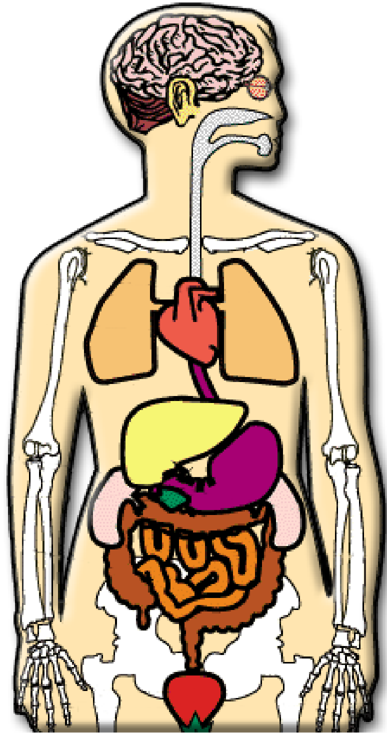
Alcohol Addiction

- **Type I**-generally refers to people over the age of 25 who are at increased psychosocial risk for alcohol addiction
- **Type II**- generally describes younger people who are genetically predisposed to alcohol addiction.
- A distinction has been made between a male or female alcoholic with drinking problems occurring late in life (Type 1) and an alcoholic with drinking problems occurring earlier in life (Type 2).

Tolerance and Sensitization

- Acute tolerance
- Metabolic tolerance
- Pharmacodynamic tolerance
- Behavioral tolerance
- Sensitization

Long-term Effects of Alcohol Use



- Decrease in blood cells leading to anemia, disease, and slow-healing wounds
- Brain damage, loss of memory, blackouts, poor vision, slurred speech, and decreased motor control
- Increased risk of high blood pressure, hardening of arteries, and heart disease
- Liver cirrhosis, jaundice, and diabetes
- Immune system dysfunction
- Stomach ulcers, hemorrhaging, and gastritis
- Thiamine (and other) deficiencies
- Testicular and ovarian atrophy
- Harm to a fetus during pregnancy
- Wernicke–Korsakoff's syndrome

Alcohol Withdrawal

- Alcohol withdrawal syndrome
- Delirium tremens (DTs)-can involve hallucinations, confusion, and agitation for up to a week
- Alcohol Hallucinosis
  - Occurs in 25% of withdrawal cases, seen in first 24 hours
  - True hallucinations include illusions and misinterpretation of real stimuli in environment
  - May include nightmares
  - Is *not* evidence of an underlying psychiatric problem
- Convulsions and Seizures
  - Used to be called "rum fits," most common 12 to 48 hours after stopping alcohol
  - Most commonly seen are one or two seizures generalized, grand mal seizures
  - Represents serious withdrawal
  - One-third of those with seizures develop DTs

Management of Withdrawal

- Detoxification is the natural process of withdrawing alcohol.
- Alcohol detoxification should be conducted under professional medical supervision, because alcohol withdrawal symptoms can be very dangerous.
- Detoxification requires the substitute of a drug for alcohol followed by tapering the dose of the prescribed medication.
- The liver function should be considered when choosing the medication.
- If multiple drugs are being used, withdrawal is conducted sequentially, not concurrently.

Cannabis: Basic Facts

Description: The active ingredient in cannabis is delta-9 tetrahydrocannabinol (THC)

- **Marijuana**: tops and leaves of the plant Cannabis sativa
- **Hashish**: more concentrated resinous form of the plant

Route of administration:

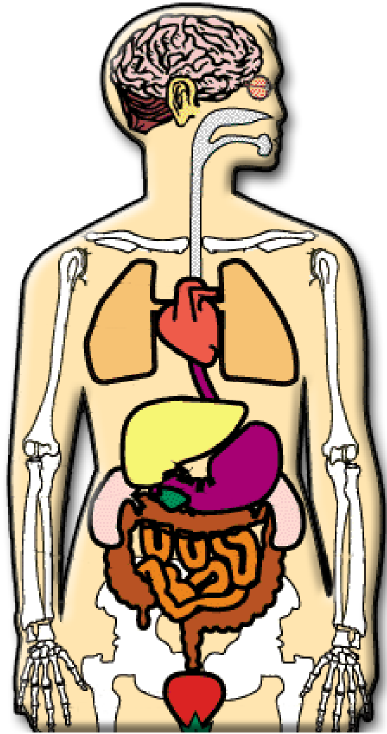
- Smoked as a cigarette or in a pipe
- Oral, brewed as a tea, or mixed with food

Cannabis: Basic Facts

Acute Effects:

- Relaxation
- Increased appetite
- Dry mouth
- Altered time sense
- Mood changes
- Bloodshot eyes
- Impaired memory
- Reduced nausea
- Increased blood pressure
- Reduced cognitive capacity
- Paranoid ideation
- Impaired tracking ability
- Lung irritation
- High dose triggers psychedelic effects
- Difficulty with multistep tasks

Long-term Effects of Cannabis Use



- » Increase in activation of stress-response system
- » Changes in neurotransmitter levels
- » Psychosis in vulnerable individuals
- » Increased risk for cancer, especially lung, head, and neck
- » Respiratory illnesses (cough, phlegm) and lung infections
- » Immune system dysfunction
- » Harm to a fetus during pregnancy

Cannabis and Co-occurring Disorders

- Heavy cannabis use may also accelerate or exacerbate schizophrenic symptoms.
- A study cited in the Diagnostic and Statistical Manual of Mental Disorders found evidence that daily marijuana users had rates of psychotic symptoms **1.6 to 1.8** times higher than those of non-marijuana users.

Cannabis Withdrawal

Withdrawal Symptoms:

- Insomnia
- Restlessness
- Loss of appetite
- Irritability
- Sweating
- Tremors
- Nausea
- Diarrhea

Triggers and Cravings:

- Anxiety/Irritability, Insomnia
- Using Friends
- Social Situations
- Paraphernalia
- Liquor Stores/Headshops
- Concerts

Substance-related and Addictive Disorders

Tobacco Use Disorder	Stimulant Use Disorder
• Cravings	• Examples: amphetamines, methamphetamine
• Irritability, anger, anxiety	• Chronic use – continued use
• Sadness, depression	• Episodic use – periods of heavy use, then reduced use
• Difficulty concentrating, impatience	
• Insomnia	
• Restlessness	

Nicotine and Co-occurring Disorders

- More than **40%** of the cigarettes smoked in the United States are smoked by individuals with a mental health disorder. In particular, schizophrenia is linked to incredibly high rates of smoking.
- According to the National Institute on Drug Abuse (NIDA), smoking rates among individuals with schizophrenia has ranged as high as **90%.**
- According to studies cited by the U.S. National Library of Medicine, nicotine may alleviate cognitive deficiencies in schizophrenic individuals and is thought to be used to reduce the severity of schizophrenic symptoms; however, the negative health consequences from tobacco use outweigh the benefits for these individuals.

Nicotine Dependency

- After inhalation, nicotine is quickly absorbed into the bloodstream from the lungs and transported to the brain.
- Nicotine reaches the brain in about 10 seconds from inhalation .Nicotine affects the amount of dopamine in the brain, which creates feelings of pleasure and reward.
- Nicotine ingestion produces both tolerance effects and physical withdrawal symptoms.
- A prominent feature of nicotine withdrawal is the strong craving to return to tobacco use.
- Because nicotine has a high risk of dependence, smokers typically adjust their smoking behavior to obtain a stable dose of nicotine.

.

Tobacco Withdrawal

Withdrawal Symptoms:

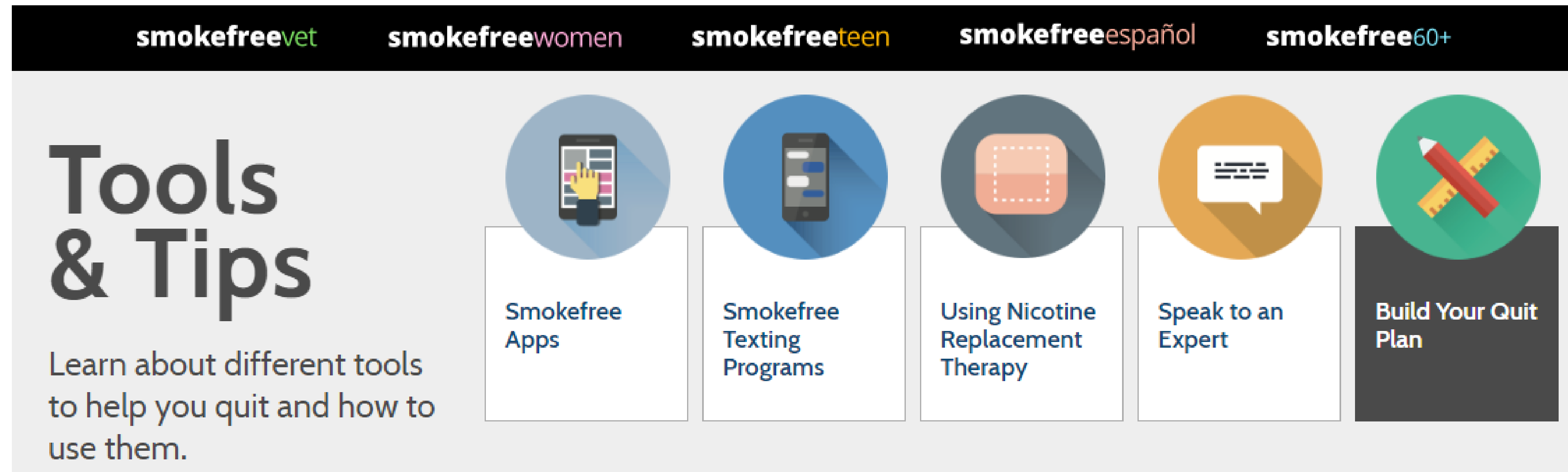
- Cognitive/attention deficits
- Sleep disturbance
- Increased appetite
- Hostility
- Irritability
- Low energy
- Headaches

Cravings and Triggers:

- Smell
- Friends
- Boredom
- With coffee
- After sex
- With alcohol
- While driving
- At social functions

Quitting Smoking

- **The Good:** Health outcomes improve all around when a person quits smoking.
- **The Bad:** Quitting smoking can be extremely difficult, due to physical dependency.
- **The Good:** There are many successful approaches and programs to assist people to stop smoking. Visit http://www.smokefree.gov for resources.



Treatment Options to Stop Smoking

Nicotine Patches and Gum

Chantix

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Zyban

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NicVax

Stimulants: Basic Facts

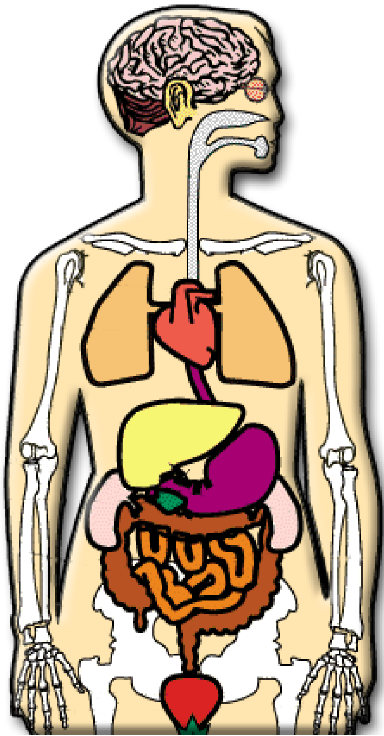
Acute effects:

- Euphoria, rush, or flash
- Wakefulness, insomnia
- Increased physical activity
- Decreased appetite
- Increased respiration
- Hyperthermia
- Irritability
- Tremors, convulsions
- Anxiety
- Paranoia
- Aggressiveness

Common Stimulants:

- Cocaine
- Methamphetamine
- Amphetamines
- Prescription stimulants

Long-term Effects of Stimulant Use



- Strokes, seizures, headaches
- Depression, anxiety, irritability, anger
- Memory loss, confusion, attention problems
- Insomnia, hypersomnia, fatigue
- Paranoia, hallucinations, panic reactions
- Suicidal ideation
- Nosebleeds, chronic runny nose, hoarseness, sinus infection
- Dry mouth, burned lips, worn teeth
- Chest pain, cough, respiratory failure
- Disturbances in heart rhythm and heart attack
- Loss of libido
- Weight loss, anorexia, malnourishment
- Skin problems

Stimulant Withdrawal

Withdrawal Symptoms:

- Physical detoxification
- Cravings
- Depression
- Low energy
- Irritability
- Exhaustion
- Insomnia
- Disordered thinking
- Memory problems

Substance-related and Addictive Disorders

Hallucinogen Use Disorder	Opioid Use Disorder
• Hallucinogens create a euphoric atmosphere and can have psychedelic effects	• Evident when it interferes with personal responsibilities; excessive drug use; tolerance and withdrawals
• Examples: lysergic acid diethylamide (LSD); mescaline, psilocybin (mushrooms); MDMA (ecstasy)	• Examples: heroin, OxyContin, Vicodin, morphine, fentanyl

Hallucinogens: The Basics

Description: Hallucinogens are drugs that alter perception, thoughts, and feelings. They can cause hallucinations. Some are synthetic, while others are plant-derived.

