Mental Health Peace Officer

Course Number 4001 (Revised)
Suggested Instructional Time: 24 Hours
Texas Commission on Law Enforcement

August 1998
This Instructor Guide is designed to assist the instructor in developing an appropriate lesson plan or plans to teach the learning objectives and information, which are required as minimum content of this course.

Abstract of Course: The purpose of this course is to educate law enforcement officers about issues pertaining to serving as a mental health officer. It covers the legal aspects of mental health commitments, liability issues’ mental disorders, and mental disabilities. In addition, it deals with a variety of developmental disabilities including epilepsy, cerebral palsey and hearing impairments. Other areas covered include: (1) indicators of mental illness, (2) understanding mental illness, (3) documenting the interpersonal relations necessary to effectively work with the mentally ill, their families, and the mental health system, and (4) intervention strategies for dealing with both low and high risk situations. This course will serve as part of the standards necessary for certification as a mental health officer by the Commission.

Edition Changes: This edition incorporates the Commission’s Course 4042, Sensitizing Police Officers to Persons with Developmental Disabilities and updates information pertaining to sharing client-identifying information between Texas Department of Mental Health and Mental Retardation (TDMHMR), local mental health and mental retardation (MHMR) authorities, the Texas Department of Criminal Justice, and directors of community supervision and corrections departments.

Target Population: Texas Peace Officers who deal with persons with mental illness

Pre-Requisites: None

Length of Time for Course: Minimum of 20 hours up to 30 hours

Material Requirements: Flip charts or marker board, overhead projector, hand out optional

Instructor Qualifications: Knowledgeable about human behavior and communications skills, thorough knowledge of Texas Family Code statutes pertaining to mental health and mental retardation, understanding of the criminal justice system, and understanding of the mental health system. Because of the variety and special nature of this course, it is strongly recommended that the course be team taught by a law enforcement officer and a mental health professional.

Authors: Adele Leinbach and Booker Joseph with Dr. Don Louis and Rosalva Resendez

Testing: The legislation establishing this course requires a written examination. The following provisions are required:
• The required test for this course and the test key can be ordered by a training academy or training provider by making a request to the Curriculum Division of the Commission.
• A passing score of 70% is required.
• A person may retake the test according to the academy’s policy on retaking tests.
ACKNOWLEDGEMENTS

The Gulf Coast Center and Galveston County Sheriff’s Office prepared Chapters 1 through 11 of this training course. The training was developed for Texas Commission on Law Enforcement and supported by Texas Council on Offenders with Mental Impairments. The curriculum is to be used to prepare peace officers to perform duties of Mental Health Peace Officers.

**Gulf Coast Center**  
*Mike Winburn, Executive Director*

**Galveston County Sheriff’s Office**  
*Joe Max Taylor, Sheriff*

**Texas Commission on Law Enforcement**  
*D. C. Jim Dozier, J.D., Ph.D., Executive Director*

**Texas Council on Offenders with Mental Impairments**  
*Dee Kiffowitt, Director*

**Project Coordinators**  
Guide written and compiled by:

Adele E. Leinbach, LMSW, LCDC,  
Community Education and Development  
Gulf Coast Center  
Galveston, Texas

Booker T. Joseph, Captain  
Mental Health Deputy  
Galveston County Sheriff’s Office  
Galveston, Texas

**Editors**  
*Eileen Bastien, M.S.*  
*Trudy Trochesset*  
Gulf Coast Center

**Contributors**

Craig Campbell, Ph.D.  
Texas Commission on Law Enforcement Officer Standards & Education

Jackie Shannon  
Texas Alliance for the Mentally Ill

Don Castellano-Hoyt, MSW-ACP  
Center for Health Care Services

Susan Stone, M.D.; J.D.  
Texas Department of Mental Health Mental Retardation

Judie Guy Hennan  
Travis County Probate Court

Steve Shon, M.D.  
Texas Department of MHMR
Chapters 12 through 17 were developed based on the work of Dr. Donald Louis and Rosalva Resendez of the University of North Texas with contributions by Dennis Graffious of the Texas Commission on Law Enforcement.

*Portions of this training manual curriculum were obtained and adapted from:*

**"Police Mental Health Training Program", 1990**  
New York State  
*Written by*  
Judith F. Cox, NYS Office of Mental Health  
Bureau of Forensic Services  
Leo F. Boland, NYS Division of Criminal  
Justice Services  
Pamela Morschauser, Ulster County Department of Mental Health  
C. Terrence McCormick, NYS Office of Mental Health,  
Bureau of Forensic Services

**"Enhancing Police Response to the Mentally Disabled Training Program", 1992**  
The Center for Health Care Services, San Antonio, Texas  
*Written by*  
Certified Police Instructors  
*Don Castellano-Hoyt, M.A., LMSW, ACP*  
*Charles Harrison, Ph.D.*

**"Emergency Guidelines for Families of People with Mental Illness", 1994**  
The Gulf Coast Center  
*Written by*  
Norma Flory, SWA  
Phyllis McKenzie, SWA

**"Partnerships Family-Professional Educational Workshop Manual", 1994**  
Texas Alliance for the Mentally Ill  
*Written by*  
*Adele Leinbach, LMSW, LCDC*  
Carolyn Karbowski  
Anthony Hempel, D.O.
“Sensitizing Law Enforcement Officers to Persons with Developmental Disabilities”

University of North Texas

Written by
Donald Louis, Ph.D.
Rosalva Resendez
This training course was reviewed by an expert "Advisory Committee for the Mental Health Officer Certification" comprised of law enforcement and mental health experts representing many regions of Texas. The following people and/or their designees participated on the Advisory Committee.

Judge Wilfred Aguilar  
Travis County Court at Law

Lana Biggerstaff, Training Coordinator  
Northeast Texas Community College LEA

Craig Campbell, Ph.D.  
Director  
Professional Programs and Curriculum  
Texas Commission on Law Enforcement

Don Castellano-Hoyt, LMSW-ACP  
The Center for Health Care Services  
San Antonio

Bill Dodson for Jack Bremmer, Sheriff  
Comal County Sheriff’s Office

Kris Faldyn  
Licensing Division  
Texas Commission on Law Enforcement

Judge Guy Herman  
Travis County Probate Court

Captain Booker T. Joseph  
Mental Health Division  
Galveston County Sheriff’s Office

David Gutierrez for Sonny Keesee, Sheriff  
Lubbock County Sheriff’s Office

Dee Kiffowit, Director  
Texas Council on Offenders with Mental Impairments

John Rhodes  
Tarrant County Sheriff’s Office

Jacqueline Shannon, President  
Texas Alliance for the Mentally Ill

Jim Shelton, Coordinator  
North Central Texas Regional Academy

Woody Simmons  
Director of Inmate Services  
Travis County Sheriff’s Office

Dr. Susan Stone for Dr. Steve Shon  
Deputy Commissioner for MH Services  
Texas MHMR

Mike Winburn  
Executive Director  
Gulf Coast MHMR

Adele Leinbach, LMSW  
Gulf Coast MHMR
INSTRUCTOR'S PRINCIPLES

(Information is taken directly from the Peace Officer Mental Health Training Program in New York with adaptations)

This guide and accompanying materials have been designed to help you conduct the Mental Health Peace Officer Training Program. The guide includes essential information about identifying, responding to, and following up on situations involving persons who are experiencing symptoms of mental illness, or are developmentally disabled. The training is designed to provide the recruit with the basic knowledge and skills necessary to handle these situations effectively. The following sections will describe the principles upon which training is based, the preparation necessary for the training, and the overall program format and content.

TRAINING PRINCIPLES

The format of this training program has been based upon three primary principles:

• A team of law enforcement and MHMR instructors most effectively presents mental health training for peace officers. This training is, therefore, designed to be conducted by a team of two experienced instructors, representing both law enforcement and MHMR backgrounds. Among many other advantages, this method provides participants with accurate and complete information from each professional field and provides an example of interagency cooperation.

• Training in handling persons with mental illness or experiencing crisis is most effective if it combines didactic and participatory learning. The program, therefore, devotes time to role-plays, as well as to other activities involving officer participation.

• This training is most effective as an interactive process that enables the trainees to confront any misconceptions, fears, and biases they may have regarding emotionally disturbed persons. If left unidentified, these issues can present a significant obstacle to learning.

The content of the training is based upon the following fundamental premises:

1. Peace officers, as a continuously available source of community response, will often be the first, and sometimes only, responders to a crisis situation or one involving a person with mental illness or developmental disabilities.

2. Trained peace officers can effectively handle crises involving persons with mental illness or developmental disabilities.

3. The approach, assessment, and intervention techniques can significantly reduce the level of danger to officers and others.

4. A coordinated law enforcement and mental health approach to assessment and management of persons with mental illness or developmental disabilities will enhance staff safety as well as the quality of life for the person experiencing a crisis and/or mental illness.
PREPARATION FOR TRAINING

Although this manual has been designed to facilitate the delivery of the training course, there is a critical need for instructor preparation as well as for instructor input into the presentation. We urge you to use your experience, creativity, and some of your own approaches for teaching this information. In addition, keep in mind that your judgment and sensitivity in responding to your training group is extremely important.

There are several tasks that are essential in preparing for this training:

1. MEET WITH YOUR TEAM PRIOR TO TRAINING TO DEVELOP A PLAN FOR CONDUCTING THE TRAINING.

   This should include establishment of a time schedule and assigning training responsibilities for each chapter. This training is most effective if the trainers interact with each other during the presentation and contribute examples and illustrations from their own experience. It is most effective for the police member of the team to introduce the program and discuss why his/her particular department has decided to implement it.

2. "LOCALIZE" THE TRAINING BY PREPARING LOCAL EXAMPLES TO ILLUSTRATE POINTS, LISTINGS OF LOCAL SERVICE PROVIDERS, AND DESCRIPTIONS OF LOCAL PROCEDURES. This will help to make the training real for participants.

3. KNOW YOUR TRAINING CLASS, and adapt the training to their level of knowledge and experience as much as possible.

4. PREPARE FOR THE ROLE-PLAYS by carefully reviewing the role-play descriptions and the guidelines for facilitating role-playing. You will need to make decisions regarding who will be in the role-plays and who will facilitate.

5. MAKE PROVISIONS FOR SUFFICIENT COPIES OF ALL MATERIALS to be distributed and for acquiring all necessary equipment.

6. REVIEW THE VIDEOTAPE AND MANUAL to become familiar with the interaction of manual content with taped footage so that your introduction of video segments will be smooth throughout the training.

7. CHECK THE AUDIOVISUAL EQUIPMENT and tapes, overhead transparencies and projector and any other equipment before each session.
MENTAL HEALTH PEACE OFFICER EXAM

Availability of the Examination

Passing the Commission examination is a requirement of 415.037 of the Texas Government Code. When an academy or training provider is prepared to teach this course, they should contact the Commission for a copy of the examination and a key for Course 4001. Please allow sufficient time for the test to be mailed. The academy or training provider is responsible for maintaining the security of the examination and grading the test. Students can retest at the discretion of the academy.
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CHAPTER 1: INTRODUCTION TO MENTAL ILLNESS

RECOMMENDED LENGTH OF PRESENTATION: 60 Minutes

METHOD OF PRESENTATION

1. Video
2. Lecture/Discussion

INSTRUCTOR PREPARATION

1. Identify the level of knowledge of the trainees.
2. Write training objectives on blackboard or flip chart.
3. Check videotape and make sure it is at proper starting point.
4. Copy and organize handouts.

MATERIALS SUGGESTED

2. Video: The Doctor, Touchstone Pictures (if you can obtain authorization)

INSTRUCTION OBJECTIVES

1. Officers will be familiar with training content and testing requirements for mental health peace officers.
2. Officers will understand the need for mental health peace officers in Texas.
3. Officers will have an understanding of devaluing effects that myths and stereotypes have on persons with mental illness.

INSTRUCTOR REFERENCES

1. Police Executive Research Forum
   "Improving the Police Response to the Mentally Disabled" Model Programs, 1986, Murphy, G.R.
2. Journal of Community Psychology

LESSON PROCEDURE

The instructors should start the program by introducing themselves to the recruit class and have class members introduce themselves if time permits. It is important to provide a brief
background that includes:

- Name
- Rank
- Department
- Years of service
- Experience/Education
- Special Duties

DISCUSS PROGRAM GOALS AND BACKGROUND

➢ Goal:
   To train knowledgeable Mental Health Peace Officers who can identify persons with mental illness and to handle situations involving persons with mental illness properly.

➢ Background:
   The training curriculum was developed by The Galveston Mental Health Deputy Program and The Gulf Coast Center with material contribution from New York State Office of Mental Health, New York Division of Criminal Justice Services, Ulster County Mental Health Services, Center for Health Care Services, Texas Alliance for the Mentally Ill, and Texas Department of Mental Health and Mental Retardation.

➢ Why is mental health training important to the Mental Health Peace Officers?
   1. It will help you to use your judgment to handle situations involving persons with mental illness more effectively;
   2. It will help you enhance the physical safety of yourself, other officers, and third parties and the safety of persons with mental illness.

   VIDEO: The Reporters "Suicide Squad" or "Kindness to Strangers"

OVERVIEW OF TRAINING

This training will:

A. Present important facts about mental illness and developmental disabilities.

B. Help to identify the behavioral symptoms of persons with mental illness or developmental disabilities.

C. Provide information about Texas laws relating to mental health and mental retardation including the situations in which you can transport, or detain persons
with mental health problems or developmental disabilities to a psychiatric
hospital, a state school, or to a local MHMR agency.

D. Help you assess and intervene in situations involving persons with mental illness
or developmental disabilities in a manner which enhances safety.

It is designed to:

1. Give you information.
2. Help you develop new skills.
3. Address and reduce fears that you may have regarding the mentally ill or
developmentally disabled.

E. Training Methods to be used:

1. Are organized in Chapters, each dealing with a different subject area and
each building upon the previous chapter.

2. Involve practical exercises such as "role plays" to give officers experience
in making observations and interventions.

3. Include a comprehensive test to qualify you as a Mental Health Peace
Officer.

4. Include videotapes, and various handouts to support learning.

ESTABLISHMENT OF MENTAL HEALTH PEACE OFFICERS

The Legislature in 1993 in H.B. 771 (Naishat & Madla) Attachment of SB 292 (Rosson)
establishes a goal in Section 531.00(g) Health and Safety Code of at least one special officer for
mental health assignment in each county and requires mental health mental retardation
authorities to assist local law enforcement agencies in their desire to certify such officers. It
allows the Commission in Section 415.037, Government Code to certify officers; issue
achievement or proficiency certificates and establish rules for training, testing, and certification.
It adds the special officer to the list of persons who can transport committed individuals to a
mental health facility. It also states that an individual with mental illness cannot be transported
with a prisoner and cannot be physically restrained during transportation except in an emergency.
(If restraining is used, the restraint and length of time must be documented and the
documentation left at the facility where the individual is transferred).

The Legislature in 1993 in S.B. 1067 (Whitmire) included an amendment to the Code of
Criminal Procedure Article 16.22. The article requires a magistrate to order the examination of,
and transfer to, the nearest appropriate mental health facility, a defendant committed to the
custody of a peace officer, if a peace officer provides evidence that the defendant is a person
with mental illness.
SHARING CLIENT IDENTIFYING INFORMATION

The following information taken verbatim from a TX MHMR Office of Policy Development memorandum dated September 22, 1997.

Effective September 1, 1997, a portion of House Bill 1747 broadened the scope of clients for whom confidential information may be disclosed or received without consent. The act provided for an increase in sharing of information between Texas MHMR, Local MHMR Agencies and Law Enforcement Agencies.

Article 614.017 of the Texas Health and Safety code provides for broad privilege of information sharing. Without the Consent of offenders, authorized agencies can:

- Receive information relating to a special needs offender regardless of whether other state law makes that information confidential, if the agency receives the information for the purpose of providing continuity of care to the offender.
- Disclose information relating to a special needs offender, including information about the offender’s identity, needs, treatment, social, criminal, and vocational history, and medical and mental heath history, if the agency discloses the information for the purpose of providing continuity of care to the offender.
- This statute does not authorize the release of substance abuse treatment information made confidential by federal law.

Restrictions on exchange of continuity of care information without a consent form:

- Continuity of care information can be shared without consent of the officer only for the purpose of providing continuity of care for the following offenders:
  a. Offenders with mental impairments;
  b. Elderly offenders, or
  c. Physically disabled, terminally ill, or significantly ill offenders.
- Disclosure of continuity of care information without a consent form should be on a need to know basis within the agencies entitled to share the information.

RESPONSIBILITIES OF MENTAL HEALTH PEACE OFFICERS

1. The Mental Health Peace Officers are empowered to function as an investigative arm of the Probate Court and to exercise their own judgment as to which individuals need psychiatric evaluation. The evaluation to determine whether an individual should be hospitalized or released is completed by a psychiatrist.

2. The Mental Health Peace Officers are responsible for carrying out all orders originating from the probate court requiring investigation of candidates for the commitment process.

3. The Mental Health Peace Officers may also investigate suicides--(attempted and successful). They may handle unstable situations with
people barricading themselves. Mental Health Peace Officers should have the power and capability to intervene in crisis situations 24 hours a day.

4. Requests for Mental Health Peace Officers come from other police departments in the county, mental health and family service agencies, family and friends of the disturbed individual.

5. If the psychiatrist has screened and evaluated the individual determining there is no urgent need for psychiatric treatment, the Mental Health Peace Officer has four options: (1) arrange for outpatient services with a social service agency, (2) release with no recommendation for the following services, and/or (3) arrange for transportation back to point of detention or home unless the detainee objects, or (4) transfer to appropriate law enforcement agency.

PERSONS SERVED BY MENTAL HEALTH PEACE OFFICERS

The Galveston County Mental Health Deputies' caseload was studied to identify reasons cited in the consideration for commitment.

A. Behaviors

Actual or threatened violence, suicide, bizarre or socially offensive behavior displayed in public, and manifestations of social and personal incompetence and impairment to self were listed as the major factors in taking an individual into protective custody.

B. Misdemeanor and Criminal Charges

The criminal charges are usually misdemeanors. The person is apprehended after ineptly executing a petty crime, such as shoplifting, and is subsequently identified by the Galveston Counties Mental Health Deputy as needing psychiatric evaluation.

MENTAL HEALTH PEACE OFFICERS’ JOB DUTIES

A. Mental Health Peace Officers are licensed first as Texas Law Enforcement Officers and must have successfully completed the 560 hours required by Texas Commission on Law Enforcement Officer Standards and Education. They have no less than three months patrol experience. The officer is trained in crisis intervention and the recognition of and handling of persons with mental illness.

B. The Mental Health Peace Officers think of themselves first as peace officers, and second as mental health professionals, collaborating with a variety of mental health providers.

C. They will frequently act under the authority of and as agents of the Probate County Judge. (Note: this may vary from county to county)
D. The officers are plain-clothes officers and drive unmarked vehicles. Since the officer is on call at all times, he/she takes their unit home to be available as necessary.

E. Situation definitions for Mental Health Peace Officers are based on four different levels of intervention:

1. **Direct, Necessary Intervention**

   The Mental Health Peace Officer is the primary, responsible officer. If the Mental Health Peace Officer is not initially on the scene, then he/she must be called in.

2. **Direct, Advisable Intervention**

   The Mental Health Peace Officer is called to assist a field officer already on site. Once on site, the Mental Health Peace Officer generally instructs and recommends actions to be taken by both the mental health peace officer and field officer. The intent of this level of intervention is to clearly indicate that on the basis of the specialized training and supervision, the Mental Health Peace Officers are the best resource persons to handle situations involving persons with mental illness.

3. **Direct, Desirable Intervention**

   Similar to #2, though more discretion is recommended for the field officer given that the number of Mental Health Peace Officers is limited.

4. **Indirect, Consultative Intervention**

   The Mental Health Peace Officer advises the field officer on the scene by radio or telephone and direct physical assistance is neither being requested nor required.
THE MENTAL HEALTH PEACE OFFICER IS TRAINED IN:

A. Mental Health

1. Warrantless Emergency Detention

2. Warranted Emergency Detention

3. Investigating suspected or known cases of strange or bizarre behavior.

4. Effectively dealing with situations involving violence, weapons or hostages and the subject is known to be a person with mental illness or developmental disabilities.

5. Intervening with non-criminal situations involving a person exhibiting symptoms of a mental illness or developmental disabilities.

6. Intervening in non-criminal situations involving an individual known or believed to be under recent or previous psychiatric or mental health care.

B. Domestic Crisis Intervention

1. A crisis situation where a weapon is involved.

2. A crisis situation which involves a state hospital discharge or a MH/MR client.

3. A crisis situation where three or more police interventions have been requested within a two week period (many domestic crises which resulted in fatality or injury have been preceded by previous requests for police assistance).

4. A crisis situation where the issues appear to be potentially explosive within the family.

C. Suicide

1. A suicide attempt is in progress.

2. A suicide attempt is completed and the individual remains alive and essentially unharmed.

These listings of intervention situations are neither exclusive nor exhaustive. However, the situations indicate the focus of skill training which mental health deputies have received.
OVERVIEW OF MENTAL HEALTH PEACE OFFICER TRAINING CHAPTERS
(Review Course Outline)

ATTITUDES EXERCISE ABOUT PERSONS WITH MENTAL ILLNESS
(Persons with mental illness are called "Mental Patients" in this section for the purpose of contrast - Ask if following statements are true or false)

A. Mental patients are dangerous, violent, likely to participate in criminal behavior and should be locked up in hospitals. (True or False)
   1. False
   2. The majority of mentally ill people do not belong in hospitals.
   3. Mental illness is a chronic illness that does not require constant confinement. It is similar to medical conditions such as diabetes, hypertension, and heart disease, which require hospitalization only during periods of acute illness.
   4. Studies indicate that a person's mental illness does not play an important role in whether the person participates in crime (Steadman, 1978; Monahan & Steadman, 1984; Teplin, 1983).
   5. The American Psychiatric Association's research, among others, has shown that the persons with mental illness are not more dangerous than the general population (Monahan, 1981).
   6. Keeping persons with mental illness under lock and key reduces their ability to cope in the community upon discharge (Cox, et al 1990).

B. Mental patients are "crazy" because of their family (True or False)
   1. False
   2. Mental illness is not a product of bad parenting.
   3. Research suggests that some mental illness may be associated with congenital or hereditary causes.
   4. Many mental illnesses are disorders of the brain; a chemical malfunction which throws it out of kilter, causing misconceptions and bizarre ideas, emotions and behavior.

C. Mental patients are just lazy; unproductive and have a weak will (True or False)
   1. False
2. As with other illnesses, it takes energy to manage the illness, which at times becomes overwhelming to the person.

3. For many persons, mental illness is a lifelong condition. It is possible to help the people with mental illness manage their illness, improve their coping abilities, and care for themselves. However, some of the behavioral symptoms may be permanent. (Cox 1990).

4. Many mental illnesses can not be cured but medication can help to control symptoms.

D. Mental patients do not have the same feelings as "sane" people do (True or false)

1. False

2. Many times, even professional mental health workers talk about an individual in front of them as if he did not understand or have feelings. Persons with mental illness may not be able to express themselves as well as others or they may be more confused than normal, but still they are feeling human beings and to treat them as such can be an enormous help. (Hoyt 1992).

E. How are mental patients described in popular books, newspaper articles, television programs, and movies? They are portrayed as being:

1. DEVIANT. A social group decides, "We are this and we are not that." The "that" becomes the deviant. The group then rewards members who are the same and punishes those who are different. In our society the "madman" is defined as deviant and we are afraid of him.

2. UNPREDICTABLE. Who knows when they will "go crazy" or where or why? What will the strange person do? Will this person turn on us, hurt us, or embarrass us? We usually decide to avoid contact if we can.

3. DANGEROUS. The press often plays up the third stereotype. You have read articles such as: "John Doe, ex-mental patient, was arrested after holding police at bay. "You have probably never read: "Bank announces promotion. John Doe, ex-mental patient, has been named bank officer in charge of new accounts."

4. EVIL. Somehow some of society's mental patients "deserve" his/her fate because he or she is "bad". This idea has its roots in primitive beliefs that mental illness results from possession by spirits or demons.
F. What words have you heard to describe mental patients?

1. Words like crazy, nuts, wacko, sicko, psycho, lunatic, demented and loony.

2. Referring to a "person with a severe mental illness" is preferable to "the mentally ill," which depersonalizes and highlights the illness, not the person. People are not their "illness" and should not be reduced to a "label" (Dvoskin, 1993)

RECOMMENDED VIDEO: Show clips of the movie "The Doctors". Physicians on Rounds "The Terminal vs. Mr. Winters"

3. Discuss labels given to patients suffering from other medical conditions.

   a. Myths and labels limit the way we see people. They keep us from seeing the strengths and needs of individuals. They can prevent us from looking beyond the surface to understand the person underneath. All men, or all Catholics, or all white people do not think, feel, or act alike. All people with mental illness do not think, feel, or act alike either. (TDMHMR 1986)

   b. Correcting the ideas about mental illness requires that we:

      (1) Learn about mental illness, its causes, symptoms, treatments, and results, and

      (2) Accept persons with mental illness as being much like the rest of us and deserving of our help. (TDMHMR 1986)

G. The fact is that there are many famous people with mental illness:

    Ludwig Van Beethoven    Ted Turner
    Abraham Lincoln          Dick Cavett
    Ernest Hemingway         Tom Eagleton
    Patty Duke

H. Mental illness is not rare.

1. Schizophrenia: six times more common than insulin dependent diabetes and is sixty times more common than muscular dystrophy.

2. One out of every hundred people will have a mental illness at some point in his or her life. (TDMHMR 1986)
3. Depression: Affects 8% of Americans severe enough to require hospitalization and the most common form of mental illness.

*Despite the numbers of people who have mental illness, it is seldom talked about openly. Relatives say, "Jane had a nervous breakdown," or "John is just peculiar." Our culture still places stigma on people with mental illness.*
CERTIFICATION OF SPECIAL OFFICERS
FOR
MENTAL HEALTH ASSIGNMENT
Sec. 415.037 (Revised)

(a) The Commission may certify a sheriff, sheriff’s deputy, justice of the peace, constable or municipal police officer as a special officer for mental health assignment if the peace officer has:

(1) Successfully completed a training course in emergency first aid and lifesaving techniques approved by the Commission;

(2) Successfully completed a training course in mental health issues administered by the Commission; and

(3) Passed an examination administered by the Commission that is designed to test the officer's:

(A) Knowledge and recognition of the symptoms of mental illness and mental disabilities and

(B) Knowledge of mental health crisis intervention strategies. (b) The Commission may issue a professional achievement or proficiency certificate to an officer who meets the requirements provided by Subsection (a). (c) The Commission by rule may establish minimum requirements for the training, testing and certification of special officers for mental health assignment.