Example Hallucinogens: Ecstasy, LSD, GHB, DMT, peyote, ketamine, PCP, Rohypnol

Route of administration: Oral (i.e. tablets, drinking, consuming), injection, inhaling, snorting

Acute Effects: Effects can be noticed within a half hour and last up to 12 hours. These include hallucinations, increased heart rate, nausea, intense feelings, altered time perception, increased blood pressure, dry mouth, confused senses ("hearing colors"), paranoia, and psychosis, among others.

Hallucinogens: Ecstasy

- Ecstasy is popular because it tends to heighten the senses and emotional closeness with others.
- Ecstasy is sold primarily to young adults and adolescents at nightclubs and bars, at underground nightclubs sometimes called "acid houses," or at all-night parties known as "raves."
- Ecstasy can cause hallucinations, depression, paranoid thinking, panic attacks, irrational behavior, and violence.
- An ecstasy overdose is characterized by a rapid heartbeat, high blood pressure, faintness, muscle cramping, panic attacks, and, in more severe cases, loss of consciousness or seizures.
- The risk of ecstasy when taken at raids is the onset of severe dehydration and heat stroke. It can also cause hyperthermia, seizures, stroke, kidney and cardiovascular system failure, and brain damage.

Hallucinogens: LSD and Peyote

D-lysergic acid diethylamide (LSD)

- Is a powerful mood-changing chemical.
- Is a clear or white, odorless material made from lysergic acid, which is found in a fungus that grows on rye and other grains.
- Typically used for recreation and spiritual purposes.
- LSD has many other names, including "Acid," "Blotter," "Dots," and "Yellow Sunshine."

Peyote

- Also known as "Buttons," "Cactus," and "Mesc."
- Is a psychoactive alkaloid, typically derived from cactus plants.
- Causes auditory and visual hallucinations and increases spiritual insight.

Hallucinogens: GHB and Rohypnol

Gamma-Hydroxy-Butyrate (GHB)

- Depresses the central nervous system, which….
- Effects include intoxication and euphoria; low doses mimic alcohol.
- High doses result in vomiting, convulsions, coma, suffocation.
- Frequently used as a date rape drug.
- Typically seen as a liquid.
- Paraphernalia may include eye drops, children's bubbles, and windshield wiper fluid.

Rohypnol

- Reduces inhibitions and causes amnesia.
- Leads to intoxication and a slow, long high.
- Does not result in a hangover.
- Much more powerful than valium.
- Commonly used as a date rape drug.
- May be present in liquid or pill form.

Hallucinogens: Ketamine and PCP

Ketamine

- Also known as "Special K."
- Effects include hallucinations and out-of-body experiences.
- Typically dispensed in liquid or powder form. May be mixed with heroin.
- Frequently used as an animal tranquilizer by veterinarians.

Phencyclidine (PCP)

- Originally developed as a surgical anesthesia, but has serious side effects
- May be dispensed in pill, liquid, or white crystal powder.
- Goes by other names, such as "Angel Dust," "Hog," "Love Boat," and "Peace Pill."

Opioids: Basic Facts

- Opioids may be extracted from opium (e.g., morphine, codeine, heroin), derived from opium (e.g., oxycodone, hydrocodone), or synthetically developed (e.g., fentanyl).
- Opioids are pain relievers that affect the nerve cells in the brain and throughout the body.
- Opioids are prescribed by a doctor for short-term use, but can be misused, leading to chemical and physical dependence.
  - Between 20-30% of patients prescribed opioids for chronic pain end up misusing them.
- Opioids are extremely powerful and run a high risk of overdose and death, particularly opioids like fentanyl.
  - Approximately 80% of heroin users first misused prescription narcotics like oxycodone or hydrocodone.

THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016...

116
People died every day from opioid-related drug overdoses

11.5 m
People misused prescription opioids[1]

42,249
People died from overdosing on opioids[2]

2.1 million
People had an opioid use disorder[1]

948,000
People used heroin[1]

170,000
People used heroin for the first time[1]

2.1 million
People misused prescription opioids for the first time[1]

17,087
Deaths attributed to overdosing on commonly prescribed opioids[2]

19,413
Deaths attributed to overdosing on synthetic opioids other than methadone[2]

15,469
Deaths attributed to overdosing on heroin[2]

504 billion
In economic costs[3]

Sources: [1] 2016 National Survey on Drug Use and Health, [2] Mortality in the United States, 2016 NCHS Data Brief No. 293, December 2017, [3] CEA Report: The underestimated cost of the opioid crisis, 2017

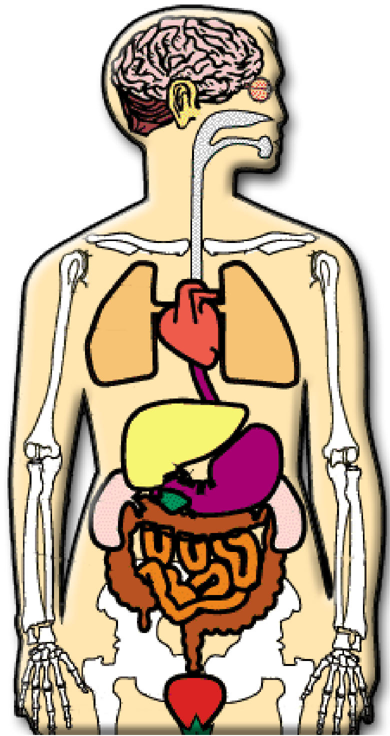
Opioid Epidemic Statistics

From the U.S. Department of Health and Human Services

Possible Acute Effects of Opioid Use

- Surge of pleasurable sensation = “rush”
- Warm flushing of skin
- Dry mouth
- Heavy feeling in extremities
- Drowsiness
- Clouding of mental function
- Slowing of heart rate and breathing
- Nausea, vomiting, and severe itching

Long-term Effects of Opioid Use



- Fatal overdose
- Collapsed veins
- Infectious diseases
- Higher risk of HIV/AIDS and hepatitis
- Infection of the heart lining and valves
- Pulmonary complications and pneumonia
- Respiratory problems
- Abscesses
- Liver disease
- Low birth weight and developmental delay
- Spontaneous abortion
- Cellulitis

Opioid Withdrawal

Withdrawal symptoms:

- Intensity of withdrawal varies with level and duration of use.
- Cessation of opioids causes a rebound in functions depressed by chronic use.
- First signs occur shortly before next scheduled dose.
- For short-acting opioids (e.g., heroin), peak of withdrawal occurs 36 to 72 hours after last dose.
- Acute symptoms subside over 3 to 7 days.
- Ongoing symptoms may linger for weeks or months.

Triggers and Cravings:

- Stress
- Secondary drug/alcohol use
- Analgesic Use
- Anhedonia, anxiety, depression
- Environmental cues
- Discontinuation of treatment, self-help groups, naltrexone

Treatment for Heroin Abuse

- Treatment for heroin abuse includes short-term detoxification and long-term interventions that address the continuing craving for the drug and physical dependence factors in the body.
- Medications to counter overdose or promote detoxification and relapse prevention:

Methadone	Buprenorphine	Antagonists
▪ Prevents withdrawal, reduces craving and use ▪ Facilitates rehabilitation ▪ Dispensed in a clinic setting ▪ Effects last 24 hours ▪ Once-daily dosing maintains constant blood level	• Subutex® or Suboxone (buprenorphine and naloxone) • Aids in early recovery by decreasing withdrawal symptoms • Prevents cravings for opioids • Minimizes risk of relapse • Dispensed in pill form by a clinic	▪ Naloxone – Narcan® ▪ Naltrexone – ReVia®, Trexan® ▪ Reverses effects of opioid overdose ▪ Dispensed through injection or nasal spray ▪ Works in as quickly as 2 minutes

Treatment

Treatment for Substance Use Disorders	
▪ Individual and group counseling	▪ Medication
▪ Inpatient and residential treatment	▪ Recovery support services
▪ Intensive outpatient treatment	▪ 12-Step fellowship programs
▪ Partial hospital programs	▪ Peer supports
▪ Case or care management	

Module 7: Mental Health Basics

Assessment, Commitment, and Legal Considerations

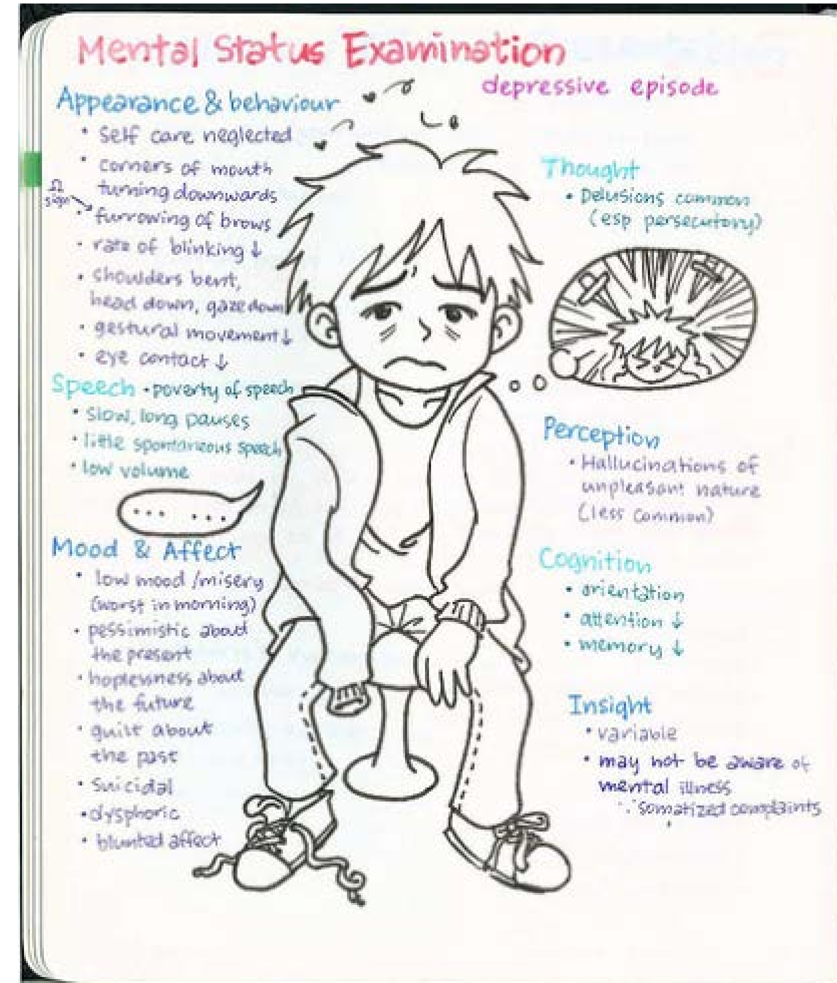
Assessment and Commitment

Assessment:

- Mental Status Exam (MSE)
- Intake assessments

Commitment:

- Mental health law
- Client rights
- Involuntary commitment
- Immunity for certain actions



Tips for Law Enforcement

- Law enforcement should recognize signs of mental health crisis.
- Some jurisdictions have CIT policies that outline pre-screening criteria for people experiencing mental health distress. Positive screens may indicate the need for a professional mental health assessment.
- While state laws vary, non-judicial custody for the purpose of a mental evaluation may be a necessary option for the safety of the person and those around them. This step occurs before issues of civil commitment are addressed; the first step is to acquire a mental health assessment to determine needs, competency, and willingness to enter treatment.
- Officers should document observed signs of mental health crisis on any requisite custody orders.

Assessment: Mental Status Exam (MSE)

- Appearance
- Behavior
- Attitude
- Level of consciousness
- Orientation
- Speech and language
- Language
- Mood
- Affect
- Thought process
- Thought content
- Suicidal or homicidal ideation
- Insight and judgment
- Judgment
- Attention span
- Memory
- Intellectual functioning

Assessment: Intake Assessment

- Determines the areas where an individual may need assistance
- Determines current symptoms
- Documents and assesses:
  - Suicide (and/or) homicide risk
  - Willingness for treatment
  - Medical history
  - Mental health (hospitalization, medication) history
  - Substance use/abuse history
  - Family history (medical, mental health)
  - Educational/occupational history
  - Legal history

Commitment: Mental Health Law

- Affordable Care Act
- Americans with Disabilities Act
- Children's Health Act
- Mental Health Parity and Addiction Equity Act
- Duty to Warn
- Mental Health Coverage Rules/Acts
- Applicable state law

Commitment: Client Rights

- Be treated with dignity and respect
- Receive appropriate services
- Cultural sensitivity
- Treatment plans – help write and receive copy
- Explanation of benefits, risks, and any potential side effects of treatments
- Confidentiality
- HIPAA
- Understanding rights, grievance

Civil Involuntary Inpatient Commitment

- Very few states make use of involuntary commitment.
- It is used when an individual may be expected to inflict serious physical pain to him/herself or someone else.
- It is used when an individual is unable to provide care for him/herself.

- Laws will vary state to state.
- Inpatient vs. outpatient services
- Treatment
- Crisis vs. severe mental illness

- St. Louis (MO) Police Department
- Kansas City (MO) CIT
- Georgia CIT
- NAMI Ventura County (CA)

Special Thanks to the following CIT programs

Day One Conclusion

- Thanks for your participation during Day 1. We look forward to seeing you tomorrow.

Module 8: Mental Health Basics

Neurodevelopmental and Neurocognitive Disorders

Neurodevelopmental and Neurocognitive Disorders

- Intellectual disability
- Communication disorders
- Motor disorders
- Delirium
- Major and mild neurocognitive disorders

Intellectual Disability

<u>Signs and Symptoms</u>

- Deficits in intellectual functions: difficulties with reasoning, problem solving, judgment, academic learning, learning from experiences, and abstract thinking
- Deficits in adaptive functioning: failure to meet developmental and social standards
- Difficulties with independence and social responsibility
- Limited functioning with daily life activities (e.g., communication, independent living, and social interactions)
- Deficits become noticeable during the developmental years (i.e. childhood and adolescence)

Communication Disorders

<u>Language Disorder</u>

- Difficulty in acquiring and using language
- Limited vocabulary
- Limited sentence structure
- Difficulties in the ability to use vocabulary and connect sentences to explain a topic or events
- Language abilities are well below those expected for individual’s age
- These difficulties limit effective communication, social interactions, academics, and occupational success

Communication Disorders

<u>Speech Sound Disorder</u>

- Difficult with speech sound production, preventing verbal communication
- Limitations in effective communication, which interferes with social abilities, academics, and/or occupational performance
- Stuttering

Communication Disorders

<u>Social (Pragmatic) Communication Disorder</u>

- Difficulties with the social use of verbal and nonverbal communication
- Difficulties using communication for appropriate social reasons (greetings, sharing information)
- Inability to change communication styles to match the needs of the listener (classroom vs. playground or adult vs. child)
  - Difficulties following rules for conversation
  - Difficulties understanding what is not specifically stated (making inferences) or ambiguous statements (humor, metaphors)
  - Deficits may cause functional limitations in social relationships, academics, or occupation

Motor Disorders

<u>Tic Disorders</u>

- Tic Disorders involve the presence of motor or vocal tics:
  - Repetitive, non-rhythmic motor behaviors (e.g., hand flapping, body rocking, head banging)
  - Rapid, apparently purposeless recurrent, vocalizations
- Tics interfere with social, academics, and other areas of life.
- Tourette's Disorder is the most common. Tourette's may also be seen in people with OCD and ADHD.

Tourette's Disorder Video

For more information, please refer to the following video:

Living with Tourette Syndrome —
https://www.youtube.com/watch?v=e8HtTb0Vk_o

Neurodevelopmental Disorders

- Neurodevelopmental disorders are sometimes referred to as "hidden disabilities."
- The symptoms may not be readily apparent to an outside observer.
- The person may be high-functioning and excel in certain skills or environments.
- The person may have learned to adapt to circumstances to overcome or hide their developmental or cognitive symptoms.
- They are often present in combination with other mental or physical disorders which may be more readily recognized.

Identifying a Potential Developmental Disability

Communication	Behavior	Interaction
• Limited vocabulary • Speech impairment • Difficulty answering questions • Short attention span	• Inappropriate actions • Easily Influenced • Difficulty with directions • Trouble with day to day tasks, such as making change or dialing a telephone • Repetitive motions or motor impairments	• Eagerness to please • Communication through others • Bluffing greater understanding than they hold • Over-engagement or under-engagement

Communication Tips for Neurodevelopmental Disorders

- Attempt to keep the surroundings quiet and free from distractions
- Make appropriate eye contact before speaking, use names if possible
- Use simple language, be clear and concise, repeat if necessary, speak slowly
- Identify yourself and explain why you are there

Communication Tips for Neurodevelopmental Disorders

- Make sure to give directives or ask questions one at a time (too many questions at once can lead to confusion)
- Ask open-ended questions; not just yes or no answers
- Be patient, wait for responses
- Observe behavior and nonverbal communication as well

Traumatic Brain Injury

Impact to the head or other rapid movement to the brain

Injury Characteristic	Mild TBI	Moderate TBI	Severe TBI
Loss of consciousness	< 30 minutes	30 minutes-24 hours	> 24 hours
Posttraumatic amnesia	< 24 hours	24 hours – 7 days	> 7 days

Delirium

Signs and Symptoms

- Serious change in mental abilities or cognitive function (e.g., memory difficulties, disorientation, altered language, altered perceptions)
- Reduced ability to focus and/or shift attention; difficulties orienting to one's environment
- Symptoms develop over a short period of time, from hours to a few days
- Symptoms can fluctuate in severity throughout the day
- Symptoms and disturbance is a change from their baseline attention and awareness
- Delirium can often be traced to one or more contributing factors, such as medical illness, changes in metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

Neurocognitive Disorders

- Neurocognitive disorders are often referred to as "dementia".
- Dementia refers to a severe loss of cognitive abilities
  - **Aphasia** – Loss of ability to understand or express speech
  - **Apraxia** – Loss of ability to execute or carry out learned purposeful movements
    - *Unable to comb hair, shave self, button shirt*
  - **Agnosia** – Loss of ability to recognize or comprehend the meaning of objects
    - *May not know what an object is nor what it is used for*
- People with dementia may also experience changes in mood or personality
  - They may isolate themselves from others and appear very passive or become paranoid
- Dementia is categorized as either a major or mild neurocognitive disorder
- May be caused by physical health conditions, which can be treated to end dementia

Neurocognitive Disorders

MINOR

- Needs more time and energy to complete routine tasks
- Unable to multi-task, makes simple mistakes
- Becomes exhausted during social interactions
- Has difficulties recalling recent events
- Needs reminders to keep track of things, such as bills or appointments
- Has trouble finding the right words
- Makes grammatical errors
- May get lost or turned around easily
- Experiences subtle changes in attitude
- Has difficulties reading social cues and facial

MAJOR

- Has difficulty remembering new information and may not be able to repeat what was just said
- Struggles to remember past information, such as names, phone numbers, or address
- Needs simple directives, directions, and information
- Is easily distracted and struggles to stay focused
- May need help with daily living skills and making basic decisions.
- Has difficulties with speech and expressions
- Demonstrates unusual behavior in social settings
- Makes decisions without the regard for others or safety

Alzheimer's Disease

Signs and Symptoms

- Diagnosed if there is evidence of a genetic mutation from family history or genetic testing AND if there is no evidence of other neurodegenerative diseases/disorders (major/mild)
- Must see a clear decline in memory and learning, and one other cognitive domain (major/mild)
- Gradual decline in cognition (major/mild)
- Earliest symptoms are typically changes to mood or personality, such as passivity

Warning Signs of Alzheimer's

1. Memory loss
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation to time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood or behavior
9. Changes in personality
10. Loss of initiative

Older Adults with Neurocognitive Disorders: Agitation

- Many older adults with dementia demonstrate agitation
  - Seen in 50% of all persons with dementia
  - Seen in 75-90% of all nursing home patients
- It is an inappropriate verbal, vocal or motor activity, not an obvious expression of need
- Signs: physical or verbal aggression, hyperactivity, disinhibition, paranoia, refusal to accept assistance, disturbed sleep
- May be caused by medical conditions, medications, exhaustion, acclimating to new homes or reduced personal capacity, fear
- Agitation may increases risk of violent behavior

Older Adults with Neurocognitive Disorders: Altered Perceptions

1. **Hallucinations**: can affect all five senses, in which persons perceive a sensation in the absence of actual stimuli. Hallucinations are seen in 15-50% of persons with dementia.
2. **Delusions:** create false fixed beliefs, often persecutory in nature. Delusions are seen in 20-75% of persons with dementia.
3. **Misidentifications** – result in the inability to recognize self or others. This is seen in 25-50% persons with dementia.

Law Enforcement Encounters With the Elderly

- **Elder abuse and financial crimes:** Remember that older adults can be easily manipulated and abused by family, caretakers, or strangers.
- **Wandering**: Consider wandering an emergency situation where immediate protective action needed. Aging services should be alerted for further assessment. Be calm and supportive.
- **Indecent exposure:** Ensure the safety of person and void reprimands. Attempt to distract and assist in order to cover and protect.
- **Shoplifting** : Distract and treat gently to avoid inciting agitation. Contact family or doctor and intervene with store personnel.
- **Self-neglect:** Remain supportive and connect with aging services. It may be difficult to intervene in situations of personal care or hoarding.
- **Erratic behavior:** Offer immediate assistance for reports of erratic driving, dangerous wandering, placing self at risk. Contact doctors or seek medical evaluation and protective measures
- **Catastrophic reactions:** Stay calm and use simple language. The event may be alarming to all concerned and dangerous in the moment. Be patient throughout response.

Communication Techniques for Neurocognitive Disorders

- Assume older adults are cognitively intact unless given clear reasons to question this.
- Trust is essential to gain vital information from older adults.
- Identify yourself as law enforcement and explain why you have approached them.
- One person should speak at a time, one officer takes lead.
- Remember to assess for visual and hearing deficits.
- Speak slowly in a non-threatening, low-pitched voice. Don't assume hearing impairment.
- Maintain a calm environment and lessen stimuli.
- Avoid restraints, confinement may trigger agitation exacerbating confusion and disorientation.
- Be open to non-verbal communication if speaking does not work.

Communication Techniques for Neurocognitive Disorders

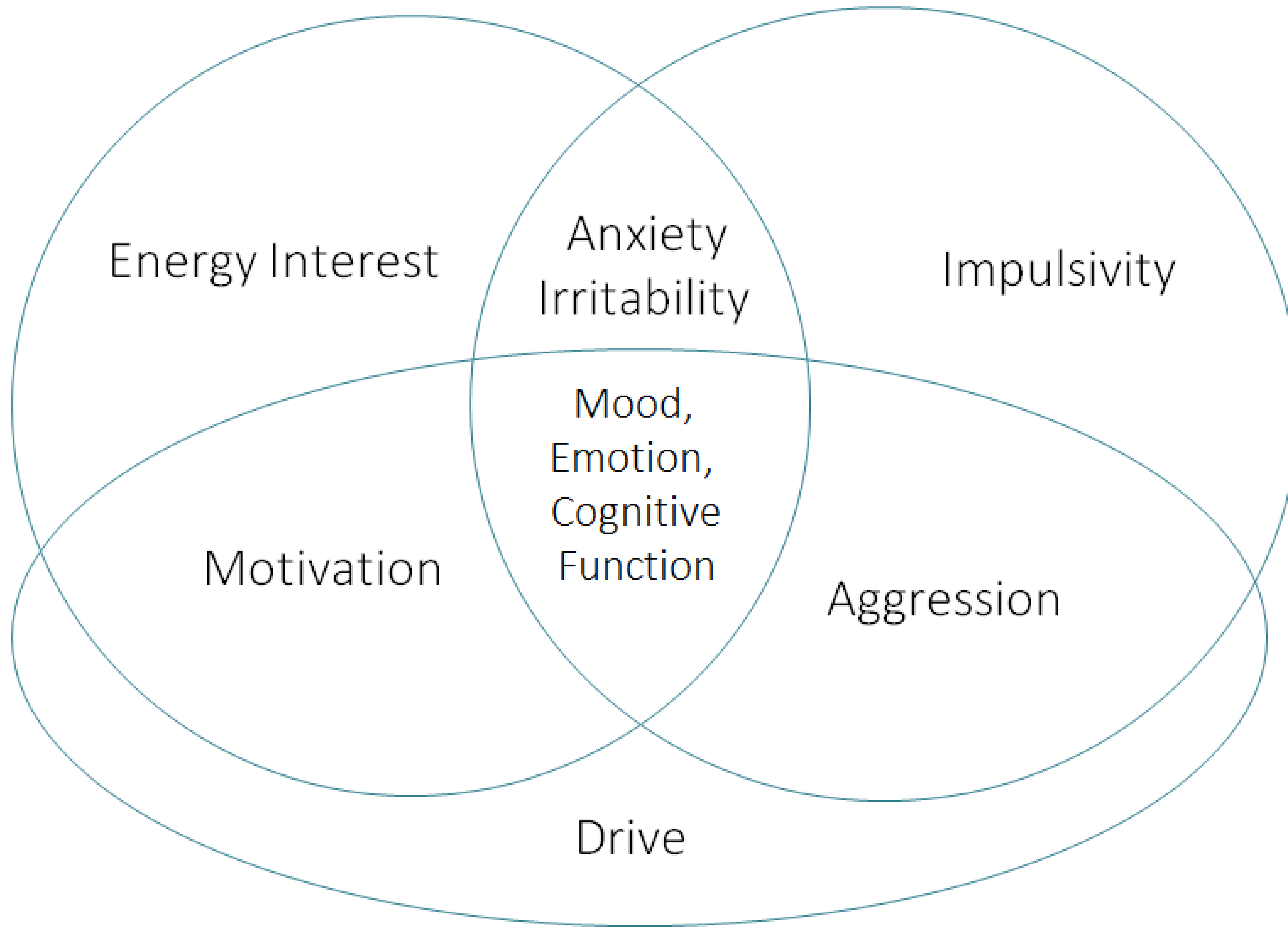
- Look for medical alert bracelets.
- Maintain good eye contact.
- Be patient.
- Ask “yes” and “no” questions.
- Avoid memory related questions.
- Ask one question at a time, allow time for response.
- Repeat with same wording if needed.
- Promote their sense of self-efficacy, even when offering assistance.
- Talk directly to the older adult as much as possible.
- Avoid demeaning tones or speaking to them as a child.
- Do not argue about their reality.
- Repeat, repeat, and repeat again if necessary.
- Acknowledge their frustration.