Comment: HB No. 771, an Act relating to treatment and care of persons with mental retardation and to the certification of special officers for mental health assignment, which provisions take effect September 1, 1993. (73rd Leg. reg sess. ch. 60 page 130 (West edition). The Act in addition other amendments, by section 18, amends Subchapter B, Chapter 415, Government Code, by adding Section 415.037
CHAPTER 2: MENTAL ILLNESS

RECOMMENDED LENGTH OF PRESENTATION: 45 Minutes

METHOD OF PRESENTATION

1. Lecture/Discussion

INSTRUCTOR PREPARATION

1. Review DSM-IV
2. Review Common Psychotropic medications
3. Check videotape to make sure on proper start point
4. Copy handouts

MATERIALS SUGGESTED

1. DSM-IV
2. "Side Effects of medications" Police Recruit E.D.P. Training, New York or "Clozaril" Sandoz Pharmaceuticals (if you can obtain authorization)

INSTRUCTIONAL OBJECTIVES

1. Officers will be able to define the term "mental illness"
2. Officers will be knowledgeable of the difference between mental illness and mental retardation
3. Officers will be able to list three characteristics of mental illness
4. Officers will be able to identify two adverse side effects of drugs commonly used to treat psychiatric conditions

INSTRUCTOR REFERENCES

1. Psychoactive Drugs and Their Effects, Jean K. Bouricius, National Alliance for the Mentally Ill, 1989
2. DSM-IV, The American Psychiatric Association Copyright 1993
LESSON PROCEDURE

DEFINITION OF MENTAL ILLNESS

Mental illness is a disorder which:

A. Primarily a brain disorder
B. Creates problems with feeling, thinking, and perception
C. Affects a person's behavior by causing bizarre and/or inappropriate behavior
D. Can be short term (acute) or long term (chronic)
E. Can occur at any time during a person's life
F. Is a brain disorder - mental illness

CATEGORIES OF MENTAL ILLNESS

A. There are many categories of mental illness.

1. Thought Disorders - Includes schizophrenia, and delusional conditions. "Psychosis" means not being in touch with reality. The term psychosis may be used to describe any type of thought disordered condition including schizophrenia.

2. Mood Disorders - primarily affect an individual's mood, major mood disorders include depression and mania

B. Strict criteria are used to determine if a person has a mental illness

1. The criteria are contained in a manual called the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, for illustration)

2. The DSM-IV for the clinician is like the Penal Law for a peace officer; both are a guide for decision making. Only certain licensed professionals in Mental Health can make a diagnosis (i.e., a Psychologist, a Licensed Social Worker, a Psychiatrist, and a Licensed Professional Counselor).

3. The DSM-IV is a labeling system based on a person’s behavior, thought and mood.

4. It is important for a medical doctor to first rule out other physical conditions which can cause bizarre behavior or other psychiatric symptoms (i.e., neurological conditions - brain injury or disease, certain medical conditions many of which resemble thought or mood disorders like Alzheimer's, AIDS dementia, stroke, thyroid disease, brain tumors, diabetic insulin reaction, epileptic seizure and infectious diseases.
ESSENTIAL CHARACTERISTICS OF MENTAL ILLNESS:
(This section was taken from "Police Mental Health Training Program" in New York with minor adaptations)

A. Abnormalities in perception

Hallucinations - A hallucination is a false perception through any one of the five senses. Most hallucinations involve hearing voices or seeing visions that are not there. Often a person with a mental illness may talk back to person or thing that is not there. Hallucinations are usually not dangerous but can be when command hallucinations order a person to commit specific acts which may involve violence (e.g., Son of Sam Case). Hallucinations are most often associated with thought disorders, substance abuse and neurological conditions.

B. Abnormalities in thought (illogical thoughts or false beliefs)

Delusions - is defined as a persistent false belief. Examples include:

1. The false belief that the person is being persecuted, attacked, harassed, cheated, or conspired against. Evidence of delusions are found in statements which may sound improbable (e.g., "My next door neighbor is reading my mind through the television").

2. The false belief of one's own self-importance such as belief that they are Jesus Christ or the devil, or that they possess special powers.

3. Persons with delusions seldom act on them. Occasionally individuals may act out to end the perceived persecution or display their perceived power. The individual's thoughts and actions are not based on reality and their ability to think clearly is impaired. The level of impairment can vary tremendously not only from person to person but also over time with each person. Delusions can be associated with thought disorder, mood disorder, substance abuse, and neurological conditions.

C. Abnormalities in mood (the general feeling or emotions displayed by the person)

1. The types of emotions that may be displayed include some common feeling such as happiness, sadness, anxiety, fear, agitation, panic, apathy, and aggression.

2. The abnormal qualities of mood in mental illness may be categorized as follows:
   a. Reduced emotional response or emotional flatness (person appears to be indifferent and/or totally apathetic)
b. Extremes of emotion (types and/or levels of feeling not usually experienced under normal conditions, such as feelings of ecstasy and omnipotence or terrifying fears about disintegration of his/her own body)

c. Inappropriate emotions (feelings which do not correspond to the situation or the content of the person's verbalizations, such as laughing while discussing the death of their child or going into rage in response to questions about what they had for dinner)

d. Mood swings (feelings that are easily changeable and move between extremes)

DISTINCTION BETWEEN MENTAL ILLNESS AND MENTAL RETARDATION

A. Mental illness and mental retardation are similar disorders and can be and led in the same way? (True or False)

1. FALSE! ! !

2. While both persons with mental illness and mental retardation may at times show signs of mental and emotional impairment, the two conditions are fundamentally different.

3. Mental illness and mental retardation are not the same thing. People who have mental retardation have needs different from those with mental illness. Understanding the needs of each group helps us serve both client groups better.

B. There are three parts to the definition of Mental Retardation:

1. The person with mental retardation has general intellectual functioning that is below average. The intelligence quotient is below 70 and intellectual impairment is permanent.

2. The impairment began before age 18 (during the developmental years).

3. Mental retardation is a condition involving below average intellectual functioning which generally is present at birth or develops during the early years of life and which results in impaired social adaptation.

C. Persons with mental retardation have deficits or impairments in adaptive behavior.

1. When compared to persons of the same age and similar background, the person lacks skills, which are needed for independent living. (Examples of these are personal care, money management, and use of leisure time).
2. A person with mental retardation usually behaves rationally within the level of functioning he has attained. He will not be violent except under circumstances in which the average person might be expected to be violent.

3. Persons with mental retardation often have the following characteristics:
   a. Short attention span
   b. Distractibility
   c. Difficulty understanding questions
   d. Difficulty in self expression
   e. Appearing uncooperative
   f. Apparent inability to understand consequences of actions
   g. Fear of unfamiliar situations
   h. Eagerness to please

D. Mental Illness is unrelated to a person's level of intellectual functioning and may not impair a person's social adaptation. Mental illness may develop at any point in a person's lifetime and is often a temporary and reversible condition. A person with mental illness behaviors may vacillate between normal and irrational; and become increasingly unpredictable depending upon the person's mental status.

E. Characteristics of mental illness and mental retardation indicate that the approach to the person and disposition of a situation should be different in each case.

F. Persons with retardation should be referred to community-based retardation or state-operated developmental centers for services. If there are questions regarding an appropriate service referral, contact your local MHMR Authority or Association for Retarded Citizens (ARC).

MULTIPLE DIAGNOSES

A. Some persons with mental retardation also have mental illness. Usually, treatment for the mental illness is given first, and then the special needs that result from mental retardation are addressed.

B. Keep in mind that real people seldom fit into neat categories you may never meet a person who exactly fits a certain mental disorder. Sometimes a person has more than one disorder, making it hard to tell which symptoms result from which problems. Even disorders as different as mental illness and mental retardation may have similar symptoms, such as confusion forgetfulness, a lowered level of ability, or inappropriate behavior. Physical handicaps cause additional problems. Problems with vision hearing, speech, or movement can make it hard to assess a person's state of being. And, in some cases, a lack of education or training may make people look less able than they really are. (TDMHMR 1986)
MENTAL ILLNESS IS AN ILLNESS

Today, it is clear that many severe mental illnesses such as schizophrenia and manic depression are one or more diseases of the brain. Brains of persons with schizophrenia or manic depression (Bipolar Disorder) are different from brains of persons without the illnesses. Researchers are unclear on what causes mental illnesses but there are several theories:

A. One theory is that schizophrenia and manic depression is inherited. Most researchers think genetics plays a role, but that genetic inheritance is not the only cause. If one identical twin has Bipolar Disorder, there is an 80% chance the other twin will also. If an identical twin has schizophrenia, there is a 50% to 85% risk for the other twin depending on the study. Since not all identical twins develop schizophrenia or bipolar disorder and identical twins have identical genes, we know that genetic inheritance cannot be the only cause of schizophrenia or bipolar disorder.

B. Biochemical theories say something is out of balance in the chemicals that send signals to the brain.

1. A symptom of a mental illness may occur when there are defects or excess in chemical messengers.

2. Each of our brains functions differently due to natural variations in structure and chemistry.

MEDICATIONS TO CONTROL MENTAL ILLNESS

A. Psychotropic medications are used to CONTROL the SYMPTOMS of mental illness and are NOT A CURE. (This is also true of other medications such as antihistamines, which can control the symptoms of an allergy, but don't cure the allergy)

1. Side effects of medications:

   a. Can be UNCOMFORTABLE, DEHUMANIZING, and often IRREVERSIBLE

****************************************************************************
Let's see if any of your brains function differently. Have course participants read the sentence on their handouts one time and count the number of times they find an F.

Finished files are the result of years of scientific study combined with the experience of many years

(Neurological patterns say F is V. There are 6 F's. Most participants will see 4 F's).

****************************************************************************
b. Can cause a subject to REFUSE TO TAKE MEDICATION, thus increasing the chance of relapse

2. Psychotropic medications are categorized as:
   a. Antipsychotic (Thorazine, Mellaril, Haldol, Prolixin) control symptoms such as hallucinations
   b. Antidepressant (Buspar, Elavil, Prozac, Paxil, Zoloft) control feelings of sadness, hopelessness and suicidal thoughts
   c. Mood Stabilizer (Tegretol, Lithium, Depakote) helps control mood swings

   (Distribute chart, "Medications Used in Treatment of Mental Illness," for more detail)

3. Some physical symptoms due to the side effects of medication are:

   Video: "Side Effects of Medications" or "Clozaril" (instructors point out side effects during video showing)
   a. Fixed muscle spasm, wry neck with protruding tongue and eyes rolled back (Dystonia)
   b. Restlessness, with constant movement of legs even when sitting down (Akathesia)
   c. Tremors of limbs (Parkinsonism)
   d. Uncoordinated twisting movements of limbs, grimacing, protruding tongue (this is an irreversible side effect called Tardive Dyskinesia)
   e. Dizziness, flushed face

   Side effects of medications can be controlled or reversed through use of other medications

   NOTE: Many medications can be lethal when taken in excess. For example Lithium is particularly lethal and requires immediate medical response

4. Discuss issues of medication non-compliance of psychotropic medications
   a. Did you ever NOT finish medication that was prescribed for you? Why not?
b. Did you ever have medication that made you feel sick to your stomach? Did you continue taking it anyway?

c. Did you ever feel drugged or controlled by the medication you were taking? What did you do?

d. Did you ever take medication that did not make you feel better? What did you do? How do you think you would have felt if people had insisted you continue taking that medication for your own good?

5. Most people with mental illness do want their life to change in some way. They don’t like what is going on.

6. If they can see medications as helping them accomplish change they will be more willing to put up with the side effects and inconvenience of taking medications.
MENTAL RETARDATION

1. Below Average Intellectual Functioning
2. Impairment Began Before Age 18
   (Usually Present at Birth)
3. Permanent Intellectual Impairment
4. General Impaired Social-Living Adaptation
   (Examples personal care, money, management, and leisure time)
5. Behaves Rationally at Functional Level

MENTAL ILLNESS

1. Illness Unrelated to Intelligence
2. Develops at Any Point in Life
3. No Cure but Medications Can Help to Control Symptoms
4. Possible Impaired Social Adaptation
5. Behavior less Predictable
   (May vacillate between normal and irrational)
FINISHED FILES ARE THE RESULT OF YEARS OF SCIENTIFIC STUDY COMBINED WITH THE EXPERIENCE OF MANY YEARS.
Chapter #2

PSCHOROPIC MEDICATIONS

ANTI DEPRESSANT
TRICYCLICS AND SSRI's

<table>
<thead>
<tr>
<th>GENERIC</th>
<th>BRAND</th>
<th>TREATMENT EFFECTS</th>
<th>SIDE EFFECTS</th>
<th>MISCELLANEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imipramine</td>
<td>Tofranil</td>
<td>Elevate mood; reduce feelings of hopelessness/helplessness</td>
<td>*Blurred vision</td>
<td>These medicines can take up to 8 weeks for effect. Some TCA's can be lethal in overdose. TCA's and other antidepressants can spiral depressed bipolar patients into mania. These drugs need close monitoring and should not be discontinued suddenly.</td>
</tr>
<tr>
<td>Desipramine</td>
<td>Norpramin</td>
<td></td>
<td>*urinary retention</td>
<td></td>
</tr>
<tr>
<td>Doxepin</td>
<td>Sinequan</td>
<td></td>
<td>*constipation</td>
<td></td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Elavil</td>
<td></td>
<td>*rapid heart rate</td>
<td></td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Pamelor</td>
<td></td>
<td>*weight gain</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*sexual desire change</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*dizziness</td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prozac</td>
<td></td>
<td>*Sexual desire change</td>
<td>Much safer than TCA's in an overdose attempt. Gaining in popularity among psychiatrists. As efficacious as the TCA’s. Usually given in the a.m.</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Zoloft</td>
<td></td>
<td>*agitation</td>
<td></td>
</tr>
<tr>
<td>Paroxetine</td>
<td>Paxil</td>
<td></td>
<td>*bloating</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>*nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*sedation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*headache</td>
<td></td>
</tr>
</tbody>
</table>

A. Hempel, D.O., M.S.

Most of these medications can be lethal when taken in excess. Certain TCA's and Lithium are particularly lethal.
# PSYCHOTROPIC MEDICATIONS

## MAO INHIBITORS AND THE MOOD STABILIZERS

<table>
<thead>
<tr>
<th>GENERIC</th>
<th>BRAND</th>
<th>TREATMENT EFFECTS</th>
<th>SIDE EFFECTS</th>
<th>MISCELLANEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tranylcypromine</td>
<td>Parnate</td>
<td>Elevate mood; reduce feelings of hopelessness/helplessness</td>
<td>*Low blood pressure arising</td>
<td>With the ingestion of when certain foods, there can be a rapid rise in blood pressure. This can be lethal. Symptoms of this crisis are headache, visual changes, sweat and nausea. Medical attention is warranted immediately. Foods that need to be avoided: alcohol, fava beans, yeast, aged cheeses, yogurt, liver, etc. There are more and the patient needs a complete list.</td>
</tr>
<tr>
<td>Phenelzine</td>
<td>Nardil</td>
<td></td>
<td>*Weight gain</td>
<td></td>
</tr>
<tr>
<td>Ilocarboxazic</td>
<td>Marplan</td>
<td></td>
<td>*Tremors</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>*Sudden rise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Sexual desire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Liver problems (rarely)</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>Eskalith</td>
<td>Stabilizer mood</td>
<td>*Nausea</td>
<td>-Periodic laboratory work is needed to check renal, Thyroid, heart and electrolytes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Diarrhea</td>
<td>-Periodic laboratory to check on lithium blood levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Tremor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Weight gain</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Tragatol</td>
<td></td>
<td>*Deceased white blood cells</td>
<td>-Commonly used with rapidly cycling patients. -Periodic laboratory for WBC count and liver function.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Dizziness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Fatigue</td>
<td></td>
</tr>
<tr>
<td>Valproic Acid</td>
<td>Depakote</td>
<td></td>
<td>*Nausea</td>
<td>-Commonly used with rapidly cycling patients. -Periodic lab for liver function and pancreas function.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Liver toxicity</td>
<td></td>
</tr>
</tbody>
</table>

Most of these medications can be lethal when taken in excess. Certain TCA's and Lithium are particularly lethal.

Adapted from Texas Alliance for the Mentally Ill; 1994 “Partnerships” Family Professional Educational Workshop Manual
# PSYCHOTROPIC MEDICATIONS

## ANTIPSYCHOTICS (NEUROLEPTICS)

<table>
<thead>
<tr>
<th>GENERIC</th>
<th>BRAND</th>
<th>TREATMENT EFFECTS</th>
<th>SIDE EFFECTS</th>
<th>MISCELLANEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>Haldol or Haldol D</td>
<td>-stabilizes disordered thinking</td>
<td>Stiffness</td>
<td>Tardive Dyskinesia usually develops after prolonged use. Abnormal involuntary movement of tongue, mouth, face, head and trunk</td>
</tr>
<tr>
<td></td>
<td>Prolixin or Prolixin D</td>
<td>-reduces and/or controls hallucinations (i.e. “hearing voices”)</td>
<td>Rigidity</td>
<td>Neuroleptic Malignant Syndrome - rare but potentially fatal side effect of these neuroleptic medications; symptoms: muscular rigidity, fever, confusion; requires immediate medical attention</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>Prolixin</td>
<td>-helps reduce delusional thinking</td>
<td></td>
<td>Akathesia inability to be still; can be treated with propanolol</td>
</tr>
<tr>
<td></td>
<td>Prolixin D</td>
<td></td>
<td></td>
<td>Muscle stiffness and tremor- can be treated with anticholinergics (e.g. Cogentin)</td>
</tr>
<tr>
<td>Thiothixene</td>
<td>Navane</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Mellaril</td>
<td></td>
<td>Low blood pressure</td>
<td>Clozapine- not associated with TD or extrapyramidal symptoms; associated with agranulocytosis, a potentially fatal condition</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td></td>
<td>Inability to urinate</td>
<td>Other side effects: sedation, salivation, fast heart rate, constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blurred vision</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Dry mouth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Constipation</td>
<td></td>
</tr>
</tbody>
</table>

Most of these medications can be lethal when taken in excess. Certain TCA's and Lithium are particularly lethal.

Adapted from Texas Alliance for the Mentally Ill; 1994 “Partnerships” Family Professional Educational Workshop Manual
CHAPTER 3: INDICATORS OF MENTAL ILLNESS

(The majority of this training chapter is directly taken from the Police-Mental Health Training Program in New York)

RECOMMENDED LENGTH OF PRESENTATION: 2 Hours

METHOD OF PRESENTATION

1. Lecture/Discussion
2. Video

INSTRUCTOR PREPARATION

1. Review cues that indicate a person is emotionally disturbed
2. Check videotape and make sure at proper starting point
3. Copy handouts

MATERIALS SUGGESTED

1. Video: "Indicators of Emotional Disturbance" Portion of Police Recruit E.D.P. Training
2. Flip Chart Paper

INSTRUCTIONAL OBJECTIVES

1. Name eight cues that indicate that a person may be mentally ill.
2. Identify 75% of the cues being illustrated in the video scenes.

INSTRUCTOR REFERENCES

LESSON PROCEDURE

PEACE OFFICER CONTACTS WITH PERSONS EXHIBITING SYMPTOMS OF MENTAL ILLNESS

A. Peace officers are routinely involved with community disturbances. These contacts sometime involve persons who are exhibiting symptoms of mental illness.

B. These situations may or may not involve criminal activity and usually are not life threatening.

C. In dealing with persons exhibiting symptoms of mental illness, peace officers will be faced with unusual, inappropriate, disruptive, and sometimes violent behavior.

INFORMATIONAL EXERCISE

All persons who are emotionally disturbed are mentally ill.

DISCUSSION: Begin by asking class if the above statement is true or false.
The purpose of this exercise is to eliminate a common error in labeling all persons as mentally ill when there may be other causes for their emotional disturbance.

A. FALSE

B. Persons who are emotionally disturbed may exhibit an exaggeration of normal behavior, feelings, thinking and/or perceptions.

C. There are, however, numerous causes of emotional disturbance.

D. Emotional disturbance and its resulting behaviors can be caused by one or more of the following factors:

1. Mental illness
2. Substance abuse
3. Medical problems
4. Situational stress

(Stress to officers, that training Chapters will focus on issues related to mental illnesses and that it is not the officers responsibility to treat the persons with mental illness rather to appropriately apprehend and transport persons exhibiting symptoms of mental illness to mental health facilities within the parameters of the law).
THE DYNAMICS OF BEHAVIORS OF PERSONS WITH MENTAL ILLNESS

A. Behaviors associated with mental disorder will depend on the severity of the affliction. With the onset of the disorder, the individual will generally exhibit three general characteristics symptomatic with a mental disorder:

1. The behaviors and mood of the person are inappropriate to the setting
2. The behavior of the person tends to be inflexible
3. The behavior of the person tends to be impulsive

B. Persons who are emotionally disturbed may:

1. Have a lower tolerance for stress than the average person does
2. Respond in what seems to be an exaggerated way to lower amounts of stress

C. The behavior of a person with mental illness

1. Unusual and upsetting to others
2. Generally not an immediate threat to that person or others

CUES WHICH SUGGEST THAT A PERSON IS EXHIBITING SYMPTOMS OF MENTAL ILLNESS

Although the video you are about to see utilizes specific terms to depict behaviors, the officer should be aware that these terms are for familiarization only. What is important is that officers know how to recognize the behaviors and to describe them in their own words.

VIDEO: "Indicators of Emotional Disturbance." [This segment illustrates three indicators of mental illness with frequent pauses for discussion. Stop video after indicators and discuss totality of cues; Do not continue at this point to "scene" section of video]

Three types of indicators that will help identify if a person is suffering from a Mental Illness:

1. Verbal Cues
   a. Content of speech -- What does he/she say?
   b. Quality of speech -- How does he/she say it?
2. Behavioral Cues
   a. Appearance -- What does he/she look like?
   b. Behavior -- How does he/she act?

3. Environmental Cues
   Condition or makeup of a person's environment -- Are there strange or inappropriate items present?

A. VERBAL CUES

1. Illogical Thoughts
   a. Loose associations (expressing a combination of unrelated or abstract topics)
   b. Grandiose ideas (expressing thoughts of greatness, e.g., person believes self to be Jesus)
   c. Ideas of persecution (expressing ideas of being harassed or threatened, e.g., CIA monitoring thoughts through TV set)
   d. Obsessive thoughts (preoccupation, often with death, germs, guilt)

2. Unusual Speech Patterns
   a. Nonsensical speech or chatter
   b. Word repetition (frequently stating the same or rhyming words or phrases, i.e., "sing-a-song-ding-dong")
   c. Pressured speech (expressing an urgency in the manner of speaking)
   d. Rapid flow of unrelated thoughts
   e. Unclear speech that does not communicate an idea
   f. Speech which is incoherent - words that do not fit together
   g. Makes up new words
   h. Repeats same words and phrases
   i. Fails to or is slow to respond to simple questions, has blank stares
   j. Extremely slow speech

3. Extreme and Inappropriate Verbal Hostility or Excitement
   a. Talking excitedly or loudly
   b. Unreasonably hostile, argumentative, belligerent
   c. Threatening harm

B. BEHAVIORAL CUES

1. Physical Appearance
   a. Inappropriate to environment (e.g., heavy coats in the summer)
   b. Bizarre clothing or makeup
2. Body Movements
   a. Strange posture or mannerisms (e.g., continuously looking over shoulder as if being followed; holding unusual body positions for a long time)
   b. Lethargic, sluggish movements
   c. Pacing, agitation
   d. Repetitious, ritualistic movements
   e. Impulsive and erratic behavior

3. Responding to Voices of Objects That Are Not There

4. Confusion About or Unawareness of Surroundings

5. Lack of Emotional Response

6. Causing Injury to Self (e.g., cutting self with sharp object, cigarette burns on body)

7. Extreme or Inappropriate Expressions of Sadness or Grief

8. Inappropriate Emotional Reactions
   a. Overreacting to situation in an overly angry or frightened way
   b. Reacting with opposite of expected emotion (e.g., laughing at auto accident)
   c. Rapid switch to severe depression

C. ENVIRONMENTAL CUES

Surroundings are inappropriate, such as:

1. Decorations
   a. Strange trimmings; inappropriate use of household items (e.g., aluminum foil covering window)
   b. Pictures or windows turned over

2. Waste Matter/Trash
   a. "Pack-ratting"; accumulation of trash (e.g., hoarding string, newspapers, paper bag; clutter)
   b. Presence of feces or urine on the floor or walls

3. Childish Objects
TOTALLITY OF CUES INVOLVING PERSONS WITH MENTAL ILLNESS

A. Seek information from witness and the individual

1. Questions for family members or witnesses:
   a. Has the individual threatened or attempted to use violence, or acted dangerously towards self or others?
   b. Has the individual threatened or attempted suicide?
   c. Has the individual been neglecting personal care or bodily functions?
   d. Has the individual recently suffered a traumatic experience?
   e. Does the individual have a history of mental illness?
   f. Does the individual take medication or have any physical handicapping condition?

2. Questions for concerned individual:
   a. What is your name?
   b. Where do you live or sleep?
   c. Where are you right now?
   d. What date/day/time is it?
   e. When did you last eat?
   f. When did you last sleep and for how long?
   g. Are you going to hurt yourself?
   h. Tell me what’s going on.
   i. What kind of problems are you having?
   j. Are you going to hurt someone?
   k. Are you supposed to take any medication(s) and are you taking your medication(s)?
   l. Do you have a doctor and for what is your treatment?
   m. What types of fears do you have and what is causing those fears?
   n. What are your plans, what are you going to do now?

(The questions should be asked in a manner to elicit more than a simple yes or no answer. The person should be asked in a manner that allows for the individual to explain the problem or situation).

B. Watch for as many cues as possible. This helps develop a clear picture of the situation.

C. Be aware of the situation as a whole and that taking cues out of context distorts the situation.

D. Be sensitive to cultural and environmental factors in assessing bizarre or inappropriate behavior and/or speech.
Some examples of cultural and environmental differences are:

1. Some homeless persons wear many layers of clothing because they always carry all their possessions with them.

2. It is not abnormal/decisional for Haitian woman to say that she has been pregnant for over eight years. This is called "Perdition" and is a culturally generated means of allowing a woman who has fertility problems to save face.