Module 9: Mental Health Basics

Psychopharmacology

Why Understand Psychopharmacology?

- Medication helps a lot of people with mental illness; mental illness is treatable and many people do well on medication.
- There is increasing acceptance of mental illness as a chemical imbalance in brain.
- Psychotropic medication is becoming more accepted in society at large.
- Psychotropic medication alters chemical levels in the brain, impacting mood and behavior. Medications may impact the contacts law enforcement have within the community.
- It is important to know that medication is NOT a cure-all.
- CIT officers should understand why language such as "why don't you just take your meds?" is NOT helpful.



Psychotropic Medications

Medication Use for Various Disorders

Bipolar Disorder:

- Mood stabilizers
- Antipsychotics
- Antidepressants

Psychotic Disorders:

- Antipsychotics
- Antidepressants and Mood Stabilizers

Depressive Disorders:

- Antidepressants
- Antipsychotics and Mood stabilizers

Anxiety:

- Antidepressants
- Benzodiazepines

Post Traumatic Stress:

- Antidepressants
- Antipsychotics

Anti-Depressant Treatment

Psychotropic Medications	
• Celexa	• Strattera
• Cymbalta	• Wellbutrin
• Effexor	• Zoloft
• Lexapro	• Prozac
• Paxil	

Treated Disorders
• Depressive Disorders
• Generalized Anxiety Disorder
• Social Phobia
• Panic Disorder
• Post Traumatic Stress Disorder
• Obsessive Compulsive Disorder

Anti-Psychotic Treatment

Psychotropic Medications	
• Haldol	• Abilify
• Prolixin	• Seroquel
• Trilafon	• Zyprexa
• Thorazine	• Risperdal
• Geodon	• Cloxaril

Treated Disorders
• Psychosis
• Schizophrenia
• Schizoaffective Disorder
• Bipolar Disorder

Mood Stabilization

Psychotropic Medications
Lithium (Lithobid, Eskalith)
Divalproex Sodium (Depakote, Depakene)
Carbamazepine (Tegretol, Equetro)
Oxcarbazepine (Trileptal)
Lamotrigine (Lamictal

Treated Disorders
• Depressive Disorders
• Bipolar Disorders

Stimulants

Psychotropic Medications
Alprazolam (Xanax)
Lorazepam (Ativan)
Chlordiazepoxide (Librium)
Diazepam (Valium)
Clonazepam (Klonopin)

Treated Disorders
• Attention Deficit Hyperactive Disorder

Benzodiazepines

Psychotropic Medications
Lithium (Lithobid, Eskalith)
Divalproex Sodium (Depakote, Depakene)
Carbamazepine (Tegretol, Equetro)
Oxcarbazepine (Trileptal)
Lamotrigine (Lamictal

Treated Disorders
• Panic Disorder/ Panic Attacks
• Anxiety
• Insomnia
• Alcohol Withdrawal

Psychopharmacology – Side Effects

- Dizziness, drowsiness (mood stabilizers, antipsychotics, benzodiazepines)
- Sleep difficulties (antidepressants)
- Weight gain (antidepressants, antipsychotics, mood stabilizers)
- Shaking/Tremors (antipsychotics, antidepressants)
- Loss of appetite (antidepressants, mood stabilizers)
- Pacing, inability to sit still, restlessness, involuntary movements (antipsychotics)
- Increase thirst and urination (mood stabilizers)
- Sexual dysfunction (antidepressants)
- Seizures (benzodiazepines, antidepressants)
- Anxiety/agitation/irritability (stimulants, antidepressants)

Medication Compliance Issues

People may stop taking their medications because:

- They experience side effects.
- They feel better.
- They do not believe the medication works, or not quickly enough to tell.
- They feel stigma.
- The dose and/or frequency is burdensome.
- The medications are too expensive or lack insurance.
- They do not have a strong social support who understand.
- They are homeless and/or have difficulty getting their medications.

Implications for First Responders

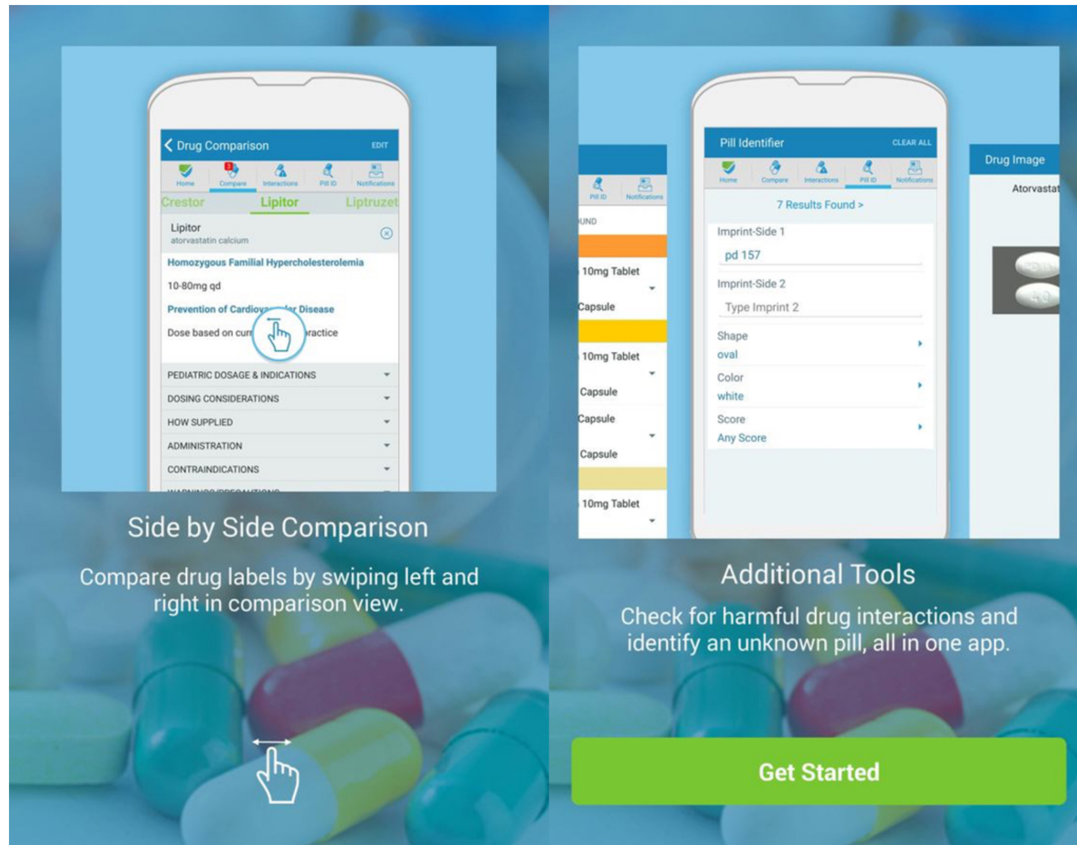
- Check with family, friends, caregivers about all medications and their compliance. Knowing the type of medication will help you know the illness and its associated symptoms.
- Being able to identify pills and know which class of drugs they are part present can give you more information to assess the situation.
- The risk of unpredictable behavior increases if the person is if off their prescribed medications.
- Always consider possibility of medical emergency – assess level of consciousness and respiratory condition and EMS if unsure.

Psychopharmacology – Officer Tips

- Officers should become comfortable talking to others about medications and why they are important.
- Officers could say, "I understand that you're not taking your medication right now and I understand that it has side effects. Can we get you to the doctor to see if they can get you on something else that works better?"

Pharmacology Resources

Mobile PDR App



BH Meds App

Module 10: Mental Health Basics

Disorders in Children, Youth, and Adolescents – Autism and Developmental Disorders

Children, Youth, and Adolescents: Autism and Developmental Disorders

- Specific Learning Disorder
- Neurodevelopmental Disorders
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
- Motor Disorders

Children, Youth, and Adolescents: Know the Warning Signs

For more information, please refer to the following video:

10 Common Warning Signs of a Mental Health Condition in Teens and Young Adults — https://www.youtube.com/watch?v=zt4sOjWwV3M

Specific Learning Disorder

Signs and Symptoms:

- Difficulties learning and using academic skills
- Reading difficulties: slow and effortful word reading, difficulties understanding what was read
- Difficulties with spelling, written expression, numbers/calculation, mathematical reasoning
- Academic skills below the norm, can cause significant impairment

Autism Spectrum Disorder

Signs and Symptoms:

- Persistent deficits in social communication and social interaction across multiple contexts (i.e., school and at home)
- Difficulties with back and forth conversations, reduced sharing of interests, emotions; doesn't often initiate conversations.
- Difficulties with nonverbal communication; poor eye contact, body language, use of gestures, lack of facial expressions
- Difficulties in understanding relationships, social contexts, or playing with peers.

Autism Spectrum Disorder

- Deficits in social communication and interactions
- Difficulties participating in a conversation.
- Less interested in sharing interests, emotions and difficult to determine how they are feeling
- Often have difficulties initiating or responding to social interactions
- Difficulties with nonverbal communication; don’t understand facial expressions
- Difficulties putting verbal and nonverbal communication together, including possible difficulties with eye contact
- Difficulties in developing and maintaining relationships with others

Autism Spectrum Disorder: TOM
A Case Study

"It started out as a Peeping Tom call in progress. Two units respond, the suspect is sitting on the porch. As officers approach a teenage boy seems indifferent, like he is in his own little world. Suddenly he reaches for one of the officer's shiny badges. The cops go hands on and suddenly all hell breaks loose. Back up arrives code three which only makes matters worse. The light bars are flashing, sirens wailing, everyone is screaming. The suspect is more than resistant, appears completely oblivious to pain, and is attempting to flee."

Autism Spectrum Disorder: MITCH
A Case Study

Mitch is a 16-year-old male. He has recently had police contact due to an issue at his school. Mitch was recently charged with property destruction and suspended due to being verbally and occasionally physically aggressive with peers and authority figures.

Quick Facts for Law Enforcement: Autism

- Working with an individual diagnosed with the Autism Spectrum Disorder can challenge your experience and training.
- In most cases, the person will have difficulties following verbal commands, reading your body language, and have deficits in social understanding.
- It may be important to understand that sirens, lights, uniforms, and loud voices might make an already difficult situation even more difficult depending on the individual.
- There is a possibility that an individual diagnosed with the Autism Spectrum Disorder might become silent and uncooperative; possibly due to feeling uncomfortable.
- A police officer might be able to gain control of the situation by remaining calm, practicing patience. This will hopefully defuse the stress, tension, or danger of a situation.
- It may be necessary to repeat directives multiple times, in a clear and consistent tone.

Attention – Deficit/Hyperactivity Disorder (ADHD)

- A pattern of behavior that is seen in multiple settings (e.g., school, home)
- Behavior creates difficulties and performance issues in education and social settings
- Behaviors: difficulty organizing, excessive talking, fidgeting, inability to remain seated
- Symptoms are as follows:
  - Hyperactivity and Impulsivity
  - Inattention
- Symptoms must be present prior to the age of 12 years.

Attention – Deficit/Hyperactivity Disorder

Inattention (6+ symptoms)	Hyperactivity – Impulsivity (6+ symptoms for 6 months)
• Careless mistakes, no attention to details	• Often fidgets or taps hands or feet, squirms in seat
• Difficulty remaining attentive on tasks	• Leaves seats when remaining in seat is expected (school, work)
• Starts quickly, but loses focus and is easily distracted	• Runs or climbs where it is inappropriate (restlessness)
• Doesn’t listen when spoken to directly	• Often unable to play or be in leisure activities quietly
• Failure to follow through; not interested in difficult tasks	• Often “on the go” and uncomfortable being still for a long period of time
• Difficulties organizing tasks and activities	• Talks excessively, blurts out answer before a question is completed
• Often losing things and forgetful in daily activities	• Difficulty waiting his/her turn; interrupts or intrudes on others

Module 11: Mental Health Basics

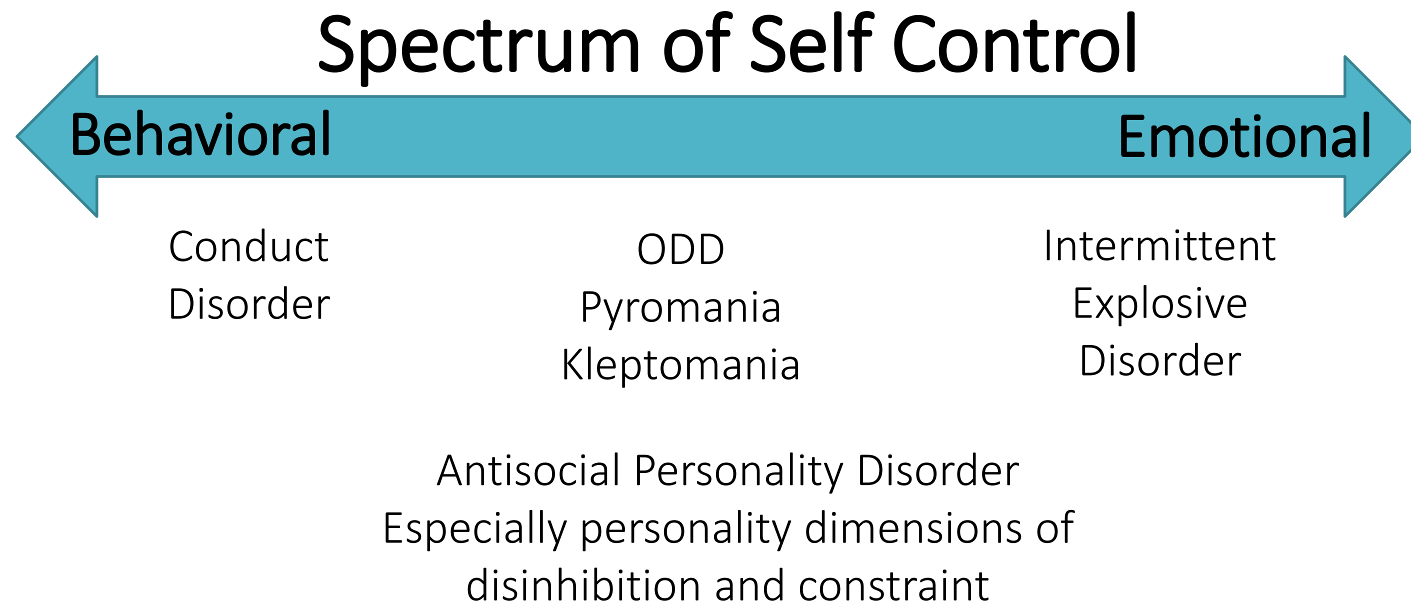
Disruptive, Impulse-Control, and Conduct Disorders

Disruptive, Impulse-Control, and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorders
- Fetal Alcohol Spectrum Disorders
- Pyromania
- Kleptomania

Disruptive, Impulse Control and Conduct Disorders

- All these disorders characterized by problems in emotional and behavioral self-control



Oppositional Defiant Disorder

Signs and Symptoms

- Angry/Irritable Mood
  - often loses temper, touchy or easily annoyed
- Argumentative/Defiant Behavior
  - argues with authorities, defies or refuses to comply with authorities or rules, deliberately annoys others, blames others for their mistakes or misbehavior)
- Vindictiveness
  - spiteful

Intermittent Explosive Disorder

- Verbal aggression
  - Temper tantrums, tirades, verbal arguments
- Physical aggression
  - Aggression towards people, animals, or property
- Unplanned behavioral outbursts
- Seen in youth over the age of six

Intermittent Explosive Disorder: BOBBY | *A Case Study*

Conduct Disorder

Conduct disorder (CD) – Children with conduct disorder purposefully engage in patterns of antisocial behavior that violate social norms and the rights of others.

- Present in 12% of males, 7% females
- Average age of onset – 11.6 years old
- Linked to antisocial behavior in adults
- Signs and symptoms:
  - Intentionally aggressive and cruel behavior
  - Manipulative and deceitful behavior
  - Does not feel guilt, remorse, or empathy
  - Commits serious violations of rules
  - May engage in substance misuse and early sexual activity

Conduct Disorder: Video Example

For more information, please refer to the following video:

7 Yr. Old Bad Boy Strikes Again — https://www.youtube.com/watch?v=0-Mr3irlWIk

Fetal Alcohol Spectrum Disorders

- Fetal Alcohol Spectrum Disorder (FASD) was added to the DSM-5 under "Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure."
- Conditions related to FASD are caused by the alcohol use of a mother while pregnant.
- FASD can lead to physical, learning, and behavior challenges, such as:
  - Low body weight or smaller than average features
  - Poor coordination
  - Hyperactive behavior and difficulty with attention
  - Poor memory
  - Difficulty in school (especially with math)
  - Learning disabilities or low IQ
  - Poor reasoning and judgment skills

Pyromania

- Deliberate, purposeful fire setting
- Tension/affective arousal before act
- Fascination, interest, curiosity, attraction to fire

Kleptomania

- Failure to resist impulses to steal objects
- Objects stolen are not needed for personal use or monetary value
- Tension before committing the theft
- Pleasure or relief when committing the theft
- Stealing is not a way of expressing anger or vengeance
- Recurrent failure to resist impulses to steal objects not needed for personal use or monetary value
- Increasing tension before/pleasure, gratification or relief at time of theft

Kleptomania: JERRY | *A Case Study*

Module 12: Mental Health Basics

Personality Disorders

Personality Disorders

- Paranoid Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder (HPD)
- Narcissistic Personality Disorder
- Obsessive – Compulsive Personality Disorder (OCPD)

Paranoid Personality Disorder

<u>SIGNS and SYMPTOMS</u>

- Pervasive distrust and suspiciousness of others.
- Suspects others are harming, exploiting, or deceiving him/her
- Preoccupied with loyalty or trustworthiness of friends
- Reads hidden threating meaning into benign remarks or events
- Perceives attacks on his/her character that others don't notice, quick to react angrily
- Suspicions (without reason) of spouse or partner infidelity

Paranoid Personality Disorder: Interactions and Treatment

- Help the individual exhibiting symptoms stay calm
- Do not argue with the paranoia. Be empathic and focus on the emotions, not the facts.
- Attempt to determine if they are aware of any current mental health difficulties, attempt to determine their mental health history
- Individuals may be suspicious of doctors, so it may take time
- Talk therapy
- Medication for some of the symptoms of the disorder.
  - Possible anti-anxiety medication
  - Possible anti-psychotic medication tor severe agitation, delusional thinking

Paranoid Personality Disorder: ROBERT | *A Case Study*

Robert has made multiple calls to the police department for various reasons; most calls were lengthy complaints of a suspicious person with stories that could not be validated.

Antisocial Personality Disorder

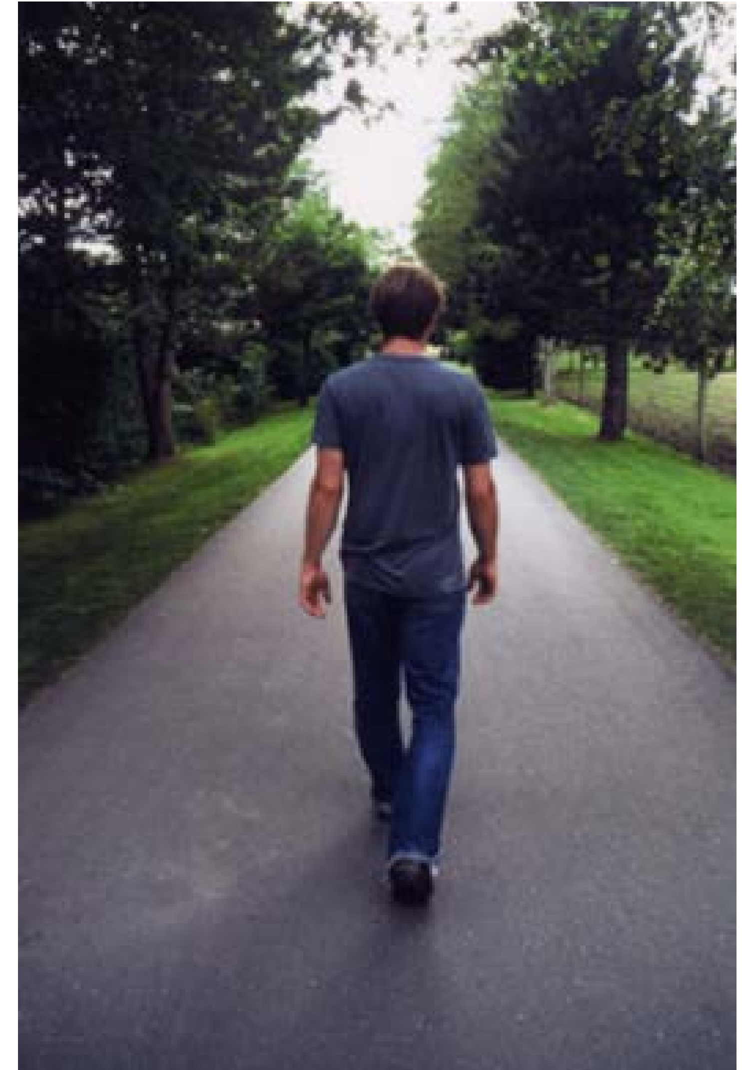
<u>SIGNS and SYMPTOMS</u>

- Disregard for and violation of the rights of others
- Failure to conform to social norms and laws
- Impulsive, irritable, aggressive, involved in fights or assaults
- Frequent lying, using aliases, or conning others for personal pleasure or profit
- Complete disregard for safety of self or others
- Lack of remorse

Antisocial Personality Disorder: Ani

A Case Study

Ani was referred to therapy by the court, as part of a rehabilitation program. He is serving time in prison, having been convicted of grand fraud. The scam perpetrated by him involved hundreds of retired men and women in a dozen states over a period of three years. All his victims lost their life savings and suffered grievous and life-threatening stress symptoms.



Antisocial Personality Disorder: The Iceman Interview

For more information, please refer to the following video:

Richard Kuklinski Part 2 —
https://www.youtube.com/watch?v=dhEEskkeJ7k

Video: Iceman Interviews

For more information, please refer to the following video:

The Iceman Interview - Analysis of Kuklinski —

https://www.youtube.com/watch?v=S-4nzmdYQTA

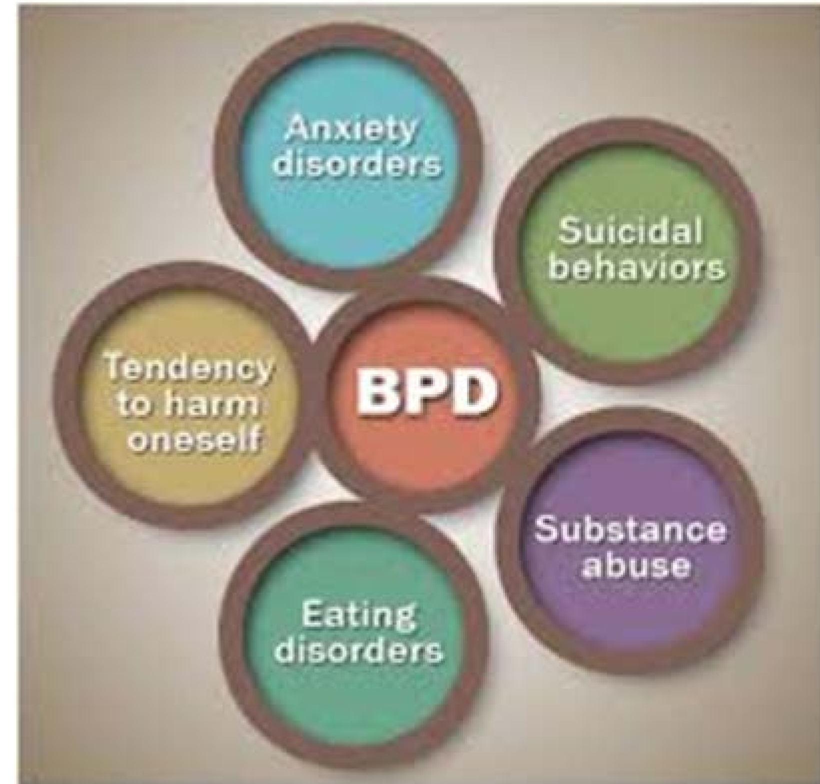
Borderline Personality Disorder

<u>SIGNS and SYMPTOMS</u>

- Unstable and intense interpersonal relationships (extremes)
- Efforts to avoid real or imagined abandonment
- Unstable self-image/sense of self
- Impulsive in areas that are self-damaging (e.g., substance misuse, driving, binge eating, spending)
- Recent suicidal behavior, gestures, threats, or self-harm
- Intense mood irritability or anxiety
- Consistent feelings of emptiness
- Intense anger, difficulties controlling anger

Borderline Personality Disorder: Amanda *A Case Study*

"I have had various symptoms for years, like feelings of claustrophobia, waking up happy one morning and depressed the next, together with panic attacks and I have had very little control over those emotions and feelings. It is debilitating, and sometimes difficult for others to deal with. I have had therapy for many years – Psychotherapy, Hypnotherapy, one to one counselling, Adlerian psychology, and, although they have helped in the short term as someone there to talk to, they have not cured me and my symptoms have continued to get worse and my life stuck on hold by them."