VIDEO -- Show the "scene" section of "Indicators of Emotional Disturbance." Divide the class into small groups. Ask each group to list the cues it identifies in the video. Ask each group to write and discuss their lists. Reinforce use of clear descriptions; discourage use of labels and jargon.
INDICATORS OF MENTAL ILLNESS
From New York, 1990; Police Mental Health Training Program

VERBAL CUES

○ ILLOGICAL THOUGHTS
  - Loose associations (expressing a combination of unrelated or abstract topics)
  - Grandiose ideas (expressing thoughts of greatness, e.g. person believes self to be Jesus)
  - Ideas of persecution (expressing ideas of being harassed or threatened, e.g. CIA monitoring thoughts through TV set)
  - Obsessive thoughts (preoccupation, often with death, germs, guilt)

○ UNUSUAL SPEECH PATTERNS
  - Nonsensical speech or chatter
  - Word repetition (frequently stating the same or rhyming words or phrases, i.e. "sing-a-song-a-ding-dong")
  - Pressured speech (expressing an urgency in manner of speaking)
  - Extremely slow speech

○ VERBAL HOSTILITY OR EXCITEMENT
  - Talking excitedly or loudly
  - Argumentative, belligerent, unreasonably hostile
  - Threatening harm
ENVIRONMENTAL CUES

Inappropriate surroundings such as:

- **DECORATIONS**
  - Strange trimmings; inappropriate use of household items (aluminum foil covering window)

- **WASTE MATTER/TRASH**
  - "Packratting"; accumulation of trash (hoarding string; newspapers; paper bags; clutter)
  - Presence of feces or urine on the floor or walls

- **CHILDISH OBJECTS**
  - Strange attachment to toys, dolls, collection of shiny, round, unusually shaped items

BEHAVIORAL CUES

- **PHYSICAL APPEARANCE**
  - Inappropriate to environment (e.g. shorts in winter, heavy coats in summer)
  - Bizarre clothing or makeup

- **BODILY MOVEMENTS**
  - Strange posture or mannerisms (e.g. continuously looking over shoulder as if being followed; holding unusual body positions for a long time)
  - Lethargic, sluggish movements
  - Pacing, agitation
  - Repetitious, ritualistic movements

- **RESPONDING TO VOICES OR OBJECTS THAT ARE NOT THERE**

- **CONFUSION ABOUT OR UNAWARENESS OF SURROUNDINGS**

- **LACK OF EMOTIONAL RESPONSE**

- **CAUSING INJURY TO SELF** (e.g. cutting self with sharp objects, cigarette burns to body)
- NON-VERBAL EXPRESSIONS OF SADNESS OR GRIEF
- INAPPROPRIATE EMOTIONAL REACTIONS
  - Over-reacting to situation in an overly angry or frightened way
  - Reacting with opposite of expected emotion (e.g. laughing at auto accident)

When making observations:

1. Note as many cues as possible
2. Put the cues into the context of the situation; and
3. Be mindful of environmental and Cultural factors.
CHAPTER 4: UNDERSTANDING MENTAL ILLNESS

(A Consumer and Family Emotional Perspective)

RECOMMENDED LENGTH OF PRESENTATION: 60 to 90 Minutes

METHOD OF PRESENTATION

1. Video and/or Guest Speakers
2. Lecture/Discussions

INSTRUCTIONAL PREPARATION

1. Review with client and family speakers what they are to focus on and time frame.
2. Check videotapes and make sure in proper starting points.

MATERIALS SUGGESTED

1. Video: "NBC Today Show"-April 13, 1992 (if you can obtain authorization)
2. Video: "When the Music Stops: "The Reality of Serious Mental Illness"
   Delaware Alliance for Mental Illness"
3. "Mental Illness First Hand Account" Police Recruit E.D.P. Training Video

INSTRUCTIONAL OBJECTIVES

1. Ability to identify feelings that may be expressed by families.
2. Ability to identify feelings persons with mental illness experience.
3. Increased understanding of officers' emotional reactions to persons with mental illness.
4. Ability to identify the elements of a constructive response by a peace officer.
LESSON PROCEDURE

UNDERSTANDING MENTAL ILLNESS - A CLIENT'S PERSPECTIVE

A. A person diagnosed with a mental illness has emotions related to the symptoms of mental illness.

VIDEO: "NBC Today Show - Personal account of recovery" and/or "Mental Illness First Hand Account (David's & Kathy's Story")" and/or invite person with a mental illness to speak and recall their symptoms when they were ill.

B. Key discussion points.

1. Persons with mental illness do have a life beyond being "crazy" (hobbies, special interest, family, etc.).

2. Persons with mental illness do contribute to the community (vocation; civic activities; volunteer work, etc.).

3. Experiencing a psychotic break is remembered and has an emotional impact on a person with a mental illness. The person experiences:
   a. Feelings of confusion related to psychotic episode.
   b. Feelings of strangeness and uneasiness related to psychotic episode.
   c. Overwhelming feelings of being different, isolated and alone doing psychotic episode.
   d. Feelings of persecution; being terrified and fearful, if applicable.

4. How peace officers can help during psychotic episode.

C. If person with mental illness is guest speakers give them:

   a. A copy of key discussion points listed above to use as guide for talk
   b. A time range in which to finish talk
Example

UNDERSTANDING MENTAL ILLNESS
(A Client's Perspective)

In understanding mental illness, families and mental health professionals need to gain an awareness of what a person with a mental illness is going through. I am a consumer of mental health services. Many people have a stereo-typed label in which they expect persons with mental illness to fall into. People are not labels or categories of their illness. They are family members, artist, workers, friends, and the list goes on and on. Stigma plagues people with mental illness. They are sometimes treated as less than human, are thought of as crazy, and not given an opportunity to contribute to society. People who suffer from mental illness cannot help having their illness any more than someone with diabetes.

I am a person with a mental illness.

I often become strange and confused when I have an episode and experience an overwhelming feeling of being different from other people, and this means feeling alone. It is hard to filter the thoughts and images one perceives in an episode. I hear voices that probably come from my subconscious. Sometimes they would come through the T.V. often mentioning me by name. Saying in one instance, "The president can take a vacation but you can't because you're too important.

I have felt strangled by self persecution or imagined persecution by others. I am afraid of people during these times, afraid they might hurt me, or afraid they'll stare and laugh. That hurts me too; and along with the hurt comes the anger. I often suffer visual and auditory hallucinations, especially when I can't sleep. Sometimes I think these hallucinations, especially then I can't sleep. Sometimes I think these hallucinations come from god or the devil or both. When you are psychotic, this can be terrifying.

I once decided Jesus was coming so I ran down the street pointing to the heaven with my pool stick and shouting "Jesus is coming." I was arrested for carrying an illegal weapon and transported to the hospital. I was terrified and felt alone. When a person becomes sick from the illness in his/her brain the whole world changes. Sometimes fear becomes so predominant that I am even afraid to speak or be out in public.

Sometimes I blame myself for my problems and even other people's problems. Having a sense of guilt concerning things I can't do anything about. Today I have a brighter future and understand mental illness. Professionals, families, and consumers still have a long way to go in educating each other and the public about mental disorders. With medication, education, and therapy I am finally stepping out of the darkness, trying to recover.

With my medicine I am able to help myself and lead a more normal life. I am a member of a community and social support program. I hope that with my varied experiences I might be able to help someone else cope with their mental illness better and help others to understand mental illness.

Submitted by Barbara Tuck, President of Executive Council of Community and Social Support (CASS) Program.
UNDERSTANDING MENTAL ILLNESS - A FAMILY MEMBER'S PERSPECTIVE

A. **VIDEO**: "When the Music Stops" (first ten minutes) and/or invite a family member or relative with mental illness to recall and share an experience when their son/daughter was acutely ill.

B. **Key Discussion Points:**

1. The enormous stress a relative’s symptoms of mental illness places on the family.

2. Mixed emotional reactions families have when calling the Mental Health Peace Officers.

3. How families should be treated by the Mental Health Peace Officers.

4. The need for reassurance that the family has made the right choice to seek help from the Mental Health Peace Officers.

5. The importance that families receive information about the legal system, emergency detention, and commitment process.

6. That families know they are not alone. Refer families to Local Alliance and to the Identified family support staff person at local community MHMR center.

**NOTE:** Solicit help from relatives and friends of the individual. Yet be aware of how the person reacts to his relatives and friends, at times they may only arouse the individual and not help the situation.

C. If a family member with a loved one is guest speaker give them

1. Example discussion is listed below.

2. A time range in which to finish talk.

**Example Discussion**

**UNDERSTANDING MENTAL ILLNESS**

**(A Family's Perspective)**

I would like to share with you the family perspective about mental illness and a little about where the family is coming from.

First, I want to say that I am so thankful for our mental health peace officer program. We have a wonderful program here in our area. We have some wonderful kind people in the program. But I must tell you, it was one of the most painful things I have ever experienced to have to use their service.
The peace officer that came to our house was a gentle, kind, and considerate person. My son was extremely ill. He was very psychotic, hadn't slept in days, was pacing, and was extremely agitated. The peace officer talked to him calmly and followed him into his room and sat and visited with him to try to gain his confidence. After some time the peace officer came out and said he could not convince him to go with him. He said he really didn't want to have to hand cuff him or take him down because he knew that would only escalate the situation. He went back in and talked to my son some more. Finally after about 30 minutes of his patient talking, my son walked out of the house and got into the car. After the car pulled away, my husband and I went inside and sat on the couch and cried.

When a person is diagnosed with a mental illness, many times the family feels as though they have lost the son or daughter they once had. You lose your hopes and dreams that you have for your child. It takes time to reestablish different goals and to understand what is happening to your loved one.

The reason I shared my story with you is for you to understand how painful and traumatic it is for families to call. By the time we make that call, many times we have been struggling for a long time. Sometime months or years. Because you are the ones that are called, it is critical the way you approach families and their loved one.

This is a traumatic loss for families.

It is difficult to call for help. You are having to call authorities for your loved one that you had tremendous aspirations for. There is not one family that holds their new born child in their arms and says, "When you grow up I hope you have a mental illness." It is a terrible devastating illness that we have to learn to cope with. There is also a lot of stigma to overcome dealing with mental illness.

If your loved one was sick and in a crisis state with any other illness, you wouldn't be calling peace officers. You would be calling an ambulance. This is what makes it so difficult to call. You know your loved one is sick and you want to do something to help, but it is out of your power. Sometime you call, and by the time the peace officer gets there, your loved one has pulled it together and they are not presenting like they are in crisis. So you are fearful to call again because you think the same thing might happen.

Another great fear the family has is that after you do get the courage to call and your loved one is taken to the hospital, there is no guarantee that they will be admitted. If they are not admitted and are sent home, they can become angry with the family member for calling the peace officer and having them picked up.

This can close the communications you have previously had open with your loved one. Many family members fear for their own lives if their loved one comes back home and is both psychotic and angry.

Many families have shared that even though it was the hardest thing they had done to make that call—it also turned out to be the best thing for them. Their loved ones were so out of control that they could not have set in the emergency room with them for any length of time and they were so exhausted themselves that they just simply couldn't do any more. After receiving treatment their
loved one stabilize and the situation de-escalated. The family also had some rest and time to get their own lives back on track.

I would like to end by emphasizing some things I have already stated about what families would like mental health peace officer to know.

- Families need respect and trust from Peace Officers. For every person that is ill, there is a hurting family member. A hurting family who needs reassurance that their call for help was the right choice to make.

- Help us to be well informed about the legal system. It is frightening to have to call the mental health peace officers. Have written information with you to give to families about our peace officer program.

- Tell us where our loved one is being taken and call us back. Let us know if our loved one has been admitted.

- Refer families to the local alliance group or if you don't know if there is a local alliance group, families can always call the Texas Alliance for the Mentally Ill at 1800-633-3760. Families do not have to be alone when dealing with a crisis or with mental illness. We all want the same thing, help for people with mental illness and we need to work together to see this happen.

(Submitted by Carolyn Karbowski, Executive Director of Gulf Coast AMI)

PROFESSIONAL OBJECTIVENESS AND PERSONAL DEVELOPMENT
(This lesson was adapted from enhancing police response to the mental disabled from the Center for Health Care Services)

A. One of the most controversial issues in peace officer work is that of personal involvement vs. objectiveness.

B. On the one hand a peace officer can remain so aloof and detached from his/her work that he/she may seem indifferent to the plight of others and thus cause the public to have an image of peace officers as uncaring, disinterested, and unconcerned.

C. On the other hand, there is the peace officer who gets so involved in his/her work that it causes him to lose a professional perspective that is essential in effective peace officer. Emotional involvement can also be the cause of precipitating early stress and burnout.

D. How aloof or how involved a peace officer should be is not a question that can be answered by stating percentages. In fact, to try and answer it may be an exercise of futility. In that each peace officer and situation which is encountered is unique.

A more helpful set of questions for peace officers is:
1. What situations in my work trigger an emotional reaction?

2. How do I react to these issues?

3. What would be a more constructive response to these issues?

The last question of developing a constructive response is the crux of this section on handling persons with mental illness. When dealing with a person with a mental illness, many people think that the person should be able to control them self. Anyone's emotional response (including a peace officers) to a person who supposedly can control their behavior is anger, frustration, impatience or rejection. Thus, when a peace officer's conduct mirrors his/her emotions, a person with a mental illness is either berated or ignored. Yet, a more constructive response for a peace officer lies in trying to:

- Understand the behavior of persons with mental illness
- Understand what motivated (logical or illogical) the person to act in such a way;
- Understand what was the context in which the behavior took place;
- Understand how can the situation be stabilized?

The peace officer is thus involved but in a more constructive mode. This attitude of trying to understand demonstrates a willingness to help and allows the peace officer to remain a professional, in command of feelings and conduct.

**Discussion Point:**

What is the main difference between a professional objectiveness and personal involvement on the job?

**ELEMENTS OF A PEACE OFFICERS’ CONSTRUCTIVE RESPONSE**

(This lesson was adapted from Community with Families Texas Department of Mental Health and Mental Retardation)

A. Improving Communication with Families and Persons with Mental Illness

1. Why improve communication?
   a. Reduces misunderstanding
   b. Fosters cooperative relationships

2. Results of poor communication
   a. May imply you don't know
   b. May imply you don't care
   c. May imply you don't think they are important
   d. May arouse suspicions
e. May make families and persons with mental illness uncomfortable and negatively affect their willingness to be involved with a mental health peace officer in the future.

3. Results of Improved Communication
   a. Encourages involvement of families
   b. Establishes trust with all involved persons
   c. Increases job satisfaction
   d. Establishes a positive rapport for future situations

B. Skills Needed to Communicate
   1. Identify feelings
   2. Seek family perspective and clients perspective
   3. Provide reliable information
   4. Make referrals
   5. Use active listening skills
   6. Use language which can be easily understood

C. Identifying Feelings
   1. Why understand feelings?
      a. To show care and concern
      b. To address feelings
   2. How We Come to Understand Feelings
      a. Allowing persons to talk about feelings
      b. Not labeling feelings as good or bad
      c. Not telling people how they should feel
      d. Remembering how it feels when we have had similar feelings

D. What is Most Often Asked Regarding the Detention of Persons with Mental Illness
   1. Where is the person being taken?
   2. What will happen?
   3. Are you going to arrest the person?
   4. Will the person be safe?

E. Providing Reliable Information to Families and Caretakers
   1. Use reliable information sources - Why provide reliable information?
      a. to maintain truth
      b. to decrease anxiety
2. Reliable information sources to give to family
   a. Telephone number of Local Alliance for the Mentally Ill (AMI)
   b. Name and telephone number of identified family support person at local MHMR
   c. Know your local commitment process; provide family with written information.

3. Provide the information specifically.
   a. A positive example of providing information specifically would be saying, "I will take your son to John Doe hospital. A psychiatrist will see him. If they do not admit him, I will be back with him in four to six hours."
   b. A negative example would be saying, "He will be fine, don't worry."

**Show Empathy and Understanding**

**A. How to Allow for Expression of Concerns**

1. Listen.
2. Ask questions to understand and clarify.
3. Put yourself in the other person's place.

**B. How to Validate the Other Person's Concern.**

1. Identify with person's feelings and concerns.
2. Tell him/her the feelings

**Use Active Listening Skills**

Practice active Listening skills to promotes the accurate exchange of information and feelings.

**Use Non-Jargon Language**

**A. Reasons to Use Non Jargon Language**

1. So people understand you
2. So you do not offend others

**B. Specialized Language**

1. Often developed within specialized fields
2. Is inappropriate if it is demeaning
3. Is inappropriate for use in communicating with families and persons with mental illness especially if they don't understand it
C. People First Language

1. People First Language refers to people who have disabilities.
2. People are not defined by their disabilities.
"FAMILIES OF THE MENTALLY ILL FACE A DRASTIC CHANGE IN THEIR LIVES, WHICH REQUIRES SIGNIFICANT CHANGES IN BEHAVIOR AND CAPACITIES...FAMILIES SEE MENTAL ILLNESS AS A TERRIBLE FAMILY TRAGEDY AND THEIR FEELINGS OF BEING OVERWHELMED BY GRIEF, ANXIETY, AND REMORSE ARE QUIET APPROPRIATE TO THE TRAUMA THEY HAVE SUFFERED."

What peace officers should tell families if taking relative into custody:

-- Where the person is being taken
-- What will happen
-- That the person will be safe
-- Phone number of:
    1) Family support person at local MHMR or State Hospital
    2) Advocate Groups.
        a. Local Alliance for the Mentally Ill.
        b. National Association for Mental Illness.
        c. The Texas Alliance for the Mentally Ill.
        d. Manic Depressive Association.
CHAPTER 5: HANDLING PERSONS IN ACUTE PHASE OF MENTAL ILLNESS

RECOMMENDED LENGTH OF PRESENTATION: 60 Minutes

METHOD OF PRESENTATION:

1. Lecture/Discussion
2. Role Play
3. Video

INSTRUCTOR PREPARATION:

1. Check video and make sure at proper starting point
2. Prepare for role plays
3. Copy handouts

MATERIALS SUGGESTED:

1. Video: "Person Disturbing the Peace"
   Police recruit E.P.P. Training video, New York
2. Props for role play (optional)

INSTRUCTIONAL OBJECTIVES:

1. Aware of reasons a person with a mental illness may relapse
2. Use proper communication and intervention techniques in role play
3. Knowledge of appropriate non-verbal intervention techniques
LESSON PROCEDURE

ACUTE PHASES OF MENTAL ILLNESS

A. The onset of or relapse of mental illness results in a person's symptoms becoming more severe and less manageable, and this can:

1. Cause the subject to feel frightened, threatened, and/or suspicious
2. Include hallucinations and delusions, these perceptions seem real to the person
3. Sometimes be dangerous, especially if the person is made to feel more threatened
4. Be treated by mental health agency serving the person or emergency mental health services
5. Require short hospitalization

Point out the stress tolerance level of persons with mental illness is lower than that of the general population.

Ask the class to give some examples of stressful situations. Give examples of how low stress situations may be high stress situations to the person with mental illness.

B. Relapse into mental illness may be precipitated by:

1. Life stresses
2. Decrease of or failure to take medications
3. Changes in the body's response to medications
4. Natural progression of illness

DEALING WITH AN ACUTELY MENTALLY ILL PERSON

Video (Show communicating with mentally ill "Person Disturbing the Peace")

A. How might you approach and initiate communication with an emotionally disturbed person?

1. BRAINSTORM how participants would initiate communication with "Mark." Accept all responses without criticism. Use exercise as ice breaker.
2. Discuss how to deal with a person who is acutely mentally ill and discuss participants' responses as you cover chapter content.
B. When dealing with a person who may possibly be mentally ill, an officer should:
(This lesson is adapted from TXAMI "Partnership" Training Program)

1. Look and listen for cues (symptoms) and evidence of a mental illness. This may include grinning or laughter which is inappropriate, moving lips without sound, rapid blinking, increased motor activity, slow speech responses, silence, frequent telephone calls, turning over picture frames, covering windows, televisions, radios or withdrawing.
   a. Give the person feedback; this helps the individual control his illness instead of the illness controlling him/her. ("I see that you are turning over pictures, how do you feel? or "I see that your eyes are moving back and forth, What is happening?")
   b. In a street situation where you suspect the person may be mentally ill, it is OK to ask them if they receive any services or medications for an illness.

2. Continually assess the situation to be aware of potential danger. Don't be fooled by the individual's size. People who are experiencing a mental breakdown may demonstrate remarkable strength and endurance (Hoyt and Harrison 1992).

3. If a person is experiencing delusions or hallucinations, REMEMBER:
   a. The person is genuinely hearing voices or seeing images or they are convinced of their beliefs. The experience is very real to them.
   b. Individuals vary on the degree to which they are convinced that their delusions and hallucinations are real. Some people can learn to understand their symptoms and cope with them.
   c. The voices being heard, may become threatening if the individual doesn't follow commands.
   d. The hallucination sometimes become elaborate and may be interwoven with delusions.
   e. The individual may have no control over their focal awareness and be living in terror.
   f. The individual may feel suicidal as a result of being told to kill themselves by the voices or to stop the commands.
   g. The individual may become violent or catatonic.
4. Maintain adequate space between you and the subject.
   a. Move into the individual's "personal space" as slowly as the situation permits unless there is an emergency that must be handled immediately. If circumstances develop too quickly this may only confuse and threaten the individual.
   b. Seek information from the person regarding their perception and beliefs. Never be intrusive. Be firm and caring.
   c. A person with a mental illness may be frightened and act out based on their misconceived perceptions and/or beliefs. Ask the person:
      (i) What are you experiencing?
      (ii) What are you seeing or hearing?
      (iii) Where is it at or where is it coming from?
   d. Remember the person may not be able to respond to you due to the amount of stimulation they are experiencing.
   e. Many people with mental illness have been mocked for their beliefs and experiences, consequently they have learned to hide their symptoms from others. 
      *If this is the case, let them know you are there to help.*

5. Respond to the apparent needs/feeling of the subject - Be Empathic.
   a. Don't meet hostility with hostility. Try to turn away an angry attitude by being calm, objective and by trying to understand that the person is ill and in need of help.
   b. Focus on the subject's emotional state rather than their perception or beliefs. Common emotional states are fear, loneliness, anxiety, and/or grief (e.g., "You look/sound scared", "That sounds frightening", "I can see why you are angry").

   **Example:**
   The subject tells you that the devil's voice is telling him/her that he will take him/her away to eternal damnation at 8 p.m. His/her emotional state is that of being scared. Do not try to persuade him/her that the devil will not be taking him/her away at 8 p.m. Instead discuss with him/her what can be done to make him/her feel safer.
6. **Ask:**
   
a. Has this happened before?

b. What has made him/her feel less scared in the past?

c. What could be done to make him/her safe right now?

7. **Be helpful and use reflective listening.**

Indicate you are listening by saying:

a. Tell me more about that.

b. What would help?

c. What would make you feel safer/calmer?

d. Clarify - Let me make sure I understand, please explain....

Reassure them that you are not going to harm them or allow anyone else to harm them. Tell them you are there to help. In most cases, mentally ill persons will respond to questions concerning their safety and protection.

8. **Give firm, simple, clear directions.**

a. One step at a time. Repeat if necessary. Allow the person a little time to understand what you are saying. With most people, a string of several requests can usually be given with a reasonable expectation that they will get accomplished. With a person with a mental illness, several requests to be carried out sequentially can and will frequently result in an over load.

b. Persons who are actually mentally ill need structure to provide a sense of time and space. Knowing what to expect gives the person a sense of security, making them less anxious. This is because the person with mental illness is often suffering from severe distortions of shape, size, color, space and time. Medications can reduce perceptual distortions, cognitive confusion and structure enhances the persons abilities to cope.

c. Allow plenty of time when you approach a situation involving a person with mental illness. Be brief. Say what you mean. Tell them exactly what it is that you want them to do.
d. Sometimes it is helpful to use parroting. Have the person repeat back to you what you said. This works well with very ill persons.

**Example:**
(speak calmly and gently)

I want you to put the stick on the ground.

What did I say?

Put the stick on the ground.

Right now, put the stick on the ground.

Watch for signs of fading -- (when they stop paying attention to you and what is going on). If you notice them fading call them by name (if known). Say look at me and listen.

9. Be calm and speak slowly.

a. Persons with mental illness relate better when verbal messages come in a soft tone and in a controlled manner. Most people do not cope well with angry, sharp comments and loud voices. Instructions should be in plain English and gently presented.

b. This takes a great deal of effort. It is natural for our voice, volume and pitch to go up when we get excited. It is very difficult to have a low and controlled voice when someone is cursing and/or pacing in front of you.

10. Do NOT argue or agree with the person about their false beliefs and/or perceptions -- rather defer them and focus on feelings and when possible agree.

a. If asked, be honest and tell them you are not having the same experience.

b. ever say it's not there.

c. do not argue about whether the hallucination is real as you will not win.

d. indicate you believe the person is in distress by what he/she is experiencing.

e. Express empathy for the feeling the person is experiencing without agreeing with their beliefs and/or perceptions.
f. Don't say "But" say "Yes" and ...

**Example:**

If the person insists that his head is being bombed with rays on Mars focus on his emotions instead of the content of what he is saying. An appropriate response may be "I see that you are quite upset. Let's go to get you some help." (Hoyt and Harrison 1992)

11. Keep the surroundings as low key as possible.

   a. Reduce number of activities, demands and noise. It may be helpful to think of some types of mental illness as an allergy to stress and intensity. Avoid "cherry-top" or sirens that may attract a crowd.

   b. You can help to quiet things down with fewer people and by keeping conflict away from the person with mental illness. Allow the person to have a time out or quiet time if possible. People with mental illness tend to be extremely sensitive to almost everything going on around them. They tend to take it all in and have great difficulty sorting it out which at times makes them confused and anxious and they may respond inappropriately or act out.

12. State positive choice choices.

   Give the person as many "choice points" to gain/regain control as the situation permits.

   a. Ask which would you rather do, choice A or B?

      **Example:**

      Would you like to come out and talk or prefer for us to come in to talk to you?

   b. Do NOT threaten a person.

      **Example:**

      You better come out or we will come in and get you.

13. Preserve dignity to the extent possible in the situation.

   a. Most persons with acute severe mental illness will remember the experience of being apprehended, even though at the time they may appear "out of it".

   b. Allow the person to "Save Face"
c. Do not deceive the person by making promises you cannot keep. You may have to work with the individual in the future. Establishing a trust relationship is very important! Handle a person you suspect is mentally ill as you would wish your closest relative handled under the same circumstances.

**WHEN DEALING WITH A PERSON WITH A MENTAL ILLNESS, A PEACE OFFICER SHOULD NOT:**

A. JOIN in behavior related to the person's mental illness, such as agreeing/disagreeing with delusions/hallucinations

B. STARE at the subject. This may be interpreted as a threat.

C. CONFUSE the subject. One person should interact with the subject if direction or command is given and follow through.

D. GIVE MULTIPLE CHOICES. Giving multiple choices increases the subject's confusion.

E. WHISPER, JOKE, or LAUGH. This will increase subject's suspiciousness and the potential for violence.

F. DECEIVE the subject. Being dishonest increases fear and suspicion. The subject will likely discover the dishonesty and remember it in any subsequent contacts.