Histrionic Personality Disorder

<u>SIGNS and SYMPTOMS</u>

- Excessive emotional and attention seeking
- Uncomfortable in situations where he/she is not the center of attention
- Interaction with others often includes inappropriate sexually seductive or provocative behavior
- Shifting and shallow expressions of emotions
- Uses physical appearance to attract attention
- Self-dramatization, theatricality, exaggerated expression of emotion
- Is easily influenced by others
- Sees relationships as more intimate than they actually are

Living with HPD: “Praise Me”

- Living with someone with HPD can be exhausting, humiliating, frustrating, and isolating
- Feeling as though you are the “reasonable” one
- Individuals with HPD do not typically look for solutions to their problems
- Trying to make someone with HPD feel “happy” feels like an uphill battle
- Individuals with HPD often don’t see their own destructiveness
- Important problems may be considered less important than the more fabricated or exaggerated issues
- Experience extreme emotional highs and lows

P	Provocative behavior
R	Relational intimacy
A	Attention
I	Influenced easily
S	Splashy speech
E	Emotional liability
M	Make-up
E	Exaggerated emotions

Narcissistic Personality Disorder

SIGNS and SYMPTOMS

- Grandiosity, need for admiration, lack of empathy
- Grandiose sense of self-importance; exaggerates talents
- Preoccupied with fantasies of unlimited success, power
- Believes he/she is “special” and unique (only to associate with high status people)
- Requires excessive admiration
- Sense of entitlement, unreasonable expectations

Obsessive – Compulsive Personality Disorder

SIGNS and SYMPTOMS

- Fixating on lists, organization, schedules, rules, and minor details
- Rigid following of moral and ethical codes
- Excessively devoted to work, causing impairment in social activities
- Perfectionism
- Rigid and/or stubbornness
- Does not work well with others

Identifying and Treating OCPD

- Individuals diagnosed with OCPD typically do not believe they require treatment
- Psychotherapy:
- Cognitive Behavioral Therapy (CBT): improving insight, providing techniques
  - Lessen expectations
  - Learn the value of relationships
  - Understanding interpersonal conflict and it’s connection to job satisfaction (or lack thereof) may be a motivator for therapy
  - Less emphasis on work and productivity
- Medication: SSRIs (will be discussed more in Module 11) – assist individuals in focusing less on the minor details, assists with rigidity
- Relaxation: Breathing and Relaxation techniques to reduce stress

Obsessive – Compulsive Personality Disorder
Video: Jeff Lewis on Living with OCPD

Module 13: Mental Health Basics

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD)

PTSD can occur after an individual has been exposed to actual or threatened death, serious injury or sexual violation, including when he/she:

- Directly experiences traumatic event;
- Witnesses traumatic event;
- Learns that a traumatic event (violent or accidental) occurred to a close family member or close friend;
- Repeatedly hears about the extreme details of a traumatic event;
- Causes significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning.

Post-Traumatic Stress Disorder (PTSD)

Symptoms of PTSD

- Reliving the event, such as through bad memories, nightmares, or flashbacks
- Avoiding situations or people that remind them of the event; Avoiding talking or thinking about the event
- Negative changes in beliefs and feelings about self and others.
- Feeling jittery, always alert, or on the lookout for danger
- Irritable behavior, difficulties concentrating, self-destructive behavior
- Remaining always on alert – hypervigilance

Post-Traumatic Stress Disorder (PTSD)

Possible Traumatic Events
Combat exposure
Sexual or physical abuse
Terrorist attack
Sexual or physical assault
Serious illnesses or accidents, like a car accident
Natural disasters, like a fire, tornado, hurricane, flood, or earthquake
Community violence

Remember: People respond and react to trauma in very different ways. A majority of individuals might have some stress-related reactions after a traumatic event; however, not everyone will experience PTSD symptoms or receive a PTSD diagnosis.

Acute Stress Disorder

- Acute stress disorder shares many of the same signs and symptoms as PTSD.
- Acute stress disorder is what is experienced during the first month after a traumatic event. PTSD may be diagnosed after a month.
- A person experiencing acute stress disorder may describe out-of-body experiences more so than a person with PTSD.
- Traumatic events in acute stress disorder can be first-hand harm or exposure to actual or threatened traumatic event

PTSD in Children and Adolescents

- Children demonstrate similar symptoms as adults.
- Nightmares are linked specifically to a trauma theme or generalized to other fears.
- Children may experience flashbacks, particularly when tied to sensory information.
- Traumatic play – repetitive acting out of the trauma or trauma-related themes in play. Older children may reenact the traumatic event.
- Fantasized actions of intervention or revenge are common.
- Adolescents are at increased risk for retribution, impulsive acting out secondary to anger and revenge fantasies.
- Related behaviors include sexual acting out, substance use or misuse, delinquency, avoidance, or regressive behaviors (e.g., fear of sleeping, bedwetting).

PTSD Health-Related Risks

- Cardiovascular disease
- Alcohol and drug use or misuse
- Sexually transmitted infections
- Domestic violence
- Endocrinological issues
- Gastrointestinal issues
- Hypertension
- Hepatitis, Tuberculous
- Musculoskeletal systems, including pain, tolerance, and chronic pain
- Sleep Problems

PTSD Interventions/Treatment

- Chemicals in your brain affect the way you feel. For example, when you have depression you may not have enough of a chemical called ***serotonin***. Selective serotonin reuptake inhibitors (SSRIs) raise the level of serotonin in your brain.
- SSRIs are a type of antidepressant medicine. These can help people with PTSD feel less sad and worried. SSRIs include:

    Citalopram (Celexa)

    Fluoxetine (Prozac)

    Paroxetine (Paxil)

    Sertraline (Zoloft)

PTSD Interventions/Treatment

What types of therapy are available to people with PTSD?

Cognitive Behavioral Therapy	Other
Cognitive therapy	Group therapy
Exposure therapy	Family therapy
Eye movement desensitization and reprocessing (EMDR)	Brief psychodynamic psychotherapy

Video: Service Dogs and PTSD

For more information, please refer to the following video:

Watch Service Dog Calm War Vet’s PTSD reaction — https://www.youtube.com/watch?v=0y_a_V1QD3U

Video: PTSD – No Warning

For more information, please refer to the following video:

‘No Warning’ – First Responders and PTSD — https://www.youtube.com/watch?v=GCXWuBYTwI0

PTSD and Law Enforcement/First Responders

How common is PTSD?

Women are more likely to experience sexual assault and child sexual abuse.

Men are more likely to experience accidents, physical assault, combat, disaster, or to witness death or injury.

Experiencing trauma is **not rare**.

About **6 of every 10 men** and **5 of every 10 women** experience at least one trauma in their lives.

PTSD and Law Enforcement/First Responders

While many people experience trauma, a much smaller percentage, however, develop PTSD.

- *About* ***7 or 8 out of every 100*** *people will have PTSD at some point in their lives.*
- *About* ***8 million*** *adults have PTSD during a given year.*
- *About* ***4 of every 100 men, and 10 of every 100 of women*** *develop PTSD sometime in their lives.*

PTSD Example: Video

For more information, please refer to the following video:

‘Suicide by Cop’ Leads Soldier on Chase of His Life — https://www.youtube.com/watch?v=zRwoK9qEHaU

Dealing With Trauma in the Field

- After a traumatic event:
  - Gently inquire about trauma as needed
  - You are thinking about trauma
  - You are open to listening
  - You provide adequate time for discussion
  - Maintain here and now, reality testing, safety
- A victim of trauma may shut off the images and feelings as a form of protection to cope with the strong memories
- Remember: Talking about the trauma is traumatic itself!

PTSD: HARVEY | *A Case Study*

You and your partner walk into the Silver Diner for your lunch break. You notice a white male in his mid-50s wearing a baseball cap that reads "Vietnam Veteran" sitting with his back to the wall, yelling at the waiter about another customer blocking his vision of the front door.

Module 14: Community Support

Local Resources

Module 15: Managing Encounters

Scenario-based Skills Training

What is required in responses to mental health crises?

- Approaches that are person-centered
- Approaches that are non-judgmental
- The “why” behind the “what” of behavior
- A here-and-now approach
- *Objective*: To reduce anxiety to encourage meaningful communication

Why is it important?

- Safety for all
- Fewer tragedies
- Better decisions
- Better outcomes
- "Slowing the situation down" and getting a supervisor to the scene can reduce the chances of violence (PERF, 2012)

Training to De-escalate

For more information, please refer to the following video:

San Francisco Police Train to De-escalate Confrontations Before Using Deadly Force — http://abc7news.com/news/sf-police-train-to-de-escalate-confrontations-before-using-deadly-force/1406096/

A Different Mindset

- If you take a *less* authoritative, *less* controlling, and *less* confrontational approach, you will have *more* control
- You are trying to give the person a sense that he is in control.
- Why? Because she is in a crisis, which by definition means that she is feeling out of control; her normal coping mechanisms are not working at this time.

Models of Response

- This curriculum does not endorse a particular model of response to mental health crisis, but rather endorses the ***concept*** of slowing a situation down to defuse a crisis situation.

- We acknowledge that there are many models/instructors/concepts to choose that may be utilized with success.

CAF: A Model for First Response

- **CAF**, which stands for ***Calm, Assess, Facilitate***, was developed by the University of Southern Florida.
  - **Calm**: to decrease the emotional, behavioral, and mental intensity of a situation
  - **Assess**: to determine the most appropriate response as presented by the facts
  - **Facilitate**: to promote the most appropriate resolution based on an assessment of the facts

SEAR: A Staged CIT Model

- **SEAR** stands for **Safety, Engagement, Assessment, and Resolution** and was developed by the Ohio CIT, adapted from the E.A.R. framework created by the Findlay/Hancock County CIT Program.
  - **Safety:** The responding law enforcement officer needs to feel that the situation is safe or he/she will not be effective, because safety needs always come first.
  - **Engagement**: Gain rapport and build trust.
  - **Assessment**: Gather needed information, maintain focus.
  - **Resolution**: Return to pre-crisis state; Set clear limits; Communicate directly; Create options; Take action

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Maintain a safe distance
- Use a clear voice tone
- Use a voice volume lower than that of the individual
- Use a relaxed, well-balanced, non-threatening posture (yet maintaining tactical awareness)
- Set limits

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Be active in helping
- Build hope
- Focus on strengths
- Present yourself as a calming influence
- Demonstrate confidence and compassion

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Remove distractions, disruptive or upsetting influences
- Be aware of body language and congruency
- Be aware that your uniform and your tools may be intimidating
- Be consistent
- Use "I" statements

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Be in the here and now
- Validate and accept
- Make no promises you cannot keep
- Recognize that a person with mental illness may be overwhelmed by sensations, thoughts, beliefs, sounds and the environment; provide careful, clear explanations and instructions

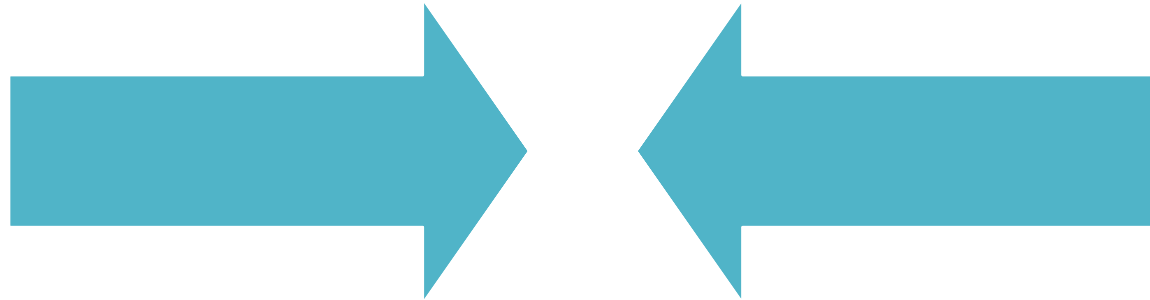
How do you do it?

Guidelines to defuse a potential mental health crisis:

- Determine the person’s need for basic needs, including food and water
- Be patient
- Use active listening skills
- Be non-judgmental

Behaviors and Attitudes

- Officer behaviors and attitudes impact the behaviors and attitudes of the individual in question – and vice versa.



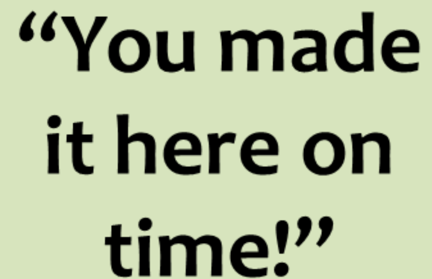
Behaviors and Attitudes

- Officers should *model* appropriate behaviors:
  - Tone of voice, volume, rate of speech, word choices
  - Body language / body positioning / non-verbal cues
  - Empathic listening
  - Active listening
  - Respect (please and thank you)

Quick Class Role Play

Sometimes it's not ***what*** you say, but ***how*** you say it.

Try it! Say the following sentence with different tones.



1. in a suspicious tone
2. in a happy tone
3. in a patronizing tone
4. in an irritable tone

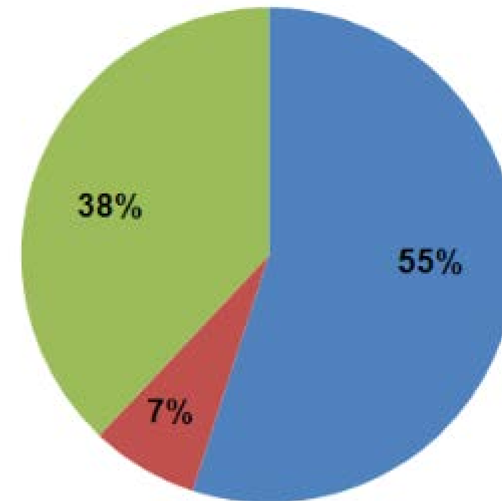
The DOs and DON'Ts of crisis verbal interaction

Don't	Do
Threaten	Show empathy and understanding
Argue	Use modeling
Challenge	Reassure
Order	Respond and encourage
Shame	Use active listening techniques
Blame	Guide the situation toward resolution

Mehrabian's Rule

- Albert Mehrabian established the importance of three elements in any face-to-face encounter:

    1. Words used (7%)
    2. Tone of voice (38%)
    3. Body language (55%)



- There must be congruence among all three elements for effective communication.

How do you do it?

- **Introduce yourself.**
- An introduction promotes communication
  - "Hi. My name is Doug Smith [or Deputy Smith]. I'm a CIT officer with the local police department."
  - "Would you please tell me your name?"
- State what you see/know: "I can see that you're upset."
  - Convey that you are there to help.
  - Be prepared to explain the reason you are there (e.g., a neighbor called to say that someone is upset.)

Empathy and Rapport – key concepts

- Empathy is not sympathy. Sympathy is “an expression of pity or sorrow for the distress of another”; Empathy is “the ability to identify with or understand the perspective, experiences, or motivations of another individual and to comprehend and share another individual's emotional state.”
- Rapport – building relationships of mutual trust through verbal and non-verbal communication.

What is sticking with you?

- What is the most interesting thing you have learned so far?
- What is the most valuable thing you have learned so far?
- How has your understanding of your job changed?
- How have you changed?

- Fox Valley (WI) CIT
- St. Louis (MO) CIT
- Colorado Springs (CO) CIT
- Florida CIT
- Virginia CIT
- Ohio CIT

Special Thanks to the following CIT programs

Day 3 Conclusion

Thanks for your participation during Day 3. We look forward to seeing you tomorrow.

Module 16: Mental Health Basics

Suicide

Suicide Overview

<u>Demographics</u>

- Suicide Rates by Gender
  - Men die by suicide 3.5 times more often than women
- Suicide Rates by Age
  - The rate of suicide is highest in middle age — white men in particular
- Suicide Rates by Race/Ethnicity
  - The rate of suicide is highest among Whites and second highest among American Indians and Alaska Natives

Suicide: The Numbers

- For every completed suicide, **25 attempts** are made
- Suicide costs the United States approximately **$44 billion** annually
- Each year **42,773 Americans** die by suicide
- On average, there are **117 suicides** per day
- Suicide is the **10th leading cause of death** in the United States

***Suicide** claims more lives than war, murder, and natural disasters combined.*

Suicide Trends

Suicide Methods

- Firearms are the most common method of death by suicide, accounting for almost 50% of all suicide deaths.
- The second most common method is suffocation (including hangings).

Suicide Attempts

- 12 people harm themselves for every reported death by suicide.
- At least one million people in the United States engage in intentionally inflicted self-harm each year.
- Females attempt suicide three times more often than males.
- The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly.

Stories of Hope and Recovery

For more information, please refer to the following video:

Stories of Hope and Recovery: David's Story — https://www.youtube.com/watch?v=mVXLj0bNe0o

Suicide: Introduction

Definitions:

- **Suicide thoughts:** the person is just thinking about it; they do not act on it (sometimes called ideation)
- **Suicide attempt:** the person does not die, maybe did not actually intend to die. Over their lifetime, 7-10% of these people die by suicide eventually.
- **Suicide, completed suicide, successful suicide:** the person actually dies. 1.4% of U.S. people will die by suicide.
- **Self-mutilation:** the person harms their self, but not with the intent to cause death.

Suicide: Introduction

<u>Definitions (continued):</u>

- Assisted Suicide / Euthanasia: terminally ill or people in chronic pain with no hope of relief choosing suicide as a way to deal with it; may or may not involve the help of a physician.
  - These cases are often grouped with other suicide statistics, which is accurate or not depending on your view of it. This may skew the numbers on "suicides" of older people.

Continuum of Suicide Ideation

Suicide Assessment

Warning Signs	
Verbal	Person may talk about being a burden to others, feeling trapped, or having no reason to live.
Psychological	Person may have a mental health condition, substance misuse, or serious or chronic health condition and/or pain.
Emotional	Person may display a depressed, irritable, or anxious mood.
Behavioral	Person may be looking for a way to kill themselves, acting recklessly or aggressively .
Situational	Person may be undergoing a divorce, job loss, or have access to lethal means, such as firearms and drugs.

Risk Factors
✓ Male
✓ Age: young or old
✓ Previous suicide attempts
✓ Constant suicidal thoughts
✓ Recent losses
✓ Family history of suicide
✓ Feeling hopeless
✓ Few existing resources
✓ Alcohol or drug use
✓ Disorientation
✓ Hostility
✓ Well-developed plan for suicide
✓ Well-developed plan for final arrangements

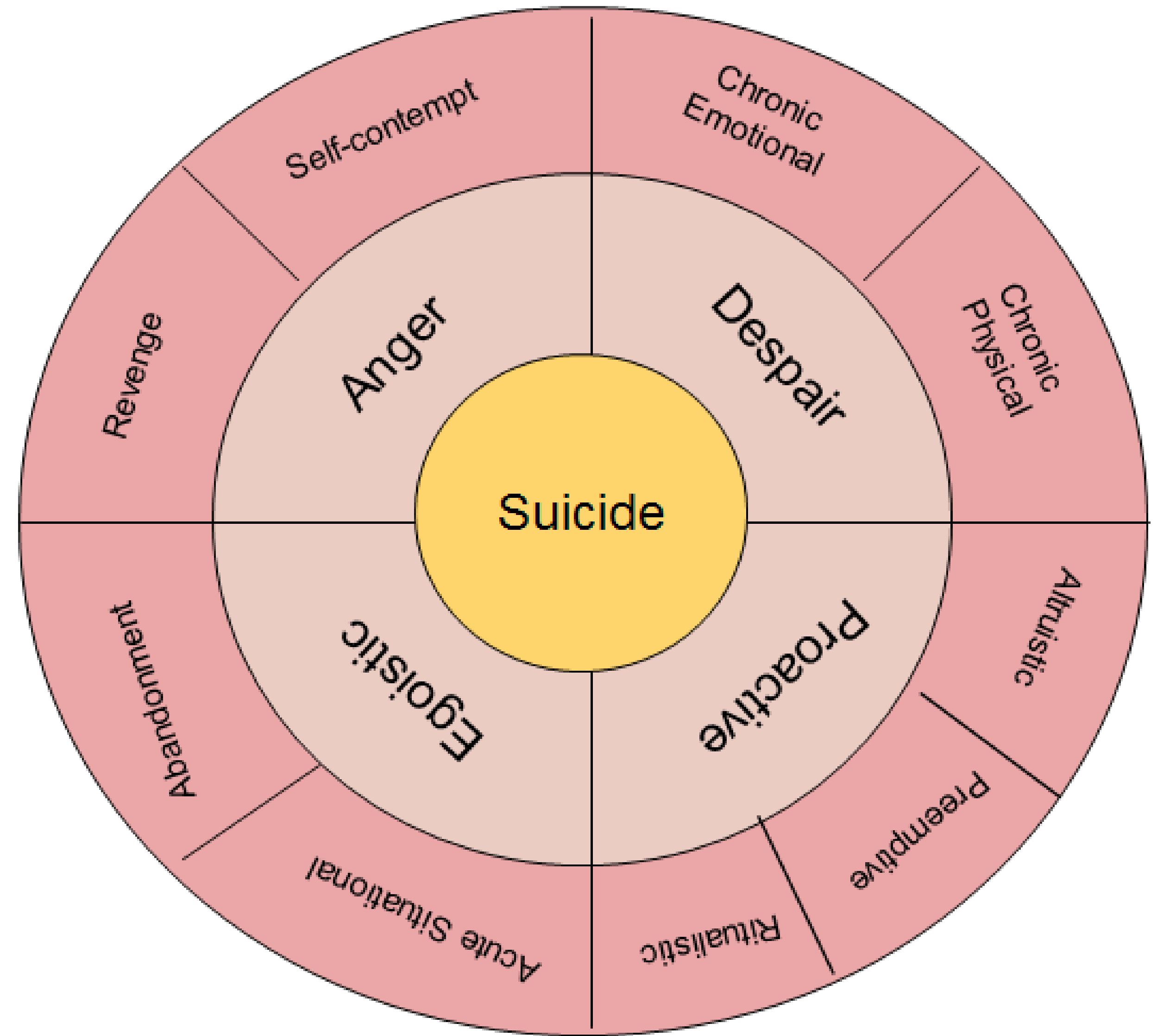
Suicide: Interventions

1. Stay CALM.
2. Take the person seriously.
3. Be empathic and non-judging.
4. DO NOT SAY things like:
   - *"I know how you feel."*
   - *"Things could be worse."*
   - *"You won't go to Heaven."*
   - *"Things can't be that bad."*
5. Assess the Risk
   - Don't be afraid to ask directly

Assess Severity of Suicide Plan	
S	Specificity
L	Lethality
A	Availability
P	Proximity

Types of Suicide

- For those who respond to threatened suicides, a unified theory is less important than an understanding of the various types of suicide, and the risks they each pose for responders.



Anger Suicide

- **SELF-CONTEMPT**

Suicide resulting from a hatred or dislike directed inwardly. Examples may include the alcoholic who cannot stop drinking, or the former soldier who committed war crimes and is now succumbing to extreme guilt. Another example might be the individual facing extreme financial hardship and feels they failed their family.

- **REVENGE**

Suicide resulting from a desire to exact revenge on another person. An example is the man who kills himself and his children following a divorce, or the teenager who kills himself as an act of revenge against his parents.

Despair Suicide

- CHRONIC PHYSICAL

Suicide resulting from unending physical pain and suffering. Many assisted suicides fall into this category. The person simply wants relieved of their constant suffering.

- CHRONIC EMOTIONAL

Related to extreme depression. Like the chronic physical suicide, this person simply wants to end their suffering. Some assisted suicides have fallen into this category, however, because mentally ill people are not terminally ill, assisted suicide for this reason is illegal.

Egotistic Suicide

- ACUTE SITUATIONAL

Suicide resulting from a sudden event that causes a deterioration of the person's self-identity. Examples include the man who loses his career, the wife who loses her husband in an unwanted divorce, or perhaps the pastor of a church caught trading child pornography on the internet.

- ABANDONMENT

One of the most complex emotions in the human repertoire. It results from an insecure attachment during childhood being transferred to a significant other in adulthood. Suicide results from an inability to emotionally separate from a significant other who has already made the decision to do so. Many murder-suicides fall in this category.

Proactive Suicide

- RITUALISTIC

Suicide resulting from reasons external to the individual. They are seen as sacrificial acts carried out for religious, spiritual, or political reasons. Examples include the Kamikaze pilots of WWII Japan, and the various mass suicides that have taken place among cults.

- ALTRUISTIC

Suicides resulting from a desire to avoid becoming a burden on others. For example, the terminally ill patient who does not want his family to bear the physical and financial hardship of caring for him.

- PRE-EMPTIVE

Suicides resulting from a person's desire to end their life before their personal circumstances worsen, such as a terminally ill individual or someone sentenced to prison.

The Criminal Justice Response

- Large amounts of resources are committed each day to saving the lives of those who would rather die.
- Police officers are routinely dispatched to threatened suicides, and suicide is a daily occurrence in America's prisons and jails.
- For first responders, threatened suicides can be a very dangerous type of intervention.
- The person in crisis may try to provoke the police into shooting them, and if desperate enough, may threaten violence against anyone attempting to prevent their final act.

Steps for Intervention

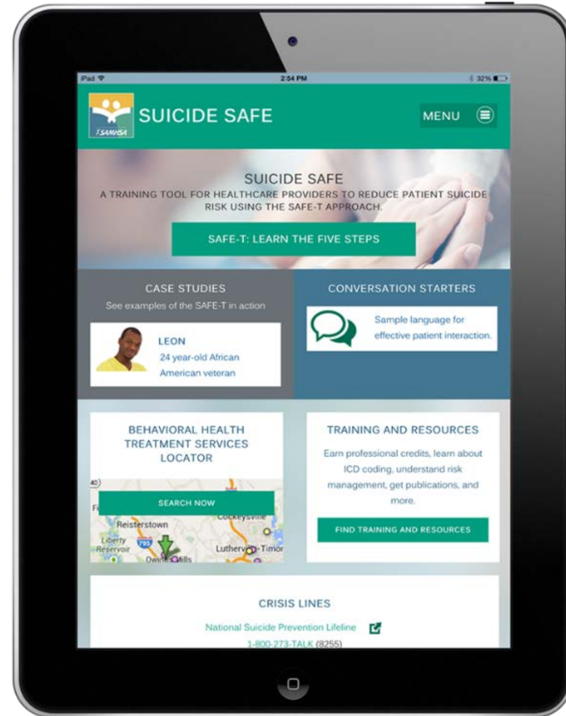
1. Engagement
2. Establish Rapport
3. Listen
4. Offer Help
5. Gain Commitment

Suicide Intervention

Appropriate Questions/Conversation

- Are you thinking about hurting yourself or killing yourself?
- Do you ever feel so badly that you think about suicide?
- Do you have a plan to commit suicide or take your life?
- Have you thought about when you would do it (today, tomorrow, next week)?
- Have you thought about what method you would use?