G. TOUCH. Although touching can be helpful to some people who are upset, to others it may cause more fear in the person and lead to violence.

H. RELY ON YOUR WEAPONS. Remember you are dealing with a deranged individual, and he will not react in a conventional manner to orders. The use of a weapon must be restricted to defending your life and that of other persons.

**BRIEF ROLE PLAYS (2 minutes to 5 minutes each)**

Purpose:

A. To illustrate use of effective communication techniques in dealing with an acutely mentally ill person who is not very agitated and does not become violent.

B. To give officers experience in initiating communication with a nonviolent mentally ill person.

C. To let officers get in touch with their tears regarding the mentally ill

D. Gain greater understanding of importance of proper communication techniques.

1. **Role Play #1: Setup**

   a. Ask for three volunteers.
b. Instructor #1 takes two volunteers out of the room. Explain that they are going to stand behind the "person with a mentally illness" and be "the voices." Give each person playing a voice a slip of the papers. Tell them to begin speaking softly then raise their volume. Stating the following:

"Don't believe him/her!"
"She/he is out to get you!"
"She/he is evil!"

c. Instructor #1 plays the third voice

d. Instructor #2 informs remaining volunteer to play the role of a person with a mental illness who refuses to move from a public bench and occasionally yells at passersby.

e. Instructor #2 instructs workshop observers to close their eyes during the role play exercise.

f. Instructor #2 plays role of Mental Health Peace Officer demonstrating communication techniques. (As voices are being shouted in "the person with a mental illnesses" ear).

g. Discuss reactions with volunteer peace officer and playing the "person with mental illness".

(i) How do you feel"

(ii) Could you concentrate on the conversation?

g. Discuss reactions from observers.

2. **Role Play #2 and #3: Setup**

a. Ask for volunteers.

b. Instructor #1 plays mentally ill person.

c. Ask volunteer officer to initiate communication for purpose of getting basic information from subject in effort to assess situation.

d. Instructor #2 is not in role play but starts and stops role play and monitors time.
e. Instructor #2 debriefs role play with participation from Instructor #1.

   Ask for feedback from observers to focus on the following points:
   - Officer feelings
   - Effective/ineffective communication
   - Techniques

Role Play #2: Scenario

Delusional Person: "Man annoying" call

a. Person is on "main street".

b. Person believes he is Jesus Christ and has been sent to save all people in town.

c. Person is calm, but is convinced about his beliefs.

Role Play #3: Scenario

Disoriented Person: "Person wandering" call

a. Person is on public street, wandering aimlessly

b. Person greets officers as if the person knows them, denies having problems

c. Person answers questions willingly and responses make sense

d. Content of responses to similar questions changes during conversation (e.g., "Where do you live?" "Grand Street." "What is your address?" "201 White Street").
Dealing With A Person Experiencing Mental Illness

DO:

Continuously Assess for Danger
Maintain Personal Space
Be Calm
Give Firm, Clear Directions
Respond to Needs/Feelings
Be Helpful

DON'T:

Join in Disordered Thinking/Behavior
Stare at Subject
Confuse Subject
Give Choices
Whisper, Joke or Laugh
Deceive Subject
Touch Subject
Rely on Your Weapons
COMMUNICATING WITH A PERSON WITH MENTAL ILLNESS

People who have a mental illness have symptoms and characteristics that require adaptations in the way you communicate. This style of communication will increase your chances of being understood. The following table shows symptoms of mental illness and corresponding adaptations. Always speak in a calm, patient, and reassuring tone to voice.

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<th>BEHAVIOR or CHARACTERISTIC</th>
<th>ADAPTATION</th>
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<td>Confusion about what is real</td>
<td>Be simple and straightforward</td>
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<tr>
<td>Difficulty in concentrating</td>
<td>Be brief, repeat if needed</td>
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<td>Over stimulation</td>
<td>Limit input, don't force discussion</td>
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<td>Poor judgment</td>
<td>Don't expect rational discussion</td>
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<tr>
<td>Preoccupation with internal world</td>
<td>Get their attention first</td>
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<td>Agitation</td>
<td>Recognize agitation and if possible, allow the person an exit, let them &quot;save face&quot;, give them &quot;their space&quot;</td>
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<tr>
<td>Fluctuating emotions</td>
<td>Don't take words or actions personally</td>
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<tr>
<td>Fluctuating plans</td>
<td>Stick to one plan</td>
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<tr>
<td>Little empathy for others</td>
<td>Recognize this as a symptom</td>
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<tr>
<td>Withdrawal</td>
<td>Initiate conversation</td>
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<tr>
<td>Belief in delusions or hallucinations</td>
<td>Don't argue; respond to needs and feelings</td>
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<tr>
<td>Fear</td>
<td>Stay calm</td>
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<tr>
<td>Insecurity</td>
<td>Be caring and accepting</td>
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<tr>
<td>Low self-esteem</td>
<td>Stay positive and respectful</td>
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Adapted from: "When Someone You Love Has A Mental Illness” by Rebecca Woollis, M.F.C.C., 1992
CHAPTER 6: THE LAW AND MENTAL HEALTH

(Based on 9th Edition of Texas Mental Health Code)

RECOMMENDED LENGTH OF PRESENTATION: 2 Hours

METHOD OF PRESENTATION

1. Lecture/Discussion
2. Role Play

INSTRUCTOR PREPARATION

1. Prepare packet of local legal forms.
2. Prepare a list of facilities where emergency psychiatric services are available in county and/or nearest state hospital.
3. Copy handouts

MATERIALS SUGGESTED

1. Packet of local legal forms
   (Use local forms - examples below)
   a. Application for Emergency Detention
   b. Application for Emergency Apprehension and Detention
   c. Magistrate's Order for Emergency Apprehension and
   d. Detention Warrant for Emergency Detention
   e. Other

INSTRUCTIONAL OBJECTIVES

1. Define the function of the Mental Health Code.
2. Identify types of admissions to a psychiatric hospital.
3. Identify the essential characteristics of voluntary hospitalization.
4. Identify the types of admission criteria which must be met in order to hospitalize a person without consent.
5. Highlight problems a mental health peace officer might encounter when attempting emergency admissions.
6. Describe the legal requirements which must be present for a peace officer to take a person into custody under Mental Health Code.

INSTRUCTOR'S REFERENCES

2. An analysis of the Texas Mental Health Code, Hogg Foundation (1994), Michael J. Churgin,
LESSON PROCEDURE

IMPLEMENTATION OF TEXAS MENTAL HEALTH CODE

A. Civil Procedure vs. Criminal Arrest - A civil detention differs from a criminal arrest in that it:

1. Requires no arraignment or jail; and

2. Occurs for the purpose of getting the mentally ill person help.

Mental Health Code detention may also involve the USE OF REASONABLE FORCE to take the person into custody; there is a duty of care owed to a mentally disturbed person while he/she is in custody.

A degree of IMMUNITY also applies to officers who, in good faith undertake to detain a person under the Mental Health Code (Cox, 1990).

B. Civil Process

1. This section of the course focuses on the care of a person with mental illness as a civil process. Civil proceedings are defined as: "application or claim made in court with the object of declaring or enforcing a right for the advantage of the person claiming, or recovering money or property, as contrasted with administrative or criminal proceedings which have the object of securing a benefit or the punishment of a public offense respectively." (D.M. Walker, The Oxford Companion to Law, 1980, p. 224).

2. Cases involving persons with mental illness are processed as civil rather than criminal cases. This affects the officer's dealings with them in several ways. The following are the most common scenarios: barricaded situations; credible eyewitnesses; Department Critical-Incident Policy; the Texas Commission on law Enforcement’s training regarding Texas Department of Health Services; and local Mental Health Authority policies. (Hoyt and Harrison 1992)

Discussion: State the main differences between a civil and criminal process.

LEGAL DEFINITION OF MENTAL ILLNESS - Section 571.003. Definitions

A. Mental Illness means an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that:

1. Substantially impairs a person's thought, perception of reality, emotional process or judgment; or

2. Grossly impairs behavior as demonstrated by recent disturbed behavior.
Discussion Points on Legal Definition of Mental Illness:

- Mental illness, in and by itself, is insufficient grounds for detention. This definition emphasizes both behavior and loss of contact with reality as factors to be considered when deciding on detaining a person who is mentally ill. (Hoyt and Harrison 1992)

- Discuss how this definition affects the function of a peace officer.

ROLE OF A MENTAL HEALTH PEACE OFFICER IN RELATION TO TEXAS MENTAL HEALTH CODE Section 571.002

The purpose of The Texas Mental Health Code is to provide to each person having severe mental illness access to humane care and treatment by:

A. Facilitating treatment in an appropriate setting;

B. Enabling the person to obtain necessary evaluation, care, treatment and rehabilitation with the least possible trouble, expense, and embarrassment of the person and the person's family;

C. Eliminating, if requested, the traumatic effect on the person's mental health of public trial and criminal like procedures;

D. Protecting the person's right to a judicial determination of the person's need for involuntary treatment;

E. Defining the criteria the state must meet to order involuntary care and treatment;

F. Establishing the procedures to obtain facts, to carry out examinations, and make prompt and fair decisions;

G. Safeguarding the person's legal rights so as to advance and to not impede the therapeutic and protective purposes of involuntary care; and

H. Safeguarding the rights of the person who voluntarily requests inpatient care.

Discussion Points on Role of Peace Officer in Relation to Mental Health Code

- What elements will you, as a peace officer, be most directly involved in?

- In what manner will you be involved? Give examples.

- What element will you be least involved with? Give examples of why.
WHEN IS IT APPROPRIATE FOR A PEACE OFFICER TO MAKE AN EMERGENCY DETENTION USING THE "WARRANTLESS APPREHENSION" PROVISION?

A. Is it appropriate to use the "warrantless apprehension" provision when there is not enough time to get a warrant and the peace officer needs to respond to a true emergency?

YES, in fact, a warrantless detention is the preferred method of emergency detention because of the very nature of the situation requiring intervention. If an officer comes in contact with a person who truly meets the criteria for emergency detention, there should never be time to secure a warrant. If a person shows a substantial likelihood of causing serious risk and imminent harm to self or others unless immediately restrained, common sense tells us that we would be remiss in leaving the person in such a state in order to obtain a warrant. The officer's belief of substantial likelihood of imminent harm can be based on behavior observed or reliably reported. If, for example, an officer arrives on a scene where a person is preparing to harm or is harming himself/herself or another person, and the individual appears to require psychiatric care, the harm may be demonstrated by emotional distress and deterioration as well as by behavior.

Review: Apprehension by Peace Officer

Section 573.001 Apprehension by Peace Officer Without Warrant

1. A peace officer, without a warrant, may take a person into custody if the officer:

   a. Has reason to believe the person has a mental illness

      (1) the person is mentally ill; and

      (2) because of that mental illness there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained; and

   b. A substantial risk of serious harm to the person or others under subsection (a)(1)(B) may be demonstrated by:

      (3) the person's behavior; or

      (4) evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person can not remain at liberty.

2. The peace officer may form the belief that the person meets the criteria for apprehension.

   a. from a representation of a credible person; or
b. on the basis of the conduct of the apprehended person or the circumstances under which the apprehended person is found.

3. A peace officer who takes a person into custody under subsection (a) shall immediately transport the apprehended person to:

   c. the nearest appropriate inpatient mental health facility; or

   d. a facility deemed suitable by the county's mental health authority, if an appropriate inpatient mental health facility is not available.

4. A jail or similar detention facility may not be deemed suitable except in an extreme emergency.

5. A person detained in a jail or a nonmedical facility shall be kept separate from any person which is charged with or convicted of a crime.

   NOTE: It must be remembered this process is based on the peace officer's judgment in the situation.

Discussion Points on Warrantless Apprehension:

1. A peace officer must believe three things before he/she can apprehend a mentally ill person. What are these criteria?

2. How can a peace officer determine if a person is "mentally ill" or "deteriorating" without the benefit of training as a psychologist?

   The officer only has to have "reason to believe" that the person is mentally ill because of his/her behavior or statements others have made about that person. For example, if there is sufficient cause to arrest the person for his actions, but the officer believes the person may have a mental illness contributing to their actions, it may be more appropriate to divert the person from jail and instead take him/her to an appropriate facility for an examination. The officer should document the facts that led him/her to believe that the person is mentally ill. (Flory and McKenzie 1994)

3. What criteria are used to determine if the person is a serious risk to self or others?

   Examples of dangerous to self:
   
   • An individual has indicated by words or actions an intent to commit suicide or inflict bodily harm on self.
• The individual exhibits such gross neglect for their personal safety that they receive or are at risk of receiving serious injury.

• The individual's statements or actions indicate a specific plan by which to commit suicide or inflict harm on self.

• The individual's plans or means are available or within the individual's ability to carry out.

**Examples of danger to others:**

• An individual has indicated by words or actions an intent to cause bodily harm to another person.

• The individual's threats or intentions are specific as to the particular person to whom harm would be done.

• The individual, though not focused on a particular person, is agitated, angry, and appears explosive.

• The individual is engaging in or intends to engage in acts or behavior of such an irrational, impulsive or reckless nature, such as destruction of property or misuse of a vehicle, as to put others directly in danger of harm.

4. A peace officer may apprehend a mentally ill person on the testimony of a credible witness. What constitutes/does not constitute a credible witness?

A credible witness is one upon whom another can rely upon to speak the truth. A physician or mental health professional is considered as credible a witness as any other citizen.

5. What does "deteriorating" mean when discussing situations involving a person with mental illness?

"Deteriorating“ refers to the condition in which a person, as result of a mental disorder, is becoming unable to provide for basic personal needs of food, clothing, medical care or shelter which results in gross neglect of personal safety. Evidence of inability to provide for food, clothing, shelter or medical care may include the following examples which can be verified by observations:

NOTE: The danger must be specific and imminent. Persons with mental illness cannot be treated involuntarily because of vague, ambiguous and unspecific or potentially dangerous behavior. A person with a mental condition does not necessarily indicate risk because he/she is hearing
voices or is paranoid. Many persons with mental illness function quite well despite such symptoms.

a. Food - person is malnourished and dehydrated; little or no food in the house and the person is unable to establish where or how meals are obtained; person has no realistic plan for obtaining food; person has repeatedly indicated intention to no longer eat or believes food is poisoned; person frequently obtains food from garbage cans or similar sources; person has been losing substantial weight without reasonable explanation; person repeatedly eats items not ordinarily considered fit for human consumption.

b. Medical - a person appears to have impaired judgment regarding their medical condition which puts him/her at great risk.

c. Clothing - the person repeatedly destroys personal clothing; person regularly fails to wear clothing in keeping with prevailing climatic conditions; clothing repeatedly is grossly torn or dirty; person has no realistic plan for obtaining needed clothing.

d. Shelter - the person is observed to frequently sleep in abandoned buildings, doorways or buildings, near public thoroughfares, in prohibited areas or in other than ordinary shelter; person is repeatedly ejected from living quarters by landlords because of behavioral problems, person has no realistic plan for obtaining shelter due to present mental state and does not appear to be able to care for self.

NOTE: All such examples must be shown to be the result of a mental disorder and not merely the result of a lifestyle or attitude choice, including chronic alcoholism.

In the assessment by an officer in the field, it is important to make accurate observations, to document what was said and/or done, to determine if the person makes sense and to evaluate the incident for the degree of seriousness. In reflecting on these observations, it may be helpful to consider factors which may connect the behavior and thinking to emotional problems, such as a known psychiatric history, recent drug use, information from family or bystanders, personal observations, etc.

6. Where should a peace officer take a person suspected of being mentally ill and at risk of harm?

Take the person to the nearest inpatient mental health facility that has services available for detaining and evaluating the person. For example, a hospital emergency room with psychiatric services and secure beds, or a facility deemed suitable by the community mental health center. As the last resort, transport the person to a state mental hospital, if it is nearby.
and an appropriate local inpatient mental health facility is not available. Section 573.001 (Flory and McKenzie 1993)

7. The code says a peace officer can take a person suspected of being mentally ill to a jail or similar detention facility only in an extreme emergency. What is considered an "extreme emergency"?

An example of "extreme emergency" could be if a person is extremely difficult to handle, a state facility is too far away and the person needs immediate attention, but there is not a mental health facility available where he/she can be detained safely. In any case, a person under an Order of Protective Custody may not be detained longer than 72 hours in a nonmedical facility where persons charged with or convicted of a crime are held. When the use of a jail or other non-medical facility is necessary, the person must be held away from any person who is being held on charges. In addition, the county health officer must provide health care services to the person while detained. Section 574.027(c)(d).

8. What are the implications of the language allowing emergency detention by a peace officer under Section 573.001(c)2 based on the mentally ill person's conduct or on the circumstances under which the apprehended person is found?

This language allows the officer to detain a mentally ill person who is at a substantial risk of causing serious imminent harm to self or others based on overt acts (conduct) or who is at a substantial risk of causing serious imminent harm based on the circumstances in which the mentally ill person exists (condition is to deteriorated that person is at serious risk of harm).

9. Is the apprehension of a person thought to be mentally ill without a warrant is allowed in Section 573.001 of the Texas Mental Health Code constitutional?

YES! It is presumed constitutional unless otherwise found by a court of competent jurisdiction. The warrantless detention provision has been in the law since 1983 and has never been declared unconstitutional.

Some peace agencies have expressed concern about this provision because it differs from the procedures in criminal law. There should not be any concern because it is a civil procedure that was created to protect an individual from self-inflicted harm or to protect society from harm from another that is a result of the person's mental illness and not from any criminal intent. The legislature fully understood this when it enacted the Texas Mental Health Code.

The constitutionality of the warrantless apprehension has not been challenged in court and there is not an Attorney General's opinion on it. Many jurisdictions are using the provision successfully, but some areas of
the state are not fully utilizing this code provision. Some metropolitan areas claim the warrantless detention provision is unnecessary because of having magistrates available 24 hours to issue warrants. Investigation shows that more often than not the officers are detaining the person without a warrant and then obtaining a warrant, or a warrant is obtained after these people are arrested for criminal charges, and the charges are subsequently dismissed. In light of there being a warrantless detention provision, some believe this is a waste of paperwork, jail space, and valuable human resources.

10. Because of the increasing amount of interrelated medical problems being encountered with mental deterioration, the following assessment information may be a helpful guide in determining if the situation is a medical emergency rather than psychiatric emergency; if the situation is questionable, it is always best to consult with a physician.
**SPECIFIC MEDICAL QUESTIONS**

**FOR PEACE OFFICERS TO ASK (Hoyt and Harrison 1992)**

Any "yes" answers require medical emergency intervention.

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*(If in doubt consult a physician)*
Before the law was changed in 1983, peace officers sometimes picked up persons suspected of being mentally ill and took him/her to an emergency room.

(Wasn't this a warrantless detention in the first place?)

WHILE THE PERSON WAS IN THE HOSPITAL THE OFFICER RAN DOWN TO THE COURTHOUSE TO GET A WARRANT. Many officers ask, "Is this necessary any more"?

No! If requirements for a warrantless apprehension have been met, this is not necessary. Officers must file an application for detention after transporting the individual to the nearest appropriate inpatient facility. The completed form must be given to the hospital and signed by the physician after the person has been examined. Section 573.002

Review: Section 573.002 Peace Officer’s Application for Detention

A. A peace officer shall immediately file an application for detention after transporting a person to a family under section 573.001.

B. The application for detention must contain:

1. A statement that the officer has reason to believe and does believe that the person evidences mental illness;

2. A statement that the officer has reason to believe and does believe that the person evidences a substantial risk of serious harm to himself or others;

3. A specific description of the risk of harm;

4. A statement that the officer has reason to believe and does believe that the risk of harm is imminent unless the person is immediately restrained;

5. A statement that the officer's beliefs are derived from specific recent behavior, overt acts, attempts or threats that were observed by or reliably reported to the officer;

6. A detailed description of the specific behavior, acts, attempts, or threats; and

7. The name and relationship of any person to the apprehended person who reported or observed the behavior acts, attempts, or threats.

Discussion Points about "Applications for Detention":

1. Section 571.006.2 authorizes the Texas Department of Mental Health/Mental Retardation (TDMHMR) to develop the form and content of all Mental Health Code documents.
2. A sample of the "Application for Detention" is included in your packet. At this time there is not a standardized document for the entire state of Texas. (Hoyt and Harrison 1992)

3. What questions do officers have regarding the various elements in an application for detention?

WHAT IS A MENTAL HEALTH WARRANT?
A Mental Health Warrant serves as a Magistrate Order for Emergency Apprehension and Detention. It is a civil court order issued by a judge. The warrant provides for the emergency apprehension and transportation of an individual to receive psychiatric evaluation for possible detention in an appropriate mental health facility. The warrant does not guarantee admission, but rather guarantees evaluation for the need of treatment in the least restrictive environment. With the issue of a warrant a person may be detained to 24 hours for an evaluation.

Review: Texas Health & Safety Code, Section 573.012

A. An applicant for emergency detention must present the application personally to a magistrate. The magistrate shall examine the application and may interview the applicant.

B. The magistrate shall deny the application unless the magistrate finds that there is reasonable cause to believe that:

1. The person evidences mental illness;
2. The person evidences a substantial risk of serious harm to himself or others;
3. The risk of harm is imminent unless the person is immediately restrained; and
4. The necessary restraint cannot be accomplished without emergency detention.

C. A substantial risk of serious harm to the person or others under Subsection (b)(2) may be demonstrated by:

1. The person's behavior; or
2. Evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty.

D. If the magistrate finds that each criterion under Subsection (b) is satisfied, the magistrate shall issue to an on-duty peace officer a warrant for the person's immediate apprehension.

E. A person apprehended under this section shall be transported for a preliminary examination in accordance with Section 573.021 to:

1. The nearest appropriate inpatient mental health facility; or
2. If an appropriate inpatient mental health facility is not available, a facility found suitable by the county's mental health authority.

F. The warrant serves as an application for detention in the facility. The warrant and a copy of the application for the warrant shall be immediately transmitted to the facility.

Discussion Points on Mental Health Warrants:

1. Section (d) has been recently added. It prohibits civilians from being deputized (or otherwise designated) to execute these emergency warrants. This is for the protection of both civilian and the person with mental illness.

2. What are the common criteria that are seen in (1) Apprehension by Peace Officer Without Warrant? (2) Peace Officer's Application for Detention? and (3) Issuance of Warrant?

3. On weekends it is often difficult for officers to get a warrant. Officers often ask who can issue warrants?

The Texas Mental Health Code authorizes any "magistrate" to issue a warrant. The definition of "magistrate" in the Code of Criminal Procedure include "the justices of the Supreme Court, the judges of the Court of Criminal Appeals, the justices of the Court of Appeals, the judges of the District Court, the judges of the Statutory Probate Courts, the county judges, the judges of the county courts at law, judges of the county criminal courts, the justices of the peace, the mayors and recorders and the judges of the municipal courts of incorporated cities and towns."

4. Does a peace officer have access to records in mentally ill dockets of county clerks?

Law enforcement personnel have access to court records to obtain necessary information in the execution of a writ or warrant. Section 571.015

WHAT IS AN ORDER OF PROTECTIVE CUSTODY (OPC)

A. OPC - An order issued by a Probate Court after an Application for Court Ordered Mental Health Services has been filed. Before an OPC can be issued, there must be at least one Physician's Certificate on file with the Court showing sufficient facts for the Court to believe that the proposed patient is mentally ill and as a result of the mental illness is substantially likely to cause serious harm to self or others. If there is an independent finding by a master or a magistrate of a substantial likelihood of the proposed patient causing serious harm to self or to others made at a probable cause hearing held within 72 hours of detention under the OPC, a patient may be held for up to 14 days.
B. **Review** Protective Custody

1. **Motion for Order of Protective Custody: Section 574.021**

   a. A motion for an order of protective custody may be filed only in the court in which an application for court-ordered mental health services is pending.

   b. The motion may be filed by the county or district attorney or on the court's own motion.

   c. The motion must state that:

      (i) the judge or county or district attorney has reason to believe and does believe that the proposed patient meets the criteria authorizing the court to order protective custody; and

      (ii) the belief is derived from:

         (A) the representations of a credible person;
         (B) the proposed patient's conduct; or
         (C) the circumstances under which the proposed patient is found.

   d. The motion must be accompanied by a certified of medical examination for mental illness prepared by a physician who has examined the proposed patient not earlier than the fifth day before the day the motion is filed.

   e. The judge of the court in which the application is pending may designate a magistrate to issue protective custody orders in the judge's absence.

2. **Issuance of Order: Section 574.022**

   a. The judge or designated magistrate may issue a protective custody order if the judge or magistrate determines:

      (i) that physician has stated his opinion and the detailed reasons for his opinion that the proposed patient is mentally ill; and

      (ii) the proposed patient presents a substantial risk of serious harm to himself or others if not immediately restrained pending the hearing.

   b. The determination that the proposed patient presents a substantial risk of serious harm may be demonstrated by the proposed patient's behavior or by evidence of severe emotional distress and
deterioration in the proposed patient's mental condition to the extent that the proposed patient cannot remain at liberty.

c. The judge or magistrate may make a determination that the proposed patient meets the criteria prescribed by Subsection (a) from the application and certificate alone if the judge or magistrate determines that the conclusions of the applicant and certifying physician are adequately supported by the information provided.

d. The judge or magistrate may take additional evidence if a fair determination of the matter cannot be made from consideration of the application and certificate only.

e. The judge or magistrate may issue a protective custody order for a proposed patient who is charged with a criminal offense if the proposed patient meets the requirements of this section and the facility administrator designated to detain the proposed patient agrees to the detention.

3. Apprehension Under Order: Section 572.023

a. A protective custody order shall direct a peace officer or other designated person to take the proposed patient into protective custody and transport the person immediately to:

(1) a facility of the single portal authority for the area;
(2) an appropriate inpatient mental health facility, if no single portal authority serves the area; or
(3) a facility deemed suitable by the county’s mental health authority, if no single portal authority serves the area and an appropriate inpatient mental health facility is not available.

b. The proposed patient shall be detained in the facility until a hearing is held.

c. If a single portal authority lacks the local resources to care for a proposed patient, the authority shall transfer the proposed patient to a state hospital or, on the request of the authority, the judge may order the proposed patient be detained in a state hospital.

d. A facility must comply with this section only to the extent that the Commissioner determines that the facility has sufficient resources to perform the necessary services.

e. A person may not be detained in a private mental health facility without the consent of the facility administrator.
WHAT IS THE DIFFERENCE BETWEEN A PROBABLE CAUSE HEARING AND A COMMITMENT HEARING?

**Discussion:**

Probable Cause Hearing: This is the judicial hearing to determine whether the proposed patient presents a substantial likelihood of causing serious harm to self or others pending the final hearing on court-ordered services. This hearing is held within 72 hours of detention under an OPC. The patient, the patient's attorney, and the state's attorney will present evidence on the issue to a Special Master or a Magistrate.

Commitment Hearing or Mental Health Court: This hearing is held by the probate court within 14 days of the filing of the application for Court Order Mental Health Services. Prior to this hearing, two Physician Certificates are required to be on file; one of which must be by a psychiatrist. The hearings usually occur weekly and are generally held at the hospital at which the patient is detained.

WHO DETERMINES IF A PERSON IS ADMITTED TO A FACILITY FOR EMERGENCY DETENTION?

**Review:** Emergency Admission and Detention: Section 573.022

A person may be admitted to a facility for emergency detention only if the physician who conducted the preliminary examination of the person makes a written statement that:

A. The person is acceptable to the facility.

B. States that after a preliminary examination it is the physician's opinion that:

1. The person is mentally ill,
2. The person evidences a substantial risk of serious harm to himself or others;
3. The described risk of harm is imminent unless the person is immediately restrained; and
4. Emergency detention is the least restrictive means by which the necessary restraint may be accomplished; and

C. Includes:

1. A description of the nature of the person's mental illness;
2. A specific description of the risk of harm the person evidences that may be demonstrated either by the person's behavior or by evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty; and
3. The specific detailed information from which the physician formed the opinion in Subdivision (2).

**Discussion Points on Emergency Admission and Detention:**

**A. Problems Encountered by Peace Officers in Attempting Emergency Admissions**

The behavior of the subject may have changed from the officer's initial contact at the time of admission examination.

1. Result may be behavior failing to meet the admission standard.

2. Complete and accurate documentation of initial contact by officer can minimize this problem.

The person's behavior may not be seen as meeting the admissions standards by the facility physician(s), who has the responsibility to approve all emergency admissions. There can be and often is disagreement on the need for hospitalization between peace officer and the approving hospital physician (Cox 1990).

Mental Health Service Providers are bound by the Texas Mental Health Code, which establishes the admission criteria, and a Diagnosis System (DSM-IV) which identifies what constitutes mental illness. The physician exercise professional judgment in interpreting the Mental Health Code and the Diagnostic System.

Their judgment may not always concur with the peace officer's judgment. In addition, passage of time from the first contact with the subject to the physician's evaluation may result in a change in the behavioral symptoms of the subject.

**B. Sometimes an emergency room will turn down a person who is mentally ill because "risk of harm" is not determined. What can be done to get this person help?**

The first option is a referral to the local Mental Health Authority. The second option is to go to the court and ask the county or district attorney to file an application for court-ordered mental services. The person will not be detained prior to the court hearing unless he is legally detained under an appropriate provision of the Mental Health Code, but he can be ordered to submit to an examination. Sections 574.001 and 574.023.

**C. Extent of peace officer responsibility:**

1. In general, once the peace officer has transported the subject and presented him/her to the admitting facility, legal responsibility for the subject transfers to that facility.
2. If no criminal charges are involved, peace are not responsible for the security of the subject and do not have to wait in the hospital. Since, however, the county is responsible for the cost of returning a person who is released after an examination to the location where he was apprehended, it may require less time to wait than to return to the hospital to transport an individual to the original location. Section 573.024.

Officers should be familiar with the various procedures of local hospitals or facilities. (Point out that in practice, peace officers often remain until facility security personnel relieve them of responsibility for the subject).

**PEACE OFFICER involvement AFTER COURT ORDER COMMITMENT**

*Transportation of Patient: Section 574.045*

A. The court may authorize the transportation of a committed patient to the designated mental health facility by:

1(a) A relative or other responsible person who has a proper interest in the patient's welfare and who receives no remuneration, except for actual and necessary expenses.

2. The facility administrator of the designated mental health facility, if the administrator notifies the court that facility personnel are available to transport the patient; or

3 A special offer for mental health assignment certified under Section 415.037, Government Code; or

4. The sheriff or constable, if no person is available under Subdivision (1) (2) or (3).

   a. the patient's friends and relatives may accompany the patient at their own expense.

   b. a female patient must be accompanied by a female attendant unless the patient is accompanied by her father, husband, or adult brother or son.

   c. the patient may not be transported in a marked peace or sheriff’s car or accompanied by an uniformed officer unless other means are not available.

   d. the patient may not be physically restrained unless necessary to protect the health and safety of the patient or of a person traveling with the patient. If the treating physician or the person transporting a patient determines that physical restraint of the patient is necessary, that person shall document the reasons for that
determination and the duration for which the restraints are needed. The person transporting the patient shall deliver the document to the facility at the time the patient is delivered. The facility shall include the document in the patient's clinical record.

e. The personnel transporting the patient shall give the patient reasonable opportunities to get food and water and to use a bathroom.

COMMON QUESTIONS ASKED BY PEACE OFFICERS

A. Quite often peace officers responding to calls find the identified subject appearing to be mentally ill, but not at serious harm to himself or others. Because of the lack of "risk of harm" the subject is not apprehended and not examined by a psychiatrist. How can we encourage the family to see that the person gets psychiatric evaluation?

The Mental Health Peace Officers should provide telephone numbers and the necessary information to refer the individual for outpatient services through the local Mental Health center. Families should be encouraged to assist the person voluntarily seek care.

Mental Health officers can inform the family that they may bypass the emergency detention and go directly to the county or district attorney and request that an application be filed. If the person has been examined by a physician, the family may file the application for court-ordered mental health services, as long as it is accompanied by the physician's certificate of examination for use in court hearing.

Sections 574.002, 574.009, and 574.021.

B. What does the law state regarding apprehension of persons with mental illness being taken to a hospital in a marked car and the officer wearing a uniform?

According to the Mental Health Code, a patient shall not be transported in a marked peace or sheriff’s car or accompanied by peace officers in uniform if other means are not available. This provision appears to apply primarily to the patient being taken to a facility after the commitment hearings and not to emergency situations. Section 574.045(d).

C. Do Peace Officers have to treat juveniles differently under the Mental Health Code in situations involving emergency apprehension and detention?

No. The officer's belief that mental illness is causing dangerous behavior or circumstance is sufficient for detention: the mental health code does not establish age as a criteria for or against emergency apprehension and detention.

Involuntary commitment procedures are the same for minors as for adults. Parents may request voluntary admission for their children under 16 years of age with the...
administrator of the facility, but the child must meet the criteria for voluntary admission. Section 572.001

"Delinquent behavior" is not considered a criminal charge. Juvenile court or mental health court can proceed with an application for court-ordered mental health services even if allegations of delinquent behavior are not dropped. Section 571.011(a)

D. Our office had a call where a sister created a case against her slightly retarded brother. She said he was mentally ill and violent. Peace officers thoroughly checked him out and determined that he did not fit her description. Does the Mental Health Code provide penalties for the woman who tried to get her brother an unwarranted commitment?

Yes. Any person who willfully causes, conspires with or assists another to cause the unwarranted commitment of an individual to a mental health facility, is guilty of a misdemeanor. This offense is punishable on a first offense by a fine of not more $25,000, imprisonment in the county jail not to exceed one (2) years, or both. Section 571.020

E. Where can a peace officer or other mental health professional have their questions answered about the Mental Health Code?

Call the legal division of the Texas Department of Mental Health Mental Retardation at (512) 206-4591 during working hours.
1. **Texas Mental Health Code:** This is the commonly known name of the body of law setting forth the legal requirements for the voluntary and involuntary commitments of the mentally ill. The Code is found in Chapter 571 of the Texas Health & Safety Code.

2. **Mental Capacity:** Under Texas law, a person is presumed to have mental capacity unless judicial finding to the contrary is made under the Texas Probate Code. However, there can be a capacity determination under the Psychoactive Medication Hearing provisions of the Texas Mental Health Code for the limited purpose of court-ordered psychoactive medication administration. Court-ordered mental health commitment of a person is NOT a determination or adjudication of mental incapacity and does not limit the person's rights as a citizen, or the person's property rights or legal capacity.

3. **Mental Illness:** Mental illness means a disease, or a condition which either (a) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (b) grossly impairs behavior as manifested by recent disturbed behavior.

4. **Conditions not considered "Mental Illness":** "Mental Illness" as defined in the Texas Mental Health CODE does not include epilepsy, senility, alcoholism, or mental deficiency. However, no person who is mentally ill shall be barred admission or commitment to a mental health facility because he or she is also suffering from these conditions.

5. **County or Probate Court:** The term "county court" as used in the Texas Mental Health Code means the "probate court or court having probate jurisdiction".

6. **Representation of State:** Generally, the county attorney represents the state in hearings on court-ordered mental health services, but in those counties without a county attorney, the district attorney represents the state's interest.

7. **Mental Health Authority:** This is the agency designated by the Commissioner of the Texas Department of Mental Health and Mental Retardation to direct, operate, facilitate and/or coordinate services for mentally ill persons in the state.

8. **General Hospital:** A hospital operating primarily for the diagnosis, care, and treatment of the physically ill.

9. **Mental Hospital:** A hospital operated for the primary purpose of providing inpatient care and treatment of the mentally ill.

10. **Private Mental Hospital:** A mental hospital operated by any person or private corporation.

11. **State Mental Hospital:** A mental hospital operated by the Texas Department of Mental Health and Mental Retardation.

12. **Warrantless Apprehension:** A peace officer, without a warrant, may take a person into custody if the officer has reason to believe (I) the person is mentally ill and (2) because
of that mental illness there is substantial risk of serious harm to the person or to others unless the person is immediately restrained and (3) believes that there is not sufficient time to obtain a warrant before taking the person into custody.

13. **Emergency Commitment with Warrant**: A peace officer, with a warrant, may take a person into custody if the officer has a reason to believe the person is mentally ill; and because of that mental illness there is substantial risk of serious harm to the person or to others unless the person is immediately restrained. While any adult person can make the application for the emergency commitment, the Magistrate must find there is a substantial likelihood of the alleged mentally ill person causing serious harm to self or others which is imminent before issuing a warrant for detention.

14. **Period of Detention**: Any person detained on an emergency commitment cannot be held for longer than 24 hours unless a written court order for further detention is obtained. However, the 24 hour period is extended on weekends or holidays.

15. **Order of Protective Custody**: OPC - An order issued by a probate court after an Application for Court Ordered Mental Health Services has been filed. Before an OPC can be issued, there must be at least one Physician's Certificate on file with the Court showing sufficient facts for the Court to believe that the proposed patient is mentally ill and as a result of the mental illness is substantially likely to cause serious harm to self or others. A patient may be held for up to 14 days on an OPC only if there is an independent finding by a master of magistrate of a substantial likelihood of the proposed patient causing serious harm to self or others made at a probable cause hearing within 72 hours of detention under the OPC.

16. **Attorney Ad Litem**: There is an attorney appointed by the court whose function is to represent the best interest of the proposed patient. Every patient has the right to an attorney, who works to ensure that all of the patient's rights are protected regardless of mental status. The appointed attorney, regardless of his or her own personal opinion, is to represent a patient in the civil commitment proceeding and is required to use all reasonable efforts within the bounds of the law to advocate for the patient's right to avoid court ordered mental health services if the proposed patient expresses a desire to avoid the services.

17. **Probable Cause Hearing**: This is the judicial hearing, held within 72 hours of detention under an OPC, to determine whether the proposed patient presents a substantial likelihood of causing serious harm to self or others pending the final hearing on court-ordered services. The patient, the patient's attorney, and the state's attorney will present evidence on the issue to a Special Master or Magistrate.

18. **Mental Health Commitment Hearing**: This hearing is held by the probate court within 14 days of the filing of the Application for Court Ordered Mental Health Services. Prior to this hearing, two Physician Certificates are required to be on file; one of which must be by a psychiatrist. The hearings usually occur weekly and are generally held at the hospital at which the patient is detained.

19. **Least Restrictive Appropriate Setting for Treatment**: Least restrictive appropriate setting for the treatment means that the available treatment setting which provides the patient
with the highest likelihood of improvement or cure and which is no more restrictive of the patient's physical or social liberties than is necessary for the most effective treatment of the patient and for adequate protection against any dangers which the patient poses to himself or others.

20. **Temporary Commitment**: The court can order a Temporary Commitment for a period not to exceed 90 days if it determines that the person is mentally ill, and as a result of the mental illness, is likely to cause harm to self; or is likely to cause serious harm to others; or will continue to suffer severe mental, emotional or physical distress and will continue to experience deterioration of his/her ability to function independently if not treated and is unable to make a rational or informed decision to submit to treatment.

21. **Extended Commitment**: The court can order a Extended Commitment for a period not to exceed 12 months if the person has been hospitalized under court order for at least 60 consecutive days during the past 12 months and the person's condition is expected to continue for more than 90 days.

The order for an Extended Commitment may commit the person to a hospital or to community mental health services, such as a mental health center or to a private psychiatrist or psychologist.
### SPECIFIC MEDICAL QUESTIONS
FOR PEACE OFFICERS TO ASK (Hoyt and Harrison 1992)
Any "yes" answers require medical emergency intervention.

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*(If in doubt consult a physician)*
EXAMPLE

THE COMMITMENT PROCESS OF GALVESTON COUNTY

Scenario

- A phone call is received by the Galveston County Medical Health Deputies reporting someone exhibiting bizarre behavior or threatening suicide.

- The Mental Health Deputies then go to the scene and evaluate the individual. They make a decision at the scene as to whether this person needs to be transported to the UTMB Crisis Clinic for further evaluation by a psychiatric physician.

- The psychiatric physician then makes a decision as to whether this person should be hospitalized for further evaluation or released. If the person is to be released a Mental Health Deputy is then responsible for returning that individual to their residence.

- If said person refuses in-patient services which are recommended by that physician (involuntary), he/she is put under as EAD (Emergency Admission Detention) for 24 hours.

- Two licensed psychiatric physicians submit sworn notarized statements to probate court. These statements reflect that it is their opinion that the named person is in need of services and carries a psychiatric diagnosis.

- These two statements are the beginning of the commitment procedure. Application for commitment and order of protective custody (with physician's statements attached) are then filed with the county clerk's office for the appropriate hearings in probate court.

- At this time the Attorney Ad Litem is appointed and hearing dates are set.

- The first hearing is a Probable Cause hearing and must be held within 72 hours of the filing date. It is held at the unit of location of the said person at that time. Its purpose is to provide the court with probable cause to detain said person for final hearing. Persons in attendance at this hearing are: appointed master of the court, attorney, client, at least one of the attending physicians and the judicial liaison.

- If probable cause is found at this hearing, the final hearing will be held within the ten-day legal limit.

- The final hearing is held in an appropriate conference room of the facility (where the client is located). Persons in attendance at this final hearing are: Judge Jerome Jones, client attorney, client, at least one of the attending physicians, Assistant District Attorney (representing the State of Texas),
Mental Health Liaison (representing The Gulf Coast (Center), court reporter and the judicial liaison.

- These hearings are confidential. However, the client's family can attend but are not required to testify. The client has a right to refuse attendance by and other people than the above-named required attendees.

- At this final hearing one of three decisions is to be made:
  
  ⇒ **Continuance** of hearing ... this gives the physicians opportunity for further evaluation (for a period up to, but not to exceed, 30 days).
  
  ⇒ **Commitment** decision ... the person is then committed for a period not to exceed 90 days. The committed individual is either taken to Austin State Hospital or the local contracted UTMB beds. Please note that persons not from Galveston and Brazoria counties will go to Austin State Hospital because UTMB beds are reserved for emergencies and citizens of Galveston and Brazoria counties.
  
  ⇒ **Dismissal** of proceedings ... this occurs when said person does not meet criteria for commitment.
  
  ⇒ **Criteria for commitment:**

  - Is a danger to self;
  
  - Is a threat to others;
  
  - Is in such a deteriorating state that person is unable to make a rational decision to receive treatment for their mental illness.

This information is provided by The Gulf Coast Center in conjunction with the Galveston County Mental Health Deputy Program
CHAPTER 7: RIGHTS AND LIABILITY

RECOMMENDED LENGTH OF PRESENTATION: 60 Minutes

METHOD OF PRESENTATION

1. Lecture/Discussion

INSTRUCTOR PREPARATION

1. Review Chapter

INSTRUCTIONAL OBJECTIVES

1. Determine the basic rights of persons with mental illness
2. Determine when client records and information may be disclosed
3. Determine under what circumstances a peace officer can be held liable
4. Point out similarities and differences of custody, detention, and arrest

INSTRUCTOR REFERENCES:

RIGHT TO LIBERTY

All persons have a right to freedom unless statutory authority deprives them of that freedom. The Mental Health Code is the statutory authority in cases where persons are mentally ill and meet the Mental Health Code involuntary and/or emergency standards. (If the person is merely behaving in a bizarre or irrational manner, emotionally upset or otherwise acting in an abnormal manner, this does not, in itself, establish that such person is in need of care and treatment or pose a danger of harm to himself or others)

While most admissions are made WITH THE PATIENT'S CONSENT (voluntarily) many psychiatric admissions involving law enforcement are made WITHOUT THE PATIENT'S CONSENT -- (Involuntary) because the person will not seek treatment and poses a danger to self or others. Admission criteria which must be met to hospitalize a person without their consent:

Discussion and Review on Right to Liberty:

A. There are two ways for a person to be admitted for a psychiatric hospitalization:

1. With their consent (voluntary):
   a. Patient must sign in or, if under 16, have a family member's signature. (However, many hospitals will not accept a persons voluntary consent until they are over 18).
   b. Patient must be aware that the facility is a psychiatric hospital where he/she will receive treatment.

2. Without their consent (involuntary):

Person has a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which would otherwise be likely to result in serious harm to himself or others.

"Likeliness of serious harm" means:

a. There is a substantial risk of physical harm to the person himself, as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or;

b. A substantial risk of physical harm to other persons, as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.
3. Any type of hospitalization (voluntary and involuntary) requires a psychiatric evaluation to determine whether a person meets the standards for hospitalization:

   a. Evaluations must always be provided by a physician employed by the specific hospital where the inpatient treatment will occur.

   b. Evaluation must occur prior to the patient's admission.

RIGHTS OF PERSONS WITH MENTAL ILLNESS

A. Rights Under Law, Texas Health & Safety Code: Section 576.001

   1. A person with mental illness in this state has the rights, benefits, responsibilities, and privileges guaranteed by the constitution and laws of the United States and this state.

      Unless a specific law limits a right under a special procedure, a patient has:

      a. The right to register and vote at an election;

      b. The right to acquire, use, and dispose of property, including contractual rights;

      c. The right to sue and be sued;

      d. All rights relating to the grant, use, and revocation of a license, permit, privilege, or benefit under law;

      e. The right to religious freedom; and

      f. All rights relating to domestic relations.

   2. Under Texas Health & Safety Code Section 573.025, a person has the following rights when detained on an emergency basis with or without an emergency warrant:

      a. to be advised of the location of detention, the reason for the detention, and the fact that the detention could result in a longer period of involuntary commitment;
b. to a reasonable opportunity to communicate with and retain an attorney;

c. to be transported to a location as provided by Section 573.024 if the person is not admitted for emergency detention unless the person is arrested or objects;

d. to be released from a facility as provided by Section 573.023; and

e. to be advised that communications with a mental health professional may be used in proceedings for further detention.

3. In addition, a person apprehended or detained under the Mental Health Code shall be informed of the rights provided under the Code:

a. orally in simple, nontechnical terms within 24 hours after the time a person has been admitted to the facility, and in writing in the person's primary language, if possible; or

b. through the use of a means reasonably calculated to communicate with a hearing or visually impaired person, if applicable.

ADDITIONAL RIGHTS OF PERSONS WITH MENTALLY ILLNESS

Additional Rights under the Mental Health Code are contained in the following sections:

Section 572.003 Rights of Patients
Section 572.004 Right to Release (24 hour Rule)
Section 572.023(b) Right to be Released by a Non-Physician
Section 574.003 Right to an Attorney (Applic. for C-O Tx)
Section 574.004 Duties of an Attorney (including the discussion rights)
Section 574.024 Right to an Attorney (Order of P.C.)
Section 574.007 [Right of] Disclosure of Information
Section 574.009 Right to be Present and to Privacy in Court
Section 574.032 Right to Jury if requested, for temporary commitment; mandatory for extended commitment hearing, unless waived.

Discussion Point: What do these rights tell you about our society's attitudes toward the mentally ill?

CONSEQUENCES RESULTING FROM THE FAILURE TO FOLLOW THE MENTAL HEALTH CODE

Specific procedures for apprehension, detention, and involuntary hospitalization are set forth in the Mental Health Code and MUST be followed EXACTLY or a peace officer risks BEING HELD LIABLE for false arrest and violation of various constitutional rights.

Section 571.019 (a)(b) Limitation of Liability.
A. A person who participates in the examination, certification, apprehension, custody, transportation, detention treatment or discharge of any person or in the performance of any other act required or authorized by this subtitle and who acts in **good faith**, reasonably, and without negligence is not criminally or civilly liable for that action.

B. A physician performing a medical examination and providing information to the court in a court proceeding held under this subtitle or providing information to a peace officer to demonstrate the necessity to apprehend a person under Chapter 573 (Emergency Detention) is considered an officer to the court and is not liable for the examination or testimony when acting without malice.

Discussion Points:

- Define Liability
- Define "in good faith."
- Give an example of an act that is **not** in good faith.
- Stress that police officers are "other persons" within context of this law.

(Prepare analogy to probable cause; e.g., "There must be **REASONABLE BELIEF** that the person meets the admission standard, just as there must be **PROBABLE CAUSE**").

CONFIDENTIALITY AND PEACE OFFICER’S DECISION REGARDING CIVIL OR CRIMINAL PROCEEDINGS.

Records of a mental health facility that directly or indirectly identify a present, former, or proposed patient are confidential unless disclosure is permitted by other state law.

"Privileged communication protects a client from having his confidential and private discussions revealed to the public during legal proceedings without his permission. It is important to remember that the privilege belongs to the client and he alone has the right to exercise it. The privilege does not belong to the professional and neither is it meant for his protection nor for the enhancement of his/her professional status. Once the client has waived his privilege or has compromised it through his/her actions, the professional has no grounds for withholding disclosure of the relevant information. There has been much dispute concerning the factors that should exist before a particular relationship is judged to merit protection by the privilege. Four criteria have generally been accepted as essential:

- The communications must originate in a conference that they will not be disclosed.
- This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
- The relation must be one which in the opinion of the community ought to be sedulously fostered.
The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation." (D. M. Walker, The Oxfords Companion to Law, 1980, p. 209)

Technically this means that an examining facility has no permission, unless the patient gives written consent, to contact the police to let them know the results of the examination. Indeed the Code of Federal Regulations, title 42, part 2 (Federal Register, Vol. 52, No. 110 - Tuesday, June 9, 1987) prescribes either a two year Federal imprisonment or $5,000 fine, or both, for any mental health worker giving out information without written consent from the patient. (Hoyt and Harrison 1992)

Discussion/Review

1. Unlike law enforcement activity, provision of these services is not a matter of public record.

2. There are two means of obtaining information about a person with a mental illness including:
   a. Specific written consent of the person.
   b. Court order.

3. **Confidentiality of Records: Section 576.005**
   a. Records of a mental health facility that directly or indirectly identify a present, former, or proposed patient are confidential unless disclosure is permitted by other state law.
   b. If a treating physician may disclose necessary information that may identify the patient, but only to:
      (1) a law enforcement officer; or
      (2) the patient's legally authorized representative
   c. A disclosure under Subsection (b) may not be made if the patient gives contrary written instructions to the treating physician.
      (1) a parent or legal guardian if the patient is a minor, or a legal guardian if the patient has been adjudicated incompetent to manage the patient's personal affairs;
      (2) an agent of the patient authorized under a durable power of attorney for health care;
      (3) an attorney ad litem appointed for the patient; or
      (4) a parent, spouse, adult child, or personal representative if the patient is deceased.
Discussion Points Regarding Possible Criminal Activity:

1. **What if a person is a suspect in an criminal offense?**

   If the apprehending officer thinks that criminal charges are appropriate following an examination in which the doctor finds no mental illness, the officer may either stay on hand during the examination or leave his/her telephone number so that the officer may be called to come and arrest the proposed patient.

   This is based on the arrest provisions of the Texas Mental Health Code dealing with transportation of the client, if cleared of any mental illness. (Texas Health & Safety Code, Section 573.024(b).

2. **Can a person who has criminal charges filed against him/her be picked up in an emergency and taken for psychiatric examination?**

   Yes. However, charges would have to be dropped prior to a full mental health commitment hearing. If charges are not dropped, commitment may be sought during the criminal trial under the Code of Criminal Procedure. Section 574.022(e) and Section 574.034(f).

3. **Examination and Transfer of Suspected Mentally Ill or Retarded Defendant. Art. 16.22.**

   If a sheriff provides to a magistrate evidence or a statement that establishes reasonable cause to believe that a defendant committed to the sheriff’s custody is a person with mental illness or mental retardation, the magistrate shall order an examination of the defendant under Section 3(b), Article 46.02, of this code and, if necessary, the transfer of the defendant to the nearest appropriate mental health or mental retardation facility in the manner provided by Section 3(b), Article 46.02 of this code.

   After the court receives the examining expert's report relating to the defendant under Section 3(d), Article 46.02, of this code, the court may resume the criminal proceedings against the defendant or further competency proceedings, if required, as provided by Article 46.02 of this code.

4. **Release on Personal Bond of Certain Mentally Ill Defendants: Article 17.032 - Text of article effective September 1, 1994**

   A. In this article, "violent offense" means an offense under the following sections of the Penal Code:

   1. Section 19.02 (murder);
   2. Section 19.03 (capital murder);
   3. Section 20.03 (kidnapping);
   4. Section 20.04 (aggravated kidnapping);
5. Section 21.11 (indecency with a child);
6. Section 22.01(a)(1) (assault);
7. Section 22.11 (sexual assault);
8. Section 22.02 (aggravated assault);
9. Section 22.021 (aggravated sexual assault);
10. Section 22.04 (injury to a child, elderly individual, or invalid); or
11. Section 29.03 (aggravated robbery).