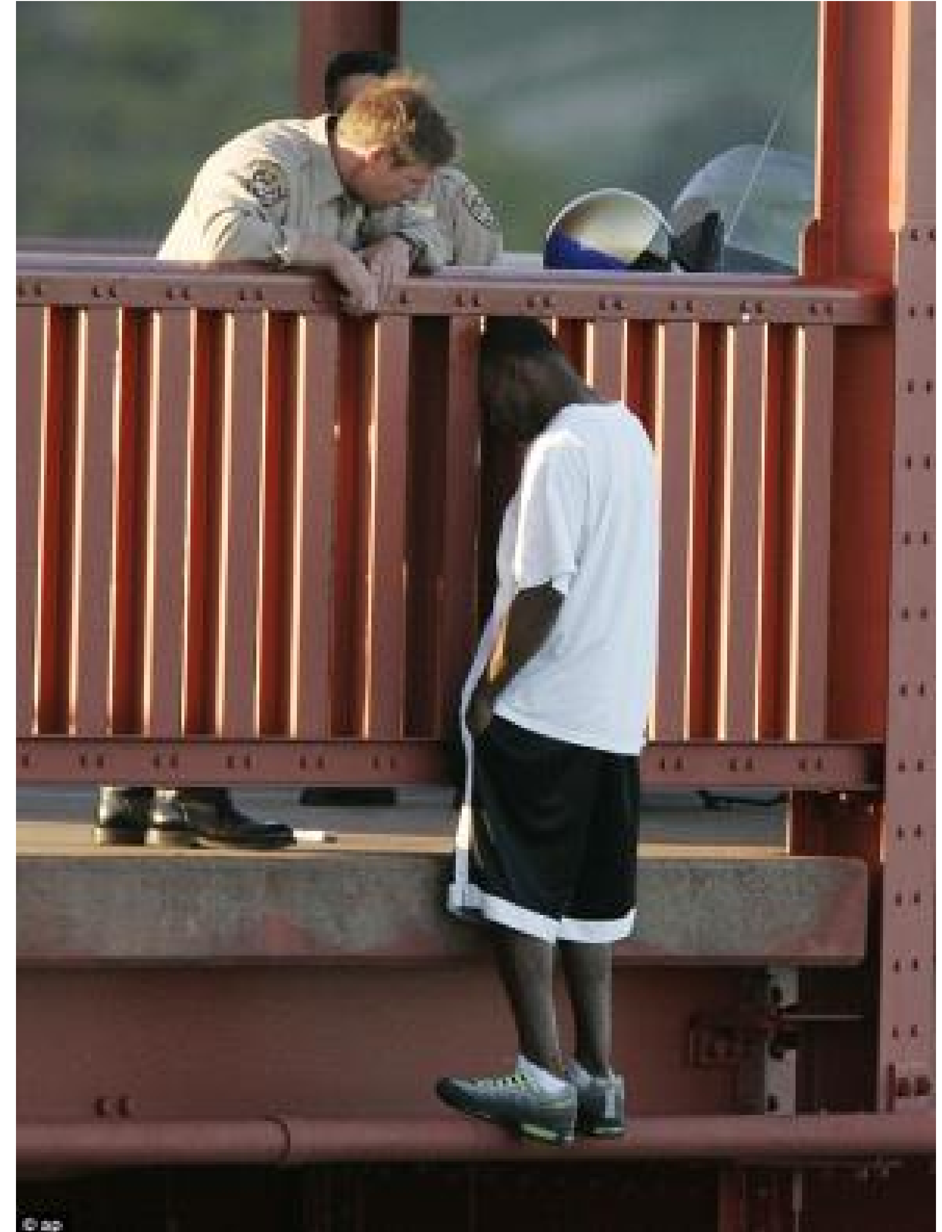
Screening Tools



Columbia-suicide Severity Rating Scale

From the Headlines

- Kevin Berthia, right, was perched on the iconic Golden Gate bridge ready to take a fatal leap on March 11, 2005, when California Highway Patrol officer Kevin Briggs, left, talked him off the ledge and back to safety.
- Briggs spent an hour talking to Berthia, as he has done with hundreds of suicidal men and women, to convince him to climb back over the rail and give life another shot.
- Berthia is now happily married with two children.



Suicide Case Study

You and your partner are driving over the Memorial Bridge and you notice a white male in his mid-30s standing on the ledge. You and your partner pull over and get out of the car and begin to approach the man. He yells at you, “If you come any closer, I’ll jump!”

Module 17: Law Enforcement

Policies and Procedures

Module Topics

- Policy and procedures
- State law
- Liability and other issues

Model Policies

Most model policies include references to:

- Specialized training for officers in crisis response
- Verbal interaction skills
- Non-engagement or disengagement
- Community partnerships
- Communication
- Diversion from jail or the criminal justice system

Your Crisis Intervention Policy

[If your agency has policies related to officer response to people with mental illness, people in crisis or barricaded subjects, please insert those policies here for discussion.]

Your Use of Force Policy

[Place your agency's Use of Force Policy here for discussion.]

Your Barricaded Subjects Policy

[Place your agency's Barricaded Subjects Policy here for discussion.]

Module 18: Law Enforcement

Liability and Other Issues

Fourteenth Amendment: Due Process

- *Did the officer inflict unnecessary and wanton pain and suffering?*

- "In determining whether this constitutional line has been crossed, a court must look to such factors as [i] the need for the application of force, [ii] the relationship between the need and the amount of force used, [iii] the extent of the injury inflicted, and [iv] whether the force was applied in a good faith effort to maintain and restore discipline or maliciously and sadistically for the very purpose of causing harm." *Orem v. Rephann*, 523 F.3d at 446 (4th Cir. 2008).

Failure to Train Police Officers

- In 1989, the U.S. Supreme Court held that municipalities could be liable for failure to properly train police officers in *City of Canton v. Harris* 489 U.S. 378 (1989), which holds that the municipality is only liable for failure to train officers if the failure to train reflects deliberate indifference to the constitutional rights of the inhabitants of the municipality.

Failure to Train Police Officers

Facts of the Case:

- April 1978: Canton Police arrested Geraldine Harris
- At station, Harris slumped to the floor
- When asked if she needed medical attention, incoherent remark
- After her release, she went to the hospital
- Years later, Harris brought claims of negligence against Canton Police Department

Failure to Train Police Officers

- Liability for the municipality in City of Canton v. Harris can be shown if "(1)the officers exceeded constitutional limitations on the use of force; (2) the use of force arose under circumstances that constitute a usual and recurring situation with which police officers must deal; (3) the inadequate training demonstrates a deliberate indifference on the part of the city toward persons with whom the police officers come into contact; and (4) there is a direct causal link between the constitutional deprivation and the inadequate training."

Other Liability Considerations

Failure to Protect

DeShaney v. Winnebago County, 489 U.S. 189 (1989). An officer’s failure to protect an individual against private violence does not constitute a violation of the Due Process Clause. However, an allegation that police in some way assisted in creating or increasing danger to an individual could implicate those Due Process rights.

Disability Discrimination

Arnold v. City of York, 340 F. Supp.2d 550 (M.D. Pa. 2004). Court found a possibly viable claim for disability discrimination under the Americans with Disabilities Act, based on alleged failure to provide adequate training for officers in handling encounters with mentally ill persons. Parents of a mentally ill man sued the police department after their son died, allegedly of positional asphyxia, after being taken into custody. Officers had transported the son to a hospital, handcuffed and hog-tied in a face-down position, and they had noticed his irregular breathing but failed to adjust his position.

Module 19: Managing Encounters

Scenario-based Skill Training

Strategies for Frequently Encountered Situations

- **Psychotic** (with disorganized thinking) and verbally aggressive behavior
  - Allow person to vent energy
  - Maintain a safe distance
  - Talk in a low voice
  - Use the broken record technique
  - Reassure the person

Strategies for Frequently Encountered Situations

- **Hallucinations**
  - Validate the experience for the person
  - Indicate you do not hear the voices, but you believe they do
  - Help the person focus on you
  - Offer help and safety

Strategies for Frequently Encountered Situations

- **Delusional statements** (may include paranoia)
  - Recognize their view
  - Indicate it is not your view, but you are willing to help
  - Do not argue or debate with them about the delusion
  - Focus the person on what you need them to do

Strategies for Frequently Encountered Situations

- **Compulsive Talking** (mania)
  - Ask concise, specific, concrete questions
  - Use the broken record technique

Strategies for Frequently Encountered Situations

- Intoxication
  - Let them vent
  - Listen
  - Use a calm, even tone when speaking
  - Move the person away from others if possible
  - Remain reassuring

Strategies for Frequently Encountered Situations

- **Depression**
  - Demonstrate active listening
  - Display empathy
  - Be patient and take your time
  - Validate their feelings
  - Reassure the person and offer hope

Strategies for Frequently Encountered Situations

- **Suicidal Person**
  - Present a calm, understanding, non-judgmental manner
  - Listen
  - Emphasize the temporary timeframe of the crisis
  - Suggest alternatives
  - Emphasize effect on survivors
  - Conduct a lethality assessment (plan, lethal, access, support)
  - Be active in offering hope and help

Tips for Effective Facilitation

- Appropriate assessment directs appropriate facilitation
- Know your community resources
- Be flexible with alternatives when appropriate

Courage

"Each time someone stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope."

~ Robert F. Kennedy

Safety is the Priority

Special Thanks to the following CIT programs

Module 20: Community Support

Perspectives: Veterans and Homelessness

Local Statistics on Veterans and Service Members

- Insert local statistics on how many veterans and service members reside in your community
- Compare your number to national averages or other communities similar to yours
- Include number of reservists residing in your state or your community
- Include other relevant statistics

Veterans and Justice Involvement

- Veterans are no more likely to be arrested than other adults
- But veterans and service members were trained for combat, which may be evident in their driving skills and other areas of life
- Some veterans find it difficult to re-adjust to civilian life
- Veterans may become justice involved easily

Guest Speaker

- [Content to be customized by agency/community.]

TIME Magazine "Crisis Intervention Teams for Vets: Sure Beats Jail"

Local Statistics on Homeless Population

- Insert local statistics on how many people who are homeless reside in your community and/or your state
- Compare your number to national averages or other communities similar to yours
- Include other relevant statistics

Nowhere To Go But Jail

For more information, please refer to the following video:

Nowhere To Go But Jail * OverCriminalized: Homelessness — https://www.youtube.com/watch?v=XJf1o5G6HMY

Houston's Homeless Outreach Team

Guest Speaker

- Content to be customized by agency/community.

Module 21: Managing Encounters

Scenario-based Skill Training

The ABCs of the CIT Scene

- be **A**ware of their view of the situation and your view
- **B**ecome the safe person they can trust and talk to
- **C**reate an open door for solutions

Silence is Golden

- You cannot talk and listen at the same time.
- You cannot be formulating your next reply and listening at the same time.

Module 22: Law Enforcement

Incident Review

Why conduct Incident Reviews?

- Law enforcement agencies are striving to become “learning organizations.”
- Incident reviews help us assess both the positive and the negative aspects of a given incident.
- It may help us avoid future tragedies.
- It helps address department deficiencies in training, tactics, policies and procedures.

Incident Review

Incident Reviews should include:

- Narrative of the police response to the incident, by stage or time (in minutes)
- Analysis of the incident, including: responses, investigations, communication, leadership, media

Incident #1: Title here

Incident #2: Title here

Module 23:Community Resources

Special Topic Presentation

Module 24: Research and Systems

Training Evaluation

What do you know about CIT *now*?

1. Please complete the **Post-course Survey**
   - Label your survey with the same unique and memorable identifier (e.g., your badge number, the street you live on) that you used on day one.
2. Please complete the **Course Evaluation**

EFFECTIVE COMMUNITY-BASED RESPONSES
TO MENTAL HEALTH CRISIS
POST-COURSE SURVEY

Please answer the following questions on a scale of one to five. 1: Strongly disagree 5: Strongly agree

	1	2	3	4	5
1. I feel comfortable working with people with mental illness.	☐	☐	☐	☐	☐
2. I believe I have an understanding of what people with mental illness face in their everyday lives.	☐	☐	☐	☐	☐
3. I believe that empathy and rapport building are unnecessary components of de-escalation in law enforcement.	☐	☐	☐	☐	☐
4. Recovery from mental illness is possible.	☐	☐	☐	☐	☐
5. I see the symptoms of the mental illness separate from the person who has the illness.	☐	☐	☐	☐	☐
6. I am able to tell if a person is psychotic.	☐	☐	☐	☐	☐
7. I know how to interact with a person with serious mental illness.	☐	☐	☐	☐	☐
8. Jail is a safe place for people with mental illness.	☐	☐	☐	☐	☐
9. I am able to tell if a person has autism.	☐	☐	☐	☐	☐
10. Mental illness does not get better with treatment.	☐	☐	☐	☐	☐
11. People with severe mental illness do not respond to de-escalation techniques.	☐	☐	☐	☐	☐
12. I believe that people with mental illness can be contributing members of society.	☐	☐	☐	☐	☐
13. People with severe mental illness often require the use of force to maintain officer safety.	☐	☐	☐	☐	☐
14. I can identify resources in my community for people with mental illness.	☐	☐	☐	☐	☐

Please answer the following questions on a scale of one to five. 1: Strongly disagree 5: Strongly agree

	1	2	3	4	5
15. I can distinguish between the symptoms of a thought disorder and a mood disorder in an individual with mental illness.	☐	☐	☐	☐	☐

Module 25: Administrative Tasks

Graduation and Presentation of Certificates of Completion

What’s the most important thing you learned this week?

How will you use what you learned?

How will your new skills enhance your safety and the safety of others?

Congratulations!

Certificate of Completion

This certifies that

Officer J. Brown

of the City Police Department

completed the 40-hour course entitled

EFFECTIVE COMMUNITY-BASED RESPONSES TO MENTAL HEALTH CRISES: A NATIONAL CURRICULUM FOR LAW ENFORCEMENT

City, State | Date

Instructor Name(s)

Date