B. A magistrate shall release a defendant on personal bond if the:

1. Defendant is not charged with and has not been previously convicted of a violent offense;
2. Defendant is examined by a mental health expert under Section 3(b), Article 46.02 of this code;
3. Examining expert, in a report submitted to the magistrate under Section 3(d), Article 46.02, of this code.
   a. Concludes that the defendant is mentally ill and is nonetheless competent to stand trial; and
   b. Recommends mental health treatment for the defendant; and
4. Magistrates determines, in consultation with a local mental health services provider, that appropriate mental health services for the defendant are available through the Texas Department of Mental Health and Mental Retardation under Section 534.053. Health and Safety Code, or through another mental health services provider.
   a. The magistrate may require as a condition of release on personal bond under this article that the defendant submit to outpatient or inpatient mental health treatment if the defendant’s:
      (1) mental illness is chronic in nature; or
      (2) ability to function independently will continue to deteriorate if the defendant is not treated.
   b. In addition to a condition of release imposed under Subsection (c) of this article, the magistrate may require the defendant to comply with other conditions that are reasonably necessary to protect the community.
c. In this article, a person is considered to have been convicted of an offense if:

1. a sentence is imposed;
2. the person is placed on community supervision or receives deferred adjudication; or
3. the court defers final disposition of the case. Added by Acts 1993, 73rd Leg., ch. 900, Section 3.06, effective September 1, 1994.

**USE OF FORCE**

A. The peace officer exercising any use of force when taking a person into custody pursuant to the Mental Health Code must keep in perspective the goal of obtaining care and treatment for the mentally ill person.

B. The officer may use force comparable to what would be justified in performing any other legal duty against any other person, such as one who is resisting arrest. The use of force must be "reasonable," and what is reasonable is determined by the goal of obtaining care and treatment. (See Section 9.51 of the Penal Code effective September 1, 1994.)

C. The criteria for the use of deadly physical force remains as defined in Article 9.51(1c) of the Penal Code: "to defend the police officer or peace officer or another person from what the officer reasonably believes to be the use of or imminent use of deadly force."

**CUSTODY VS. ARREST/DETENTION (TRANSFER OF CUSTODY)**

Section 574.027

A. A person under a protective custody order shall be detained in:

1. A facility of the single portal authority for the area;
2. An appropriate inpatient mental health facility, if no single portal authority serves the area; or
3. A facility deemed suitable by the county's mental health authority, if no single portal authority serves the area and an appropriate inpatient mental health facility is not available.

B. The facility administrator or the administrator's designee shall detain a person under a protective custody order in the facility until a final order for court ordered mental health services is entered or the person is released or discharged under Section 574.028.
C. A person under a protective custody order may not be detained in a nonmedical facility used to detain persons who are charged with or convicted of a crime except because of and during an extreme emergency and in no case for longer than 24 hours, excluding Saturdays, Sundays, legal holidays, and the period prescribed by Section 574.025(b) for an extreme emergency. The person must be isolated from any person who is charged with or convicted of a crime.

D. The county health authority shall ensure that proper care and medical attention are made available to a person who is detained in a nonmedical facility under Subsection (C).

E. If a single portal authority lacks the local resources to care for a person, the authority shall transfer the person to a state mental hospital or, on the request of the authority, the judge may order that the person be detained in a state mental hospital.

Discussion Points: (The remainder of this chapter was taken directly from Police Mental Health Training Program in New York with minor adaptations)

1. Custody v. Arrest/Detention

Legally, custody is the same as arrest and detention. The only difference between custody and arrest/detention is the degree to which liberty can be restricted, and that degree of restriction depends upon the purpose of the detention.

There is a limited purpose for which persons may be taken into custody:

a. To transport the person to a facility to receive care and treatment;

b. To prevent the person from harming himself or others. Persons taken into custody cannot be treated similarly to other arrests; that is, these persons CANNOT be housed in lockup (except in the case of extreme emergencies), NOR subjected to disciplinary procedures, NOR have restricted visiting rights, etc.

2. Custodial Responsibilities

While a person is in an officer's custody, the officer is responsible for the safety, care, and well-being of that person. It is the duty of the officer to exercise care in accomplishing this responsibility. The duty of care may be affected by specific facts known to the officer about any particular risk posed by a particular detainee.
3. Transfer of Custody

A transfer of custody occurs when that control over a person's freedom of movement is turned over to another. Where police officers or peace officers transport mentally ill persons to a facility, in most cases a transfer of custody occurs at the time facility personnel actually take physical charge of the person and certainly when he is admitted for treatment.

Where peace officers are asked to assist in controlling a mentally ill person after such person has been brought to a facility and/or admitted, they may be said to be acting at that point as agents of the director of the facility. The director has custody at that point, and officers should follow the director's orders in as far as it is reasonable to do so.

DEATH OR INJURY

A. Peace officers taking into custody (including detention in a lockup) a person whom they believe to be mentally ill must at all times treat the mentally ill person in such a manner as will prevent him from having the opportunity to injure himself. It is their duty to exercise reasonable care, which includes such things as following existing facility screening/management procedures and/or other standards developed to protect high risk inmates from death or injury.

B. This duty to exercise reasonable care as stated above extends to any person incarcerated in a jail or lockup. Although some inconsistency exists in court rulings regarding failure to act, courts have often stated that custodial institutions have a responsibility to protect the health and safety of persons in their care and that this duty includes reasonable care to prevent suicide. This duty may be satisfied by the adoption and the enforcement of evaluated screening procedures in the inmate population as a whole, and a higher level of care may be required in the care of a particular detainee whose condition or behavior indicates a higher risk of self injury.
Instructor Added (If Available)
CHAPTER 8: DOCUMENTATION

(This chapter was taken directly from
Police Mental Health Training Program in New York with minor adaptations)

RECOMMENDED LENGTH OF PRESENTATION: 45 Minutes

METHOD OF PRESENTATION

1. Lecture/Discussion

INSTRUCTOR PREPARATION

1. Prepare information on local documentation procedures.
2. Copy appropriate forms

MATERIALS SUGGESTED

1. **MH Peace Officer Forms** (Examples)
   (Use local forms - examples listed below)
   
   a. Application of Emergency Detention (legal)
   b. Voluntary Transporting form (liability)
   c. Mental Health Warrant for Emergency Detention (legal)
   d. Affidavit of Witness - General Forms (legal)
   e. Order of Protective Custody and Notice of Hearing (legal)

2. **General Peace Officer Forms**
   (Use local forms - examples listed below)
   
   a. Fraudulent Crimes
   b. General Offense
   c. Crimes Against Property
   d. Crimes Against Person

3. **Administrative Forms**
   (Use local forms - examples listed below)
   
   a. Peace Officer Tracking Disposition Record
   b. Client Service Ledger

INSTRUCTIONAL OBJECTIVES

1. Describe the important elements of a report documenting a Mental Health Code related incident.
2. List three reasons for accurately documenting a Mental Health Code related incident.

3. Describe the information which the officer should communicate to a Mental Health Facility.

4. Identify who a mental health peace officer must communicate the incident

5. Describe why it is important to keep specific notes on the incident.

6. List the local report forms specific to your department that must be filed after you have taken a person into custody under the Mental Health Code.

INSTRUCTOR REFERENCES

LESSON PROCEDURE

Elements of Mental Health detention documentation


2. In addressing the issues raised in number 1 above, include the following:

   a. Observations of overt acts to harm self or others.

   b. Medications subject is taking.

   c. Details of subject's behavior (includes nonverbal cues).

   d. Verbal statements which reflect subject's feelings or thoughts (includes verbal cues).

   e. Environmental cues which may indicate a person is emotionally disturbed.

   f. Subject's history, if known. Remember, describe what you hear and observe; conveying these details is more useful than reporting only conclusions you have drawn from your observations. For example, describe a person as crying, lethargic, expressing sad thoughts, rather than reporting only that subject is depressed.

   g. Third-party statements regarding subject's behavior/emotions.

   h. Any other observations or information that you feel is important.

PARAMETERS OF DOCUMENTATION: SECTION 595.001

Records of the identity, diagnosis, evaluation, or treatment of a person that are maintained in connection with the performance of a program or activity relating to mental health and mental retardation are confidential and may be disclosed only for the purposes and under the circumstances authorized under Section 595.003 and 595.004.

THREE REASONS FOR ACCURATELY DOCUMENTING A MENTAL HEALTH INCIDENT

1. To provide the admitting physician with a clear description of the situation and the behavior to help substantiate the legal criteria for hospital admission.

2. To provide administrative and liability protection for the peace officer.

3. For future reference in case of repeat calls.

COMMUNICATE INFORMATION TO

1. Booking Officer
2. Arraigning Judge
3. Emergency Medical/Mental Health Personnel
4. Lockup/Jail Personnel - this is mandated to prevent suicide and reduce risk of negligence.
5. Central Files
CHAPTER 8 – HANDOUTS

INSTRUCTOR ADDED

(As needed)
CHAPTER 9: SAFETY AND ASSESSMENT

(This chapter was taken directly from
Police Mental Health Training Program in New York with minor adaptations)

RECOMMENDED LENGTH OF PRESENTATION: 1 Hour

METHOD OF PRESENTATION

1. Lecture/Discussion

INSTRUCTOR PREPARATION

1. Prepare "Life Experience" examples to use as learning aids
   a. Dangerous or violent situation
   b. Suicidal situation
   c. Copy handouts

INSTRUCTIONAL OBJECTIVES

1. Common location and initiator of peace officers encounters with persons with a mental illness.

2. List the initial tasks to accomplish in responding to a situation involving a person with a mental illness.

3. List five questions an officer should ask in assessing dangerousness.

4. List two questions to ask in assessing suicide risk.

5. Describe two types of nonverbal communication.

INSTRUCTOR REFERENCES

LESSON PROCEDURE

PEACE OFFICERS ENCOUNTERS WITH PERSONS EXHIBITING SYMPTOMS WITH MENTAL ILLNESS

A. Ask class where encounters most often occur.

1. *Encounters frequently occur within the subject's home.* Studies indicate that 44-55% of encounters occur in the person's home.

2. In the same studies, approximately one-third occurred on the streets or in other public places.

3. Because encounters so often occur in a residence, officers will need to be especially conscious of interior safety precautions, particularly concerning household items which may be used as weapons. (Before providing information, ask participants to identify the single most common initiator).

B. Encounters are most often initiated by peace officer.

1. A study of 838 cases by Sheridan and Teplin indicated the following rates of initiation:

<table>
<thead>
<tr>
<th>% of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peace Officers</td>
</tr>
<tr>
<td>Subject</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Variety of other sources</td>
</tr>
</tbody>
</table>

2. Since more than one-third of contacts will be initiated by peace officer:

   a. Officers on the scene will have no prior information about the subject or situation.

   b. Officer's skills in observation and assessment at the scene become particularly important.

3. Discuss responding to a call for subject with mental illness:

   *(Everyday in your work as a Peace Officer you come in contact with people who behave abnormally. Some may confuse you, others may make you mad and some may even frighten you. Everything you can learn about persons with mental illness will help you make your job easier and make you a better officer).*
INITIAL TASKS TO ACCOMPLISH IN RESPONDING TO A SITUATION POSSIBLY INVOLVING A PERSON WITH A MENTAL ILLNESS

A. Protect the public and safeguard your own life.
   1. Make a cursory overview of the situation to assure you immediate safety and the safety of others.
   2. Be aware of the need for continuous attention to safety throughout the incident.

B. Access whether the person may be mentally ill
   1. Identify the primary symptoms indicating mental illness.
   2. Get as much information as possible about the person prior to arriving at the scene. (Keep in mind that the officer's initial information may have been passed on by several persons and may be distorted).

C. Sources of information
   1. Dispatcher
   2. Officer's observations at the scene
   3. Reports from third parties (families, friends)
   4. Person's statements
   5. Computer file and/or other central files

D. Important information to obtain
   1. Indicators that subject is mentally ill
   2. Events leading to the situation
   3. History of subject's involvement with police, and/or psychiatric treatment and/or substance abuse treatment.
   4. Whether currently under doctor's care, name of doctor, and any medication being taken.

E. Assess danger to subject or others.

ASSESSING THE PROBABILITY OF VIOLENCE

Though only very few persons with mental illness are dangerous or violent, you will undoubtedly run into these situations as a peace officer. Handling a violent person is difficult and sometimes dangerous work. But the more you know about it, the less difficult and dangerous it will be. A peace officer must be able to determine if there is evidence of violence or potential for violence.
A. Evidence of Violence: Is there ongoing violence?
   1. Situation may be dangerous even if violence is not directed at people.
   2. Violence which is clearly directed at a specific person presents a more serious situation.
   3. Is anyone involved in the situation already injured?

B. Potential for Violence
   1. Is there a weapon at the scene? This includes any weapons, even if not immediately involved in the situation. (Note that normal household items can be used as weapons).
   2. Is subject in bathroom or kitchen? (These rooms are the most dangerous)
   3. Is the subject barricaded in a room or house?
      a. Are there pills, weapons, other dangerous items in the room?
      b. Does the room have windows?
   4. Is the subject holding a hostage?
   5. Is there a history of violence?
      • Arrest for violent crimes, hospitalization for dangerous behavior, spouse or child abuse, and any self reported violent behavior are indicators that the person may be more likely to resort to violence, especially if the current circumstances are similar to those in which the past violence occurred.
      • Direct questioning of the family. "Do you ever worry that ____ will hurt someone?"
      • Direct questioning of the person. "What is the most violent thing you ever did?" "Do you ever feel you might physically hurt someone?" "What is the closest you ever came to hurting someone?"

ASSESSING DANGER TO SELF
A. Evidence of self abuse
   1. Does the suicide attempt involve a weapon?
   2. Is subject injured or currently attempting suicide?
B. Potential for self injury

1. Does the subject have the means to harm himself/herself?

2. Is subject talking about suicide, or has subject left a suicide note?
   a. Does statements of suicidal intent are a strong indicator of potential for suicide.
   b. Research has shown that of every ten persons who kill themselves, eight have given definite warning.
   c. In assessing for this factor, be aware of any statements of intent even those made in sarcastic or joking manner.

3. Does the person have a specific suicide plan?
   a. Studies have indicated that most people who die by suicide have made a deliberate plan to do so.
   b. The more specific and realistic the plan, the greater the potential for suicide.

4. Has the person made a previous suicide attempt?
   a. Within the adult population of the United States approximately 80% of people who kill themselves have made at least one previous suicide attempt.
   b. People who have made a highly lethal attempt are more at risk for subsequent suicide than those who have made an attempt using a method of low lethality.

5. Has subject recently taken any drugs or alcohol?
   a. Persons who are under the influence of drugs or alcohol often do not think rationally, they are more likely to become anxious and depressed; they become less inhibited.
   b. Because of these effects, they present a serious potential for suicide.

6. Does the subject appear depressed? This is one of the most common indicators; approximately 60-79% of all suicides are committed by depressed persons who exhibit some of the following signs of depression:
   a. Extreme sadness or crying
   b. Apathy-loss of interest in people and activities
   c. Loss of appetite
   d. Unusually slow reactions
   e. Difficulty concentrating
   f. Sleep disturbance
   g. Emotional flatness
   h. Tension and agitation or withdrawal
i. Pessimism
j. Emotional outbursts

7. Has the person experienced major life change? Loss of job or loved one; burst of anger or frustration before a chance to think things out.

8. Does person have medical problems? Pain and suffering and/or loss of independence, income, dignity.

9. Does person seem hopeless? Hopelessness has been found to be a stronger indicator of suicide intent than depression alone. Statements indicating hopelessness are "There is nothing to look forward to" or "There is no way to make things better."

10. Does person see suicide as their only option?

11. Is person making final arrangements?
   (Ask participants to give examples of final arrangements, such as writing a will, giving away possessions.)

C. Other facts to be aware of when assessing risk for suicide

1. In the United States sixty to seventy suicides occur daily.

2. Suicide rates are highest for people over 60 and for young adults (18-24 years old)

3. Males complete suicide more often than females, but females attempt more often.

4. Pact suicides are seen more frequently in older persons and teens.

ASSESSMENT OF NONVERBAL COMMUNICATION

When assessing the situation, the officer should be alert to the way the verbal messages are being sent:

A. Tone of voice

1. What emotion is being expressed through tone of voice?

2. Does the tone correspond to the content?

B. Facial expression

1. What emotion is being conveyed by the facial expression (fear, anger, and sadness)? Does the facial expression correspond to the verbal content?
C. Body language

1. Do postures and gestures correspond to the verbal content?

2. What signs in body language may suggest violence before it occurs?
   a. Clenched fists
   b. Red face
   c. Crossed arms

D. Personal space

1. Distance between parties to the communication.

2. Give examples that standing very close to a stranger may likely be intended as threatening, while moving away from the person may be an expression of fear.

**SUMMARY**

In order to make accurate assessments of incidents involving persons with mental illness, it is essential to:

A. Gather complete and accurate information.

B. Evaluate that information in the context of the whole picture.

   1. The physical environment in which the situation is occurring.

   2. The social environment; the culture the subject comes from.
CHAPTER 9 -- HANDOUTS

Assessing Danger to Self

Talking About Suicide?  Previous Attempt?
Suicide Note?  Signs of Depression?
Evidence of Injury?  Expressions of Hopelessness?
Means to Harm Self?  Suicide "Only Option"?
Specific Suicide Plan?  Making Final Arrangements?

Assessing Danger to Others

History of Violence?
Ongoing Violence or Evidence of Violence?
Threats of Violence?
Weapon at Scene?
Barricaded Subject?
Hostage?
Alcohol or Drug Use?
CHAPTER 10: INTERVENTION IN THE HIGH RISK SITUATIONS

(Lessons I through V and VII are adapted from Police Mental Health Training Program from New York. Lesson VI is adapted from Enhancing Police response to mentally disabled from The Center for Health Care Services)

RECOMMENDED LENGTH OF PRESENTATION: 2 to 3 Hours

METHOD OF PRESENTATION:
1. Lecture/Discussion
2. Video
3. Case Examples Presentation/Discussion

INSTRUCTOR PREPARATION:
1. Prepare crisis scenarios.
2. Check video tape and make sure at proper starting point
3. Copy handouts

MATERIALS SUGGESTED:
1. Video "News Footage on high risk situations from T.V. stations"
   Police Recruit E. P. D. Training Video, New York
2. Flip Chart for Scenarios
3. Video "Lockup Hanging" Suicide Prevention & Crisis Intervention Skills for Correction & Detention Officers Training

INSTRUCTIONAL OBJECTIVES
1. Define the high-risk situation.
2. List the operational and safety considerations that the responding officer must be aware of during incidents involving a person with mental illness.
3. Describe ten steps in assuring safety and approaching an emotionally disturbed person.
4. Describe six actions to avoid when handling a crisis situation.
5. Summarize alternatives following crisis intervention.
6. List ten effective communication techniques.
7. State three considerations which a police officer should be aware of when confronted with a suicide attempt.
8. Name the 4 stages of psychological First Aid.
9. List two facts about lockup suicides, and reflect knowledge of the high correlation between isolation and suicide.
INSTRUCTOR REFERENCES


LESSON PROCEDURE

RESPONDING TO PERSONS WITH MENTAL ILLNESS IN CRISIS

Only a psychiatrist or other highly trained mental health professional can help a disturbed person in a crisis situation. (Ask class if statement is true or false. Stress that this entire training and particularly the following Chapters are based upon the belief that with training and experience officers can effectively help persons with mental illness in crisis).

1. FALSE

2. An officer, with basic training in the identification and handling of disturbed persons, will have the tools that may effectively calm a crisis situation, prevent harm to the subject or others, and assist the subject in obtaining further help. The key to this process is communication: a willingness to listen and communicate a degree of understanding to the disturbed person.

3. In this "helping" crisis intervention role it is important to be aware that some traditional types of police intervention may lead to or increase violent reactions. Officers must, therefore, be aware of alternative interventions which may avoid the pitfall of rapid tactical response and, in turn, the potential for violent response (Barrocas 1974).

4. This chapter will build upon the premise that officers can effectively help people in crisis. Although tactical measures will be referred to when necessary, neither the material presented nor the real life crisis scenarios will focus upon them. This training encourages nonphysical interventions.

A HIGH-RISK SITUATION is one in which the officer is confronted with behavior posing IMMEDIATE DANGER to the subject, officer, or others.

SHOW VIDEO  News Footage of High-Risk Situations (stop tape after 4 basic tasks are listed)

SAFETY IN HIGH-RISK SITUATIONS

A. Operational Issues

1. Maintain POSITION OF SAFETY (if subject has weapon, seek cover).

2. NOTIFY DISPATCHER; REQUEST appropriate BACKUP assistance, give correct address and call back number.

3. Develop initial intervention plan. (Get as much background information you can.)

4. Wait for and ADVISE BACKUP units of danger.

5. CONFINE and ISOLATE the situation.

6. DELAY RAPID ACTIONS time is a tool (deciding to wait is an important part of the intervention plan).

7. Remain calm; try to avoid excitement,
B. Entering the site of the disturbance

1. Be aware of the environment-
   a. Does subject have weapons?
   b. Are other persons in area or with subject?
2. Note entrances and exits and the swing of doors.
3. Survey site damage, this may indicate degree of violence.
4. Determine if all disputants are at the site and their positions.

C. Approaching the subject

1. Take time to look over the situation.
2. Introduce yourself - create an impression of non-hostile authority.
3. State the REASON FOR YOUR PRESENCE at the scene. It is better to begin by saying, "I have come to talk things over and to see what I can do to help" rather than "I've come to take you in."
4. TAKE CHARGE until immediate threat is controlled. Neutralize threats to safety.
5. Use triangular approach - KEEP WEAPON side AWAY from subject.
6. SEPARATE PERSONS who are in conflict. Check out the welfare of other family members.
7. MOVE DANGEROUS OBJECTS out of reach/view of subject.
8. REMOVE PEOPLE/objects that UPSET subject.
9. UTILIZE PEOPLE/objects that have POSITIVE EFFECT on subject.
10. MANEUVER SUBJECT into "SAFE" AREA - avoid kitchen and bathroom.
11. DO NOT VIOLATE subject's PERSONAL SPACE; move slowly, explain actions and use quick moves only to restrain.
12. Avoid "Crowding" the subject. Give the subject a chance to calm down.
13. AVOID ONE-ON-ONE PHYSICAL CONFRONTATIONS - may be seen as challenge and escalate violence.
14. DIVERT SUBJECT from anxiety - ask for routine information.
15. MAINTAIN CONTROL of encounter - advise that all external controls will be used to resolve situation if necessary. Remember that a disturbed person in a crisis situation may seem unusually strong and/or unaffected by pain due to:
   - the influx of adrenaline into his/her system;
   - a higher pain threshold;
   - a lack of social judgment
16. Use good COMMUNICATION SKILLS - Encourage talking. If situation permits invite all who are present to be seated and neutralize the situation however, be alert to possible change.

COMMUNICATION SKILLS TO REDUCE RISK

1. Asking Questions
   -- Ask simple and direct questions.
-- Ask open ended questions. (Keep the subject talking, don't ask questions that can be answered "yes" or "no" never allow conversation to 'dead-end').
-- Develop rapport - helps to overcome subject's fear and mistrust.
-- IDENTIFY AND COMMUNICATE with "HEALTHY" aspect of subject - even the most disturbed person has areas of "normal" functioning.
-- Determine REASONS for subject's ACTIONS.
-- BE HONEST but do not challenge the person's perception.

2. Understanding the subject
-- Listen to the subject (be an active, empathic listener)
-- Recognize and respond to physical needs.
-- Paraphrase responses to check for understanding.
-- Summarize

3. Encouraging subject to respond
-- Use CALM, SIMPLE, DIRECT instructions/requests.
-- RESTATE subject's statements (subject: "I can't sleep, officer:"
  "You're having difficulty sleeping")
-- Use SIMPLE ACKNOWLEDGMENTS - encourages further communication: "Uh huh, I see, mmm."
-- Offer "Go on " and "And then...?" as GENERAL LEADS.
-- Give BROAD OPENINGS, such as: "You look like you need to talk things over with someone" - indicates willingness to listen and relieves tension.
-- Seek CLARIFICATION and probe for specifics - encourages talking and provides accurate information: "I'm not sure I understand; could you explain?"
-- Use POSITION OF AUTHORITY in a positive manner.
-- Stress positiveness and subject's strengths, qualities, resources.
-- Remain as neutral and objective as possible.
-- Be patient; it may take some time for the subject to respond or reply.
-- Discuss ALTERNATIVES, this enables subject to consider options:
  "When you feel this down, what can you think of that might make you feel better?"
-- RESPECT, ATTENTIVENESS, OPENNESS, UNDERSTANDING, ACCEPTANCE, AND POSITIVE ATTITUDE increase effectiveness of communication.
-- Remember, good communication skills are the most effective tool an officer has.

**ACTIONS TO AVOID IN ALL CRISIS ENCOUNTERS**

1. Do NOT use ANALOGIES (especially true for agitated person).
2. DO NOT challenge subject's DELUSIONS.
3. DO NOT allow yourself to be MANIPULATED. Avoid yes or no responses to personal questions.
4. DO NOT falsely threaten ARREST.
5. DO NOT LEGALIZE - this may intensify hostility.
6. DO NOT overreact to GANG LANGUAGE or to sexual, racial, or ethnic insults aimed at you.
7. DO NOT ORDER, command, warn, or threaten-- this creates fear and resistance, invites testing, promotes rebellious behavior.
8. DO NOT MORALIZE, preach, judge -- this communicates messages of self righteousness.
9. DO NOT call them derogatory names.
10. DO NOT NEGATE THE SERIOUSNESS of the crisis--this causes misunderstanding, evokes hostility, causes subject to be embarrassed.

SUICIDE INTERVENTION

VIDEO - Start at "Tragedy" -- suspect jumping off fire escape
(stop after consumer comments)

A. Discussion Points

1. Ask officers about experiences on duties; and feelings related to video or experiences
2. Ask officer's if statements are True or False
   a. Asking a suicidal person questions, such as "have you thought that life isn't worth living"? will plant the thought in the person's mind and increase the possibility that he/she will commit suicide. (Give brief explanations of answers.)
      (1) FALSE
      (2) The person may feel relieved that the question was asked.
      (3) Questioning in a concerned, nonjudgmental way will encourage the person to discuss what may be bothering him.
   b. Suicidal people are dangerous only to themselves.
      (1) FALSE
      (2) A person who is actively involved in a suicide attempt, particularly one involving a weapon or threat to jump from a high place, can be potentially dangerous to others.
      (3) Research indicates that 10% of suicides are preceded by a homicide.
      (4) Awareness of this potential should lead to continuous safety considerations in suicide intervention.
      (Give example such as mother who intervened with her suicidal son who had gun to his head. Mother says, "if you have to kill somebody, kill me" Son turns and shoots his mother.)

B. Approaching a suicidal person

1. Remember that suicidal subjects may attempt to have others kill them.
2. Remain CALM -- display of tension can heighten a critical situation.
3. Make a PLAN and follow it -- rushing to rescue subject increases risk to all.
4. BE ALERT -- crisis situations are unstable; CONTINUOUSLY EVALUATE the crisis. Remember that the suicidal person may become homicidal.
5. If suicidal gestures are not apparent, ASK SUBJECT ABOUT SUICIDAL INTENT.
   -- Are you thinking of killing yourself?
6. CHECK OUT THE SITUATION - What means is the person planning to use to commit suicide
   - How are you planning to kill yourself? Do you have the means to kill yourself? When are you planning to kill yourself? What time of day are you planning to kill yourself?
   - Remove the means - Insist that the person put away or get rid of any firearms, medications, or sharp objects. It is important that you convince the person to put away or give up the means rather than take them from the person. A show of force, rather than trust and rapport, can often trigger the suicide.
   - Notify and meet with significant others - With the suicidal person's knowledge, locate and talk with close friends and family to gain further insight into the problem.

C. What to say to a suicidal person
1. Have empathy. "I can see that you're hurting a lot right now".
2. Redirect their attention by talking about what they are feeling rather than focusing on the act. "I want things to get better for you; what are you thinking about?"
3. Offer alternatives. "What else could you do right now to make yourself feel better?" "Would you like to speak to a friend or relative"?
4. Let the person talk about suicidal thoughts and feelings without expressing shock or condemnation.
5. Convey information that suicidal thoughts are not unusual in severe depression (normalize the situation). This may allow the person to feel less guilty and/or less isolated.
   - Offer realistic hope - Providing false hope, stretching the truth, or denying the seriousness of the problem will not benefit the person in any way. Rather, you should stress that the problem can be overcome. Emphasize the temporary nature of the feelings the person is experiencing and how the proper authorities can help the person overcome those feelings.
6. Help the person to identify their pain. Ask "Where are you hurting?". Let the person feel comforted with "I am here to help you and you are not alone".

D. Actions to avoid in suicide situations

1. DO NOT make SUDDEN MOVES -- use this as a last resort.
2. DO NOT leave the subject unattended.
3. DO NOT deny the subject's suicidal feelings.
4. DO NOT RUSH/PRESSURE subject to make decisions or to abandon suicide plan.

PSYCHOLOGICAL FIRST AID FOR CRISIS SITUATIONS

(This lesson is adapted from Center of Health Care Services "Enhancing Police Response to The Mentally Disabled")

This intervention focuses on clarification of events and problem solving. The purpose of this intervention is to reestablish the individual's coping abilities as soon as possible, the longer a crisis lasts the more difficult it is to intervene.

Psychological first aid has 4 stages. You may not deal with all 4 stages but there will be occasions when you will use techniques associated with each stage. These stages structure the intervention which enhances the officer's sense of control and avoids panic.

The four stages are.

1. Make psychological contact
2. Clarify the precipitating event
3. Examine possible solutions
4. Take concrete action

(Stay flexible and adapt the first aid to the situation and not the other way around.)

A. Psychological Contact

1. Communicate concern to the individual.
2. Encourage and keep the person talking.
3. Engage in active listening. (It is more important for you to listen than to talk.)
4. You do not have to agree with the person's point of view. Instead of disagreeing or flat out lying it is best to defer the issue.
5. Ask for clarification instead of mechanically nodding or pretending to understand.
6. Faking it can only lead to breaking any psychological contact that may have been established.

7. Be aware of nonverbal cues, your own and those of the subject, such as tone of voice gestures, mannerisms and posture. Use nonverbal cues such as sharing food, buying a soft drink or taking a walk together.

B. Clarify Precipitating Event

1. Identify the "last straw" and assist the individual to put it in perspective. The thing that finally drives a person over the edge may seem trivial to most people but it must be kept in mind that it is only the last link in a chain of stressful events.

2. The person may over generalize and say that "everyone" is against him/her that "no one understands" or that "everybody" hates him/her. Ask the person to clarify who exactly everyone is. Try to identify the specific problem that set the person off and deal with possible, concrete solutions.

3. Convey the expectation that the person is a survivor and do not get caught up in the intensity of the person's feelings.

C. Examine Possible Solution Outcomes

1. Once a specific problem has been identified, involve the individual in arriving at his/her own solutions. This allows the person to feel in control of his/her own condition and helps dispel feeling of hopelessness.

2. Avoid rushing in to offer advice. This is often perceived as not wanting to listen and the advice is often rejected anyway. Offer suggestions only after the anxiety level is down, and you have done a lot of active listening.

3. Get the person involved in his/her own helping process by asking what that person has tried in the past to solve the problem. If there are no viable options in past attempts, ask "what if" questions. For example, "What if you get in contact with . . .,. "What if you go to. . .," What would happen if you tried to ." These type of open ended questions put the ball in the individual's court and keeps him/her talking.

4. Another strategy in helping the individual solve him/her problem is to ask him/her to identify possible obstacles and solutions.

5. If the person is so distraught and disoriented that he/she can not deal with his/her problem continue in the active listening mode to keep the person talking.

6. Try to get the message across that his/her present feelings will subside and even though things seem hopeless at the moment that solutions are possible.
D. Take Concrete Action

1. The lethality of the situation has a direct effect on what role you should take.

2. If you believe the risk of harm to self likely and/or if the person seems confused, disorganized and anxious, a firmer leadership role may be more effective.

3. If the risk to self or others is low and the person is able to act on his/her own behalf, assume a more facilitative role.

4. Convey to the person that your role is, to aid him/her in implementing an immediate solution to his/her problem.

5. Whatever role you determine to use, the basic procedures are:
   a. Remove or have removed any means that the person may have of harming himself/herself.
   b. Notify and meet with significant others to gain more information and if appropriate, enlist others in helping with the situation. (Be cautious that significant others may be part of the precipitating problem.)
   c. Offer realistic hope. Do not try to paint an overly optimistic picture but do convey the idea that solutions are possible.
   d. Establish a specific plan of action. In the event that the person does not meet the criteria for emergency detention, see that the person receives help.

PROCEDURES FOLLOWING CRISIS RESOLUTION

1. Medical treatment if required.
2. Mental health detention.
   -- SEARCH AND SECURE OR RESTRAIN subject prior to transporting. For safety reasons, family members should not be transported with the suicidal person.

3. Criminal arrest
   -- with referral to mental health agency;
   -- without referral to mental health agency (in this case be sure to communicate with booking officer regarding the crisis situation);
   Review Art. 16.22 CCP and Art. 17.032 CCP.

4. Release and/or leave subject in community, if custody is not needed.
   -- with health mental health referral
PRESENT CRISIS SCENARIOS

*Instructor presents crisis situations from Personal Case or Audience examples.*

*Audience will be asked to participate in "identifying critical factors" and "resolution" of crisis situation.*

*(Refer back to Chapter 9 assessment skills during presentation discussion)*

SUICIDE WITHIN DETENTION FACILITIES

As Mental Health Peace Officers, you may have assignments within lockups. Because suicide is the leading cause of death in correctional facilities, it is important to know some facts about suicide in lockups and preventative measures.

**Video - "Lockup Hanging" - Optional**

**A. Suicide Act**

1. The majority of suicides in the correctional system occur in lockups.
2. Fifty percent of local correctional facility suicides occur within the first 24 hours of incarceration.
3. The most critical time for local correctional suicides is from 12 midnight to 8 a.m.
4. The majority of correctional facility suicides are by hanging (a person can hang themselves with bed sheets; clothing, etc. and can die within three minutes of hanging themselves.)
5. The majority of local correctional facility suicides are made by individuals who are intoxicated or under the influence of drugs at the time of the suicide. However, some inmates who commit suicide have no serious substance abuse or mental health problem (e.g., depression). The shock of arrest and placement in the lock up environment may add to existing problems and push the inmate toward suicide.
6. Be aware of the cluster effect. Suicides often follow other suicide attempts, especially if there has been a great deal of publicity.
7. Manipulation: people sometimes say that an inmate is manipulating attempting suicide only for attention. Take all suicide attempts seriously. It certainly is possible for people to use self-destructive acts to manipulate their worlds, but remember that these people can die by accident or change their minds and deliberately kill themselves.

**B. Officer Actions to Reduce Lockup Suicide**

1. An officer assigned to duty in a lockup or detention facility should be familiar with minimum standards and regulations for management of city jails, and town and village lockups.
2. Screening prior to initial cell assignment is critical to prevent lockup suicides.
3. Lockup inmates identified as high risk for suicide should be placed on constant watch and immediately referred for mental health services. They should never be left alone; DO NOT isolate a suicidal inmate. They need constant supervision.

4. All items dangerous to inmates should be removed.

5. The arresting officer must communicate any information that might help jail staff protect the inmate.
# Operational Safety Issues High Risk Situations - *Remain Calm*

<table>
<thead>
<tr>
<th>Action</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain Position of Safety</td>
<td>Advise</td>
</tr>
<tr>
<td>Notify Dispatcher and Request Backup</td>
<td>Confine and Isolate the Situation</td>
</tr>
<tr>
<td>Develop Intervention Plan</td>
<td>Avoid Rapid Actions</td>
</tr>
</tbody>
</table>

# Entering the Site - *Remain Calm*

<table>
<thead>
<tr>
<th>Task</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be Aware of Environment</td>
<td>Survey Site Damage</td>
</tr>
<tr>
<td>Note Entrances and Exits</td>
<td>Locate All Disputants/Subjects</td>
</tr>
</tbody>
</table>

# Approaching the Subject - *Remain Calm*

<table>
<thead>
<tr>
<th>Action</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce Yourself</td>
<td>State Reason for Your Presence</td>
</tr>
<tr>
<td>Take Charge</td>
<td>Use Triangular Approach</td>
</tr>
<tr>
<td>Observe Body Language</td>
<td>Move Dangerous Objects</td>
</tr>
<tr>
<td>Remove Influences That Upset Subject</td>
<td>Maneuver Subject into a &quot;Safe Area&quot;</td>
</tr>
<tr>
<td>Do Not Violate Personal Space</td>
<td>Avoid One-on-One Physical Confrontations</td>
</tr>
<tr>
<td>Maintain Control</td>
<td>Divert Subject from Anxiety</td>
</tr>
<tr>
<td>Use Good Communication Skills</td>
<td>Use Influences That Have a Positive Effect</td>
</tr>
</tbody>
</table>
CHAPTER 11: INTERVENTION IN LOW-RISK SITUATIONS

RECOMMENDED LENGTH OF PRESENTATION: 60 Minutes

METHOD OF PRESENTATION

1. Lecture/Discussion
2. Guest Speaker

INSTRUCTOR PREPARATION

1. Review referral steps and resources.
2. Invite guest speaker if needed to discuss local community based MH services.
3. Prepare case examples which do not meet criteria for involuntary apprehension.
5. Copy handouts

INSTRUCTIONAL OBJECTIVES

1. Define "low risk" situation.
2. Describe two alternatives to custody available in low risk situations.
3. Define referral, and identify the six referral steps.
4. List four types of referral sources.
LESSON PROCEDURE

Low Risk Situations

- A situation in which an officer is confronted with bizarre/disruptive behavior, but
- Behavior does NOT POSE IMMEDIATE DANGER.

ALTERNATIVE METHODS OF INTERVENTION WHEN NO GROUNDS FOR CUSTODY

(Give case examples depicting behavior which does NOT qualify for involuntary detention throughout lessons)

A. Medical Attention

1. The first concern, after control of the situation is obtained, is rendering or obtaining urgent medical care.
2. Emergency medical personnel should be summoned if not on scene.
3. Determination of final disposition can be made after medical care is rendered.

B. Arrest of Individual

1. A person who is mentally disordered and/or developmentally disabled is not relieved from legal obligations.
2. Agency policies/procedures must be considered.
3. Officers have discretionary authority to arrest, cite and release, file a complaint, or release from custody.
4. Considerations for officer safety must be constantly evaluated, along with safety of community.

C. No Action Required

1. Some situations will not fall into alternatives listed above--no crime committed and no urgent medical care necessary.
2. Release from custody
3. Consider appropriate assistance via to agency policy and procedures, officer discretion, and available resources (i.e., appropriate social service referrals)
D. Referral for Mental Health Services

1. Individuals and families who may be in need of treatment can be referred to available mental health services.

**ALTERNATIVES WHEN THERE ARE NO GROUNDS FOR CUSTODY or ARREST**
(Unless criteria under Mental Health Code are met or a crime has been committed, the person cannot be taken into custody)

A. Neutralize or Stabilize and make no referral—this applies when a person with a mental illness refuses referral (however, families can be advised of referral services)

B. Neutralize or Stabilize situation and make referral—this applies when the person with the mental illness is willing to receive service.

*If the subject is not taken into custody:*

C. EXPLAIN to the person with mental illness and other concerned persons that the Mental Health Code CRITERIA LIMITS OFFICER’S ability to detain the person.

D. EXPLAIN what ACTION WILL BE TAKEN if the subject meets the criteria in the future.

**REFERRAL PROCESS**

A. RECOMMEND appropriate SERVICE;

B. CONVINCE subject TO OBTAIN ASSISTANCE in managing problem.

C. PROVIDE subject/parties involved with PARTICULARS of SERVICING AGENCY, verbally and in writing:

- NAME
- ADDRESS
- TELEPHONE NUMBER
- COST, IF ANY
- HOURS OF OPERATION
- ADMISSION CRITERIA
- SERVICES AVAILABLE

D. ANSWER QUESTIONS and reassure parties;

E. SUMMARIZE referral plan to check for agreement;

**TREATMENT SERVICES AVAILABLE IN THE COMMUNITY**

A. It is essential for you to be aware of the service agencies in your community. Agencies which provide both crisis and non-crisis services. (It will be helpful to you to have a listing of agencies and their contact numbers readily available).
B. Mental Health Services

1. Local hospitals with psychiatric units in area
2. State Psychiatric Hospital which serves your catchment area
3. Services offered by local community MHMR center

SERVICES THAT PEACE OFFICERS CAN EXPECT FROM COMMUNITY MHMR CENTERS:

A. The Texas State Legislature and TDMHMR require the provision of an array of core or essential services aimed at meeting individual needs and enhancing personal skills for optimum community living. (Have guest speaker from local MHMR community mental health center discuss how core services are implemented in local service area).

The Texas Mental Health and Mental Retardation Act specifies the core services as:

1. **24-hour Emergency Screening and Rapid Crisis Stabilization Services**
   Services for persons who are demonstrating a psychiatric crisis.

2. **Community Based Crisis Residential Service or Hospitalization**
   Provides stabilization for persons in crisis.

3. **Community Based Assessments**
   Includes the development of Interdisciplinary Treatment Plans and Diagnosis and Evaluation by psychiatrists and other mental health professionals.

4. **Family Support Programs**
   Services to provide education, support and counseling to a mentally ill person's family members.

5. **Medication Related Services**
   a. Medication Clinic's periodic review of psychiatric status and an update on the maintenance or revision of treatment with psychotropic medications by qualified physicians.
   b. Routine monitoring of the physiological status of persons with mental illness using laboratory tests and physical examinations.
   c. Education about medication which includes instruction to the person with mental illness regarding side effects of psychotropic medications, the importance of taking medications as instructed and the symptoms would indicate a special medication review is needed.
   d. Mental health maintenance, education and counseling including instruction to the person with mental illness in specific coping strategies.
strategies to use during times of stress, the importance of taking medications as instructed and proper nutrition in mental health maintenance and the importance of an ongoing community support network.

6. **Provision of Medications**
   Services providing medication directly or through entitlement for persons whose personal resources do not allow for the purchase of described psychotropic medications.

7. **Psychosocial Rehabilitation Programs**
   Services designed to help the person with high-risk, long-term mental illness acquire and maintain life skills that enable him or her to cope effectively with the demands of his or her personal and social environment, thereby improving independence and the overall quality of life.

8. **Social Support Activities**
   Ongoing activities to ensure the development of a social network that provides the person with mental illness with companionship, social activity and a "Support Safety Net" within the community during times of stress.

9. **Independent Living Skills**
   Activities designed to increase the ability of persons with mental illness to independently accomplish those tasks or activities demanded of them by the general community.

10. **Vocational Skills Development**
    Services that provide the person an opportunity to develop and use work related skills.

11. **Pre-vocational Training**
    Training that develops skills prerequisite to learning more formal vocational skills.

12. **Vocational Training**
    Training designed to develop vocational skills in a particular vocational area, either through formalized instruction, practical experience or actual experience on the job.

13. **Case Management**
    A system in which a single individual is identified to the client and his/her family to be available and accountable to both the client and the system. They are to monitor the client's changing needs, negotiate services, assist in problem solving, and assure that linking and coordination occur. This does not imply that the case manager:

    a. Provides all services that are needed
b. Attempts to take over the rights of the client, family or natural support system

c. Takes over or down plays the roles of other mental health team members

Priority to receive case management is to be given to persons who demonstrate characteristics such as dependency upon external public support systems, multiple hospitalizations, commitments for reasons of dangerousness, and long-term hospitalization.
WARRANT OR DOCKET #: 

THE STATE OF TEXAS
(FORE THE BEST INTEREST
AND PROTECTION OF

IN THE MUNICIPAL COURT
CITY OF SAN ANTONIO
BEXAR COUNTY, TEXAS

WARRANT FOR EMERGENCY DETENTION

THE STATE OF TEXAS: To Any Peace Officer in the State of Texas:

GREETINGS:
You are hereby commanded to apprehend
the person of

and transport said person to

for the purpose of a preliminary examination.

HEREIN FAIL NOT,
but of this Writ then and there make due return,
showing how you have executed the same.
Given under my hand this _____ day of

, 19___.

AM/PM

MAGISTRATE

Type or print the Magistrate’s name here

TO CONFIRM THE VALIDITY OF THIS WARRANT, CONTACT SAN ANTONIO CITY

MAGISTRATE’S CLERICAL OFFICE, 401 S. FRIO, AT 299-7532

PEACE OFFICER’S RETURN

RECEIVED THE _______ day of ________________, 19______, and executed by
apprehending the person, ____________________________, and
transporting said person to ____________________________ for the purpose of a
preliminary examination.

DATE EXECUTED: ________________ TIME: ________________ AM/PM

BY PEACE OFFICER ____________________________
MAGISTRATE'S ORDER FOR EMERGENCY APPREHENSION AND DETENTION

On the _______ day of, ________ 199____, came to be considered an Application for Emergency Detention of the above-referenced person, presented to me by the Applicant therefor.

After examining the Application and any accompanying relevant information, and after having interviewed the Applicant if necessary, I find there is reasonable cause to believe: (1) that the person evidences mental illness or is a chemically dependent person; (2) that the person evidences a substantial risk of serious harm to self or others; (3) that the risk of harm is imminent unless the person is immediately restrained; and (4) that necessary restraint cannot be accomplished without emergency detention.

Thus I find that the person meets all four criteria for emergency detention as set forth in V.A.T.S. Title 6, §462, Section 462.042(b) or Title 7, Subchapter B, §573, Section 573.012(b) of the Texas Health and Safety Code, Part II, 1992 Pamphlet.

It is therefore ORDERED that a Warrant be issued for the immediate apprehension and transportation of the person to the nearest appropriate in-patient mental health or treatment facility for a preliminary examination in accordance with the provisions of V.A.T.S. Title 6, §462.044 or §573.021 of the Texas Health and Safety Code. Part II, 1992 Pamphlet.

If there is no appropriate in-patient mental health or treatment facility available, the person shall be transported to a facility deemed suitable either by the county's mental health authority under the provisions of V.A.T.S. Title 7, §§73.01(c) or to another appropriate facility under V.A.T.S. Title 6, §462.043(d)(2) of the Texas Health and Safety Code, Part II, 1992 Pamphlet.

It is further ORDERED that copies of the application for Warrant and the Warrant itself be immediately transmitted to such facility and that the Warrant shall serve as an application for detention in the facility.

It is further ORDERED that the detention of the above-referenced person shall continue until such time that a physician conducts a preliminary examination, the results of which determine that the above-referenced person, in the written opinion of the examining physician, meets the criteria for further detention pursuant to the appropriate provision of the Texas Health and Safety Code; or until 24 hours has expired from the time the above-referenced person has been apprehended under this ORDER and Warrant for Emergency Detention, unless an application for court-ordered treatment is filed and a written order for further detention is obtained pursuant to the provisions of the Texas Health and Safety Code.

It is further ORDERED that if the initial 24 hour period referenced above ends on a Saturday, Sunday, or legal holiday, then the above-referenced 24 hour period may continue for detention of the above-referenced individual until 4:00 o’clock p.m. on the next day that is not a Saturday, Sunday, or legal holiday.

MAGISTRATE

..Seal..
APPLICATION FOR EMERGENCY DETENTION

CHECK WHICH FACILITY IS USED FOR THE EMERGENCY DETENTION:

- Crisis Center, 711 E. Josephine, San Antonio
- Medical Center Hospital, 4502 Medical Drive, San Antonio
- OTHER

The Applicant, [name and official title of Peace Officer], makes this application for the emergency detention of [name of person to be detained]

who was apprehended on the [day of apprehension] day of [date] at [time of apprehension].

Emergency detention is sought for the following reason(s):

1) I have reason to believe and do believe that the person evidences mental illness or is a chemically dependent person; and
2) I have reason to believe and do believe that the person evidences a risk of serious harm to self or others which is described below:

_____________________________________________________________________

_____________________________________________________________________

3) I have reason to believe and do believe that the risk of harm is imminent unless the person is immediately restrained.
4) My above-stated beliefs are based on the following specific recent behavior, overt acts, attempts, and/or threats:

_____________________________________________________________________

which were observed by me and/or [name of person reporting behavior] reliably reported to me by [name of person reporting behavior] who is related to the Proposed Patient as follows:

Executed on the day of [date], 199, at [time].

[Signature of detaining personnel]

[Signature of Detaining Facility Personnel]
APPLICATION FOR EMERGENCY APPREHENSION AND DETENTION

Now comes ______________________ (an adult person hereinafter referred to as "Applicant") on the _______ day of _______ 199____, and makes application for the Emergency Apprehension and Detention of _______________________.

The Applicant states that she/he has reason to believe and does believe that the above-named person evidences a substantial risk of serious harm to self or others, which risk of harm is specified and described:

The Applicant states that she/he has reason to believe and does believe that the risk of harm is imminent unless the above-named person is immediately restrained; and that the Applicant's beliefs are based upon specific recent behavior, overt acts, attempts, or threats which are specifically detailed:

The Applicant sets forth in detail the relationship between the Applicant and the above named person:

Applicant--Any relevant information is attached to this Application

ATTENTION: Notarization of this Application is not required by V.A.T.S. Texas Health & Safety, Code, Part II, 1992 Pamphlet, neither Title 6 §462.042. “JUDGE’S OR MAGISTRATE’S ORDER FOR EMERGENCY DETENTION” nor Title 7, §573.011. “APPLICATION FOR EMERGENCY DETENTION.” However any Magistrate may act as EX-OFFICIO NOTARY, should the Magistrate desire notarization.
MENTAL HEALTH DEFINITIONS
(OPTIONAL)
MENTAL HEALTH DEFINITIONS

Many of these definitions are taken from the

Alcohol Hallucinosis - Sensory experience or perceptions after a person who suffers an alcohol dependency has stopped or reduced the consumption of alcohol. The most common hallucinations are auditory. The disorder usually lasts a few hours or days and rarely more than a week.

Antisocial Personality - A maladaptive pattern of relating to others characterized by irresponsibility, inability to feel guilt or remorse for actions that harm others, frequent conflicts with people and social institutions, the tendency to blame others and not to learn from mistakes, low frustration tolerance, and other behaviors that indicate a deficiency in socialization. This is one of the more common of the personality disorders. The term replaces the less precise labels psychopathic personality psychopath, and sociopath.

Anxiety - A feeling of uneasiness, tension, and sense of imminent danger. When such a feeling occurs within a person with no specific cause in the environment, it is known as free-floating anxiety. When it recurs frequently and interferes with effective living or a sense of well-being or is otherwise maladaptive, it is known as anxiety disorder.

Avoidant Personality Disorder - One of the personality disorders in which the individual is hypersensitive of potential rejection, has low self-esteem, is socially withdrawn, and is generally unwilling to enter social relationships unless there is assurance of uncritical acceptance. Avoidant personality disorder is an Axis II disorder.

Bipolar Disorder - formerly called "Manic-Depressive Disorder", involves one or more Manic Episodes and usually one or more Major Depressive Episodes. During a Manic Episode, the mood is euphoric, expansive, or irritable and the disturbance in the person's behavior is usually severe enough to impair social and occupational functioning. During a depressive episode, symptoms often include deep sadness, apathy, sleep disturbance, poor appetite, self-esteem, and slowed thinking.

Borderline Personality Disorder - One of the more common of the personality disorders, it is characterized by some of the following symptoms and traits: deeply ingrained and maladaptive patterns of relating to others, impulsive and unpredictable behavior that is often self-destructive, lack of control of anger, intense mood shifts, identity disturbance and inconsistent self-concept, manipulation of others for short-term gain, and chronic feelings of boredom and emptiness.

Compulsive Personality Disorder - A type of personality disorder that has all or many of the following characteristics: perfectionistic behavior, insistence on having others submit to a certain way of doing things, limited ability to express warm feelings or tenderness, preoccupation with trivial details and rules, stinginess, stiff formality in relationships, and poor ability to prioritize and make decisions. This disorder is also known as obsessive compulsive disorder.

Confidentiality - A professional may not disclose information about a client without the client's consent. This information includes the identity of the client, content of overt
verbalizations, professional opinions about the client, and material from records. In very specific circumstances, professional may be compelled by law to reveal to designated authorities some information (such as threats of violence, commission of crimes, and suspected child abuse) that would be relevant to legal judgments. See Tarasoff.

**Decompensation** - The progressive loss of normal mental functioning or coherent thought processes, often culminating in a form of *psychosis*.

**Delusion** - An inaccurate but strongly held belief retained despite objective evidence to the contrary and despite cultural norms that do not support such beliefs.

**Dependent Personality Disorder** - One of the *personality disorders*, in which the individual is generally passive in most relationships, allows others to assume responsibilities, lacks self-confidence, feels helpless, and tends to tolerate abusiveness from others.

**Depression** - A group of emotional reactions frequently characterized by sadness, discouragement, despair, pessimism about the future, reduced activity and productivity, sleep disturbance or excessive fatigue, and feelings of inadequacy, self-effacement, and hopelessness. In some individuals, such traits may be mild, intermittent and undetectable by observers, but in others they may be constant and intense.

**Diagnosis** - The process of identifying a problem and its underlying causes and formulating a solution. In early social work delineation’s it was one of the three major processes, along with study and *treatment*. Currently, many social workers prefer to call this process assessment because of the medical connotation that often accompanies the term "diagnosis." Other social workers think of diagnosis as the process of seeking underlying causes and assessment as having more to do with the collection of relevant information.

**Disorientation** - This term describes a person who is confused about the date, time, where the person is or who they are. Mental Health Professionals often use the phrase 'oriented x3' to indicate a person knows who they are, where they are, and the date.

**Durham Rule** - The 1954 court decision declaring that if a person's unlawful act was the product of mental disease or defect, then the accused is not criminally responsible. This is a modification of the McNaughten rule but is not in effect in many jurisdictions.

**Electroconvulsive Therapy (ECT)** - Treatments administered by physicians, primarily neurologists and psychiatrists, in which convulsions are induced in patients by applying small amounts of electrical currents to the brain. Its purpose is to treat patients when medications and other treatments have not been helpful. Although its use has been significantly curtailed because of the increased use and development of *psychotropic drugs*, ECT, is reported to be effective with certain patients, especially some with mood disorders.

**Guardian** - A person (or entity) who has the legal responsibility for the care and management of another person, usually a child or an adult who has been declared in court to be incapable of acting for himself or herself.

**Guardian Ad Litem** - A court-appointed representative designated to preserve and manage the affairs and property of another person who is considered incapable of managing his or
her own affairs in the course of litigation. The guardian ad litem has no permanent control over the person's property and is considered an officer of the court.

**Hallucination** - Sensory experience or perception of some object or phenomenon that is not really present. Often a symptom of a psychosis, it may involve hearing nonexistent voices (auditory hallucination); seeing objects that are not there (visual hallucination); smelling (olfactory hallucination); tasting (gustatory hallucination); and touching (haptic hallucination).

**Ideation** - The process of developing a belief. For example, a person with suicidal ideation is one who starts thinking about death, about wanting to die, and about specific actions that will help to reach that goal.

**Ideas of Reference** - An inaccurate belief that the behaviors of others or environmental phenomena occur to have some effect on the individual. For example, a man encounters two strangers who are conversing and assumes they are talking about him. This is a form of delusion and sometimes appears as a symptom in delusional (paranoid) disorder, schizophrenia, histrionic personality disorder, and in people who have profound feelings of inadequacy.

**Inappropriate Affect** - An effect is considered inappropriate when it is not consistent with the content of speech. One example is when a person starts giggling when discussing an interpersonal conflict or reason for hospitalization. This symptom should not be confused with mere embarrassment or excessively strong affect.

**Insanity** - A legal and lay term used to indicate the presence of a severe mental disorder in an individual. Used as a legal term, the mental disorder is considered to be so serious as to negate the individual's responsibility for certain acts such as criminal conduct. The person declared legally insane is thought to lack substantial capacity either to appreciate the wrongfulness of a criminal act or to act in conformity with the requirements of the law. Used as a lay term, insanity is roughly synonymous with "crazy" or "psychotic." It is not used by mental health professionals in their diagnosis nomenclature. See also McNaughten rule.

**Loose Association** - A term pertaining to the tendency to shift abruptly from one thought to another, with little, if any, apparent direct connection between the thoughts. Loose association is sometimes symptomatic of severe anxiety or depression and in its more severe forms can be symptomatic of psychotic processes or primary process thinking.

**Magical Thinking** - A belief that the thoughts, words or acts of the person will cause some specific consequence that is highly unlikely. An example could be someone who believed that if they looked at another person, they would destroy that person's soul. This reaches delusional proportions when the individual maintains this belief in the presence of contradictory evidence.

**Manic Episode** - A period during which a person behaves in an agitated, excited, hurried, impatient manner and seems euphoric, assertive, verbal, and hyperactive. During this phase, the person's judgment and appropriate precautions are minimal, often leading to conflicts with others.
McNaughten Rule - A set of legal principles for the guidance of courts in helping to determine whether or not a defendant may be declared innocent by reason of insanity. Based on the 1843 British case of Daniel McNaughten, the accused is considered not responsible for the crime if "laboring under such a defect of reason from disease of the mind as not to know the nature of quality of the act; or, if he did know it, that he did not know that what he was doing was wrong." Some jurisdictions use different criteria for judgments in insanity pleas. For example, the American Law Institute's formulation states that "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law."

Mental Disorder - Impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, or social. Mental disorders are extremely variable in duration, severity, and prognosis, depending on the specific type of affliction. The major forms of mental disorder include mood disorder, psychosis, personality disorders, organic mental disorders, and anxiety disorder.

Mental Status Exam - A systematic evaluation of a patient's level of psychosocial, intellectual, and emotional functioning. The examiner, who is usually a psychiatrist or (physician) who observes the patient's affect, thought content, perceptive and cognitive functions. This may be done, in part, by asking such questions of the patient as, "What day is today?" and "Where are you now?" The patient may also be asked to repeat a series of numbers forward and backward and to interpret several aphorisms, such as, "People who live in glass houses shouldn't throw stones."

Multiple Personality Disorder - A mental disorder in which an individual has two or more distinct personalities. The individual may not be aware of the existence of these other personalities.

Obsessive-compulsive Disorder - A type of disorder in which the individual experiences unwanted recurrent and persistent ideas; impulses; or images (an obsession); or engages in seemingly intentional behaviors that are performed ritualistically (a compulsion).

Panic Disorder - An anxiety disorder characterized by recurrent panic attack over an extended period in situations in which there is no life-threatening stressor. Symptoms include choking and breathing difficulties, palpitations and chest pains, sweating, trembling, dizziness, and faintness. Often the individual anticipates the onset of such attacks and becomes fearful of situations in which such attacks previously occurred.

Paranoia - A mental disorder whose most prominent characteristics are permanent and unshakable suspiciousness and persecutory delusion, but in which the individual is otherwise thinking clearly. This disorder is classed as a delusional (paranoid) disorder and is not to be confused with schizophrenia (paranoid type) or paranoid personality disorders.

Psychiatrist - A physician (M.D. or D.O.) who specializes in the treatment of mental disorders. The psychiatrist makes specific diagnoses of the mental disorder and prescribes, supervises, or directly provides the necessary treatment, which may include psychotherapy, psychotropic drugs, hospitalization with milieu therapy, and other
medical treatments. Qualifications to be a psychiatrist include four years of medical school and four or more years of approved residency training, usually in mental hospitals or hospital psychiatric wards.

**Personality Disorders** - Enduring patients of perceiving, relating to, and thinking about the environment and oneself that becomes inflexible and maladaptive and causes significant functional impairment or subjective distress.

The odd and eccentric disorders include

1) Paranoid
2) Schizoid
3) Schizotypal

The dramatic, emotional, or erratic disorders

1) Anti-social
2) Borderline
3) Histrionic
4) Narcissistic

The anxious and fearful disorders

1) Avoidance
2) Dependent
3) Obsessive compulsive
4) Passive aggressive

**Psychologist** - One who studies behavior and mental processes and may apply that knowledge to the evaluation and treatment of a mental disorder. To become a psychologist a person must obtain an academic degrees in psychology, either a master's degree or a Ph.D or PsyD degree from an accredited academic institution. This is usually followed by a requirement of two years supervised work experience.

**Psychosis** - A group of serious and frequently incapacitating mental disorders that may be of organic or psychological origin and are characterized by some or all of the following symptoms: impaired thinking and reasoning ability, perceptual distortions, inappropriate emotional responses, inappropriate affect, regressive behavior, reduced impulse control, impaired reality testing, ideas of reference, hallucination and delusion.

**Right to Refuse Treatment** - The legal principle, upheld in numerous court cases or contained in explicit statutes in several states, that an individual may not be compelled to undergo any form of treatment, unless there is a life-threatening emergency or the person exhibits seriously destructive behavior. This principle has been applied to people who are involuntarily committed to mental hospitals, prisons, and other institutions.

**Right to Treatment** - The legal principle, established in the *Wyatt v. Stickney* decision, that an individual who is confined in an institution has the right to receive the treatment necessary to offer a reasonable chance for improvement so that the person can function independently and be released from that institution.
**Schizoaffective Disorder** - A *mental disorder* in which the individual has symptoms of both schizophrenia and a major *affective disorder*. This term is infrequently used in diagnosis of mental illness because it lacks necessary precision.

**Schizoid** - A term applied to personality deeply ingrained personality traits that include aloofness, social withdrawal, and indifference to the feelings of others.

**Schizophrenia** - A form of psychosis, not apparently the result of *organic mental disorder* or *mood disorder*. Its typical features include thought disturbances (often including misinterpretation of reality, misperceptions, *loose association*, *delusion*, or *hallucination*); mood changes (inappropriate affect, blunted emotions, inability to empathize, and *ambivalence*); communication problems (incoherence or poverty of speech content); and behavior patterns that may be bizarre, regressive, or withdrawn. The prognosis for complete recovery is extremely rare, although *psychotropic drugs*, *psychotherapy*, and help with social functioning enables most people to live fairly comfortable and somewhat independent lives.

**Seasonal Affective Disorder (SAD)** - A mood disorder, characterized by many symptoms of depression, which affects some individuals during the colder, darker months of the year. Some researchers attribute SAD in some people to deficiencies in needed exposure to light for an extended period of time each day. Treatment for these people may involve moving to sunnier climates or regular exposure to special light-emitting equipment.

**Schizotypal Personality Disorder** - A type of personality disorder in which the client shows many of the symptoms of schizophrenia, including disturbances of thought, perception, and speech, but not as severe. Typical but not inevitable traits are ideas of reference, paranoid ideation, magical thinking, strange fantasies, eccentric or peculiar behavior, and social isolation. The diagnostic terms borderline schizophrenia, latent schizophrenia and simple schizophrenia have been replaced by this term.

**Tarasoff** - The 1976 ruling by the Supreme Court of California (in the case of *Tarasoff v. Regent of the University of California*) stating that, under certain circumstances, psychotherapists whose clients tell them that they intend to harm someone are obliged to warn the intended victim.
INSTRUCTOR'S ROLE PLAY GUIDE

This Guide is based upon a structured improvisation training approach developed by PACT Training, Inc.

Joyce St. George
Francis P. Canavan
Linda Early
Introduction

This structured improvisation training approach has been successfully utilized in a variety of training situations including preparation of specialized emergency response units and training of airline personnel in handling hostage situations. The method was designed by professionals in the human services to be utilized by trainers from various human services fields. This approach does not require training or previous experience in acting.

This Guide is designed to assist you in implementing Chapter 11, the role play component of the Police Mental Health Training. The Guide serves as a review of the preparation you received in the Train-the-Trainer Program. The material to follow includes essential information about role play as an educational tool, exercises which will help in your preparation for conducting the role plays, as well as a videotape which will interact with the written material to reinforce important points. Remember, role play is a critical component of this training as well as an exciting and challenging learning experience for both instructor and trainee. Careful and thorough preparation for the role play segment will maximize its benefits.

Definition and Benefits

Role playing is the classroom enactment of a structured scenario which is analyzed in a debriefing exercise. The purpose of role play is to build greater knowledge of human dynamics and to facilitate interpersonal skill development.

The use of role playing in this type of training has many advantages since it enables trainees to:

- interact with an emotionally impaired person and experience the feelings this evokes;
- practice the assessment and intervention skills learned in this training;
- make mistakes in a safe environment and develop new skills so as to avoid similar mistakes on the street;
- learn some ways to correct mistakes which might be made in real situations;
- learn from their own experiences and feelings.

It is the instructor's responsibility to create a safe environment and maintain the focus on learning.

There are several potential problems in using role play which should be understood by the instructor and avoided or minimized by the instructor's response to the trainees. Some negative aspect are:

- the possibility that the role play will be treated as "make believe"; the instructor's attitude and presentation of the role play experience should set a serious tone for the trainees;

- the potential for exposing the pathology of participants; it is important for the instructor to know the trainees as much as possible and to maintain concentration and control within the role play experience in order to minimize this type of exposure;

- placing participants in a vulnerable position; maintaining structure and control of the experience and sensitively coaching and debriefing by the instructor will minimize this;
• the potential for unfair and exaggerated criticism of participants; instructors should avoid this type of criticism themselves and control any tendency toward it on the part of the class.

The Components of a Role Play
(Review the Agitated Alcoholic Man segment of the video which illustrates the components of a role play)

To use role play effectively, it is important to understand both the content and structure of the role play. The structure of the role plays includes the roles and the distinct format for each exercise.

In these role plays there are four roles:
1. the emotionally disturbed person (the EDP)
2. the facilitator/resource person
3. the responding officers
4. the audience

Each role play includes four distinct components:
1. Orientation to the role play process in general This is a description of what is about to take place, the structure of the role play, the roles to be taken, and especially the ground rules for this role play experience. (See Summary of Components, page 7 for ground rules.)
2. Introduction to the specific role play to be enacted. This is the process of providing to the responding officers and audience enough information about the scenario to allow them to respond Each role play description in Chapter 11 contains information which is known to the resource person and which can be transmitted to responding officers and audience.
3. The scene. This is the entire actual inter-action between the emotionally disturbed person and the responding officers.
4. The debriefing. This is the critical analysis of the interactions which took place in the scene and feedback to the role players. This is the segment in which the audience can be encouraged to participate and the role players can get effective feedback from their peers as well as from the instructor.
Role Play Guide

Developing the Character

(Review the Disoriented Mentally Ill Person and the Suicidal Person segments of the video focusing on the role player's portrayal of the character.)

Developing and becoming comfortable with the character to be acted out in the role play is the major portion of your preparation. The secret to good characterization is detail; you must know your character in depth and be able to respond to any question or intervention in character.

In developing your character, you must know:

• Who your character is in the past, present, and future. This should include details about:
  • education
  • family background
  • intelligence
  • ethnicity
  • methods of handling stress
  • present and past conflicts
  • response to authority
  • sense of humor
  • fears and pleasures
  • food preferences
  • style of dress and posture
  • mental status and indicators of emotional disturbance.

• What your character wants; his/her goal in this situation.

• How your character will achieve the goal; his/her actions in this situation.

• Why your character wants to achieve the goal; his/her justification.

The following is an example of describing the "what", "how", and "why" of the character of Marie, the suicidal woman:

What: "I want to get them away so that I can commit suicide."
How: Aggressive, manipulative actions aimed at making them go.
Why: "I can't stand the pain in my life."

The plausibility of the character is extremely important. IN THE ROLE PLAY, YOU SHOULD ATTEMPT TO BE THE CHARACTER, NOT SIMPLY ACT LIKE THE CHARACTER. In addition to the preparatory activities, there are other factors which contribute to the credibility of the character:

• External reality: Develop what is happening outside your character, as well as what is happening inside. For example, Inside reality- has Maggie slept or eaten; Outside - is it a hot or cold day?

• Consistency Character's needs should remain the same from beginning to end of scene. For example, if your character is hungry at the beginning of scene, he should be hungry at the end unless that need has been met.

• Motivation: Within the scene your characterization should utilize your preparation regarding the character's motivation to create a sense of urgency about the current action.

• Conflict: Drama is conflict. Your character should have conflicting feelings and needs and display them in the scene. For example, an intoxicated person in Jimmy's situation would be attempting to appear not intoxicated, the psychotic person would be attempting to seem not psychotic, and the suicidal person not suicidal.
• Emotional intensity: Attempt to bring real emotions into your characterization; use your own personal experiences to evoke feelings in your character. (i.e., to cry, allow yourself to remember a painful moment in your life.)

In developing your character, don't take shortcuts. Prepare the character's history, needs, and feelings. Utilize appropriate costume and props to help reinforce the character both for you and for your training audience. Know the character, not the stereotype.

Dramatic Technique
(Review the Indicators and the Dramatic Techniques segments of the videotape.)

After your character is thoroughly developed, you are ready to consider the structure and technique of the role play. In this training the role plays are improvisations since they have no rigid script for either the emotionally disturbed person or the responding officers; this leaves the "EDP" free to respond in character to whatever communications or interventions the responding officers attempt. This flexibility, however, occurs within a structure which is created by the “EDP” role player with the assistance of the facilitator.

The structure is the result of the following components:
• A thoroughly and carefully prepared characterization which allows the "EDP” to respond appropriately and to move the action of the role play forward; the "EDP” knows where he/she wants the role play to go;
• The planful enactment of each of the training points described in the role play description; training points are the learning objectives to be accomplished by the trainees through interaction with the instructor portraying the "EDP”;
• The “EDP's” and the facilitator's leading the trainees to a successful resolution of the crisis; this resolution may be achieved in a number of different ways within the criteria set forth by the general training.

The "EDP" role player and the Facilitator are in control of the role play particularly in the following areas:
• Safety: Safety is a primary responsibility of the trainers. The training environment must be safe for the trainees, both physically and psychologically. Props should look real, but should be articles which are harmless. Stage settings should include a door and tables placed in strategic areas to create a safety barriers. Trainer's responses to trainees should be psychologically supportive and insure that no class member is ridiculed or demeaned.
• Regulation of intensity of emotions: The "EDP" role player should avoid placing the trainee in a position of feeling so threatened that he/she sees the only resolution to the situation as the use of a tactical procedure.
• Management of the action: The facilitator should provide the responding officers with sufficient specific information about the scene to allow him/her to respond, but not so much that he/she has no need to utilize communication and assessment skills to interact effectively with the "EDP.”

There are several techniques which the "EDP" role player and facilitator can utilize to maximize control within the scene and effectiveness of characterization:
• Stage position: the most powerful position is in the center of the stage. Attempt to keep trainees at center stage so that audience can receive full impact of the action.
• Movement: if you want to maximize the effectiveness of your use of emotions, stand still. This will intensify your feeling the emotion and as a result, your ability to convey the emotion more realistically. Pacing or other constant movement tends to defuse the emotion both for you and for the audience. Avoid moving while speaking; it tends to limit the audience's ability to hear and understand you.
• Silence: the most powerful voice is silence.
• Voice projection: the "EDP" role player must make sure he/she and the trainees are heard. This includes being aware of each person's stage position as well as projecting his/her own voice. The "EDP” role player should avoid mumbling and talking to the floor even when enacting the suicidal person, and should use the "EDP's” character to make the trainees speak up. Practice a stage whisper and focus on speaking to the ceiling in situations in which you do not want to make eye contact with the trainees or audience.
• External cueing: the Facilitator and “EDP” Role player should develop signals by which the facilitator can let the "EDP know that he/she can't be heard or seen.
Teaching Role of Role Player I

TEACHING IS THE MOST IMPORTANT ROLE FOR THE “EDP”/ROLE PLAYER I. Role Player I has the responsibility for presenting each of the training points outlined in the role play description so that the trainees are able to utilize their assessment, communication, and intervention skills. THE TEACHING ROLE ALWAYS TAKES PRECEDENCE OVER THE ACTING ROLE IN ANY SITUATION IN WHICH THE TWO ROLES MAY CONFLICT.

The teaching flow of the role play is illustrated in the following diagram.

```
Role Player I                                           Trainee

Training point (cue)                                    Cue accepted

Validation                                             Validation accepted

Move to next training point
```

Role Player I has four specific teaching roles:

1. **Engaging:** capturing the attention of the trainees as the scene begins and sustaining the attention throughout the scene.
   - the role player is attempting to get the trainees totally involved with the role play and to forget that they are in a classroom setting.
   - when the trainees are immersed in their roles, Role Player I can begin to work toward accomplishing the training points.

2. **Cueing:** use of statements, questions, and actions that convey a training point. The cues can be verbal or nonverbal, subtle or obvious, depending upon the characteristics of the particular scene. The cueing process is repeated for each training point until the responding officers respond appropriately to the cue and satisfy the teaching objective.

3. **Validating:** the process used by the "EDP" to acknowledge the actions taken by the trainees in responding to the cues.
   - if the trainees correctly respond, the "EDP" will confirm the response in a verbal or behavioral way and move on to another training point.
   - if the trainees respond incorrectly, the "EDP" will continue cueing, allowing the trainees the opportunity to alter their approach.
   - continuous incorrect or inappropriate response will result in an exaggeration of "EDP" behavior to show the ramifications of the trainee's behavior.

4. **Guiding:** the process of moving the action toward an appropriate resolution. In order to do this, the "EDP" must be one or two steps ahead of the trainees in planning both the timing and content of the next interactions.

In order to perform this teaching role, Role Player I must be continually assessing the response and interventions of the trainees and responding to them appropriately within the character of the "EDP." This process requires Role Player I to maintain concentration and to respond to the "moment," while at the same time planning for advancing the scene toward a resolution.
The following chart illustrates some ways in which the “EDP” can provide cues for training points.

<table>
<thead>
<tr>
<th>Character</th>
<th>Training Point</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jimmy</td>
<td>Setting limits for a manipulative</td>
<td>Asking for more wine</td>
</tr>
<tr>
<td></td>
<td>person</td>
<td></td>
</tr>
<tr>
<td>Maggie</td>
<td>Determining custody or non-custody</td>
<td>Talking in a bizarre way</td>
</tr>
<tr>
<td></td>
<td></td>
<td>about non-threatening topics</td>
</tr>
<tr>
<td>Marie</td>
<td>How to restore control for an &quot;EDP&quot;</td>
<td>Crying, holding gun to head</td>
</tr>
</tbody>
</table>

In this teaching process, there will be time when the trainees will not be responding appropriately to the cues in spite of the efforts of the "EDP." The following are some suggested ways to handle the interaction in some problem situations:

1. If you as the "EDP" are confused about what the trainee is doing or intending, you can appear confused in character and/or, in character, ask trainee what he means.
2. If the trainee is not responding appropriately after extensive cueing and the Facilitator has not stopped the role play, the "EDP" may in character, ask for another responding officer.
3. If the trainees put you into a situation in which your character is threatened and would likely respond in such a way as to cause the trainees to take tactical action, you can turn the action in on you by taking such actions as falling into a fetal position (the psychotic person) or turning a gun to your head (the suicidal person). This will generally cause the trainees to back off and/or signal the Facilitator of your need for help.
4. If cueing is met with undesirable response the "EDP" can demonstrate the ramification of this response through a higher intensity cue.

Role Player II: The Facilitator

*Review the segment which discusses the functions of Role Player II*

Role Player I and the Facilitator must work together to achieve the training objectives of each role play. The Facilitator must know the training points and cues which the "EDP" will present and be able to support the "EDP" in the teaching role during the scene. In order to accomplish this cooperative working relationship, the two role players must rehearse together and become familiar with each of the characters.

The Facilitator acts outside of the role play action and has the following responsibilities:

1. Introducing the role play: In this role the Facilitator provides the trainees with information about the specific role play utilizing the background contained in each role play description. The Facilitator should provide only the information needed by the trainees to begin the scene, leaving room for them to use their assessment and communication skills to obtain other important information.
2. Acting as resource person: In this function, the Facilitator is the trainee’s resource for any additional backup service the trainee may want to call upon (i.e., additional officers, ambulance, etc.). The Facilitator will call upon other class members to serve in these back up service roles.
3. Facilitating the action: This is the primary and most comprehensive task of the Facilitator, and involves:
   - *keeping time* for the scene
   - stopping the action and *coaching* the trainees when the training objectives are not being met and when it is obvious that no movement is going to be made. Coaching involves assisting the trainees to assess the role play action and to consider alternative methods of interaction with the "EDP."
   - recording the action: The Facilitator notes what cues are presented by the "EDP," the skills used by the trainees, and the reactions of the class. In this training, the Facilitator should note information related to all questions on the Role Play Debriefing Sheet.
4. Conducting the debriefing of scene (see "Debriefing the Role Play").
**The Role of Responding Officer**

In the role of the responding officers, the trainees should be instructed to approach and handle the role play scene as if they were responding to a real crisis situation. Their task is to utilize the assessment, communication and intervention skills they have learned. The responding officers should be encouraged to approach the scene as if it were real and handle the situation utilizing the knowledge gained in the training program. The role play process provides the opportunity for the trainees to gain experience in dealing with emotionally disturbed persons. Trainees should be cautioned about the use of "tactical" methods.

**The Role of the Audience**

Although the class is not actively involved in the scene, members play an important role in the learning process. The class members should be instructed to be silent, objective observers of the action, to make notes about cues and skills they observe, and to be prepared to take part in the role play and participate in the debriefing of the scene. Comments from the class and the sharing of experiences among class members can strengthen the learning experience. The discussion between the class and the responding officers can be structured as a process of integrating the emotional learning experience of the responding officers with the more cognitive learning experience of the class.

**Debriefing the Role Play**

Debriefing is the process of analyzing what occurred in the scene for the purpose of expanding and reinforcing learning. The goals of the process are:

1. Reinforcing the good qualities that the responding officers displayed;
2. Pointing out in a very positive way the areas that need improvement;
3. Allowing the responding officers to explain their actions and feelings;
4. Providing the class the opportunity to give their feedback;
5. Integrating the experiences of the officers inside and outside the role play;
6. Recapping the training points that were covered in the role play;
7. Providing additional information the officers may still be lacking in order to effectively handle such situations;

As the Facilitator conducts the debriefing, he/she should follow the points noted on the Role Play Debriefing Sheet for each of the role plays. The debriefing should contain the following phases:

1. Checking on how the responding officer trainees are doing. Always begin with a discussion of responding officers’ feelings whenever the role play is interrupted and at the end of the role play. This reduces the level of stress and excitement, and validates that stress, fear, and anger are normal. Ask role players to share their feelings by asking such questions such as:
   - How do you feel now?
   - What happened?
   - How did you feel about it then?
   - Did others have the same reaction or different reaction?
   - Were there any surprises?

2. Contrasting how they are feeling now to how they would be feeling in a real situation. This process should focus upon integrating the experience of players who have been feeling intensely and trying to think effectively through the stress with the observers who have been able to think through the scene without the intensity of feelings. The trainer might include such questions as:
   - How could you apply that to other situations?
   - What other options are there?
   - How could you make the outcome better?
   - What are the consequences of the options?
   - What modifications can you make work for you?

3. Facilitating the role players cognitive analysis of the role play by helping them to apply information learned in the didactic training and by processing the role play interactions. The trainer might ask such questions as:
   - What is going on?
   - What do you need to know?
   - Would you be willing to try...?
• What would you prefer?
• Can you say that in a different way?
• How did you account for that?
• What does that mean to you?
• How might it have been different?
• Was that effective or ineffective?
• What do you understand better about yourself?
• What did you learn or re-learn?
• What principle did you see operating?
• How does this relate to other experiences?

4. Following up the resolution of the role play situation
   • explore what would be done with subject after the resolution
   • review legal/procedural authority/limitations
   • review possible referral resources

When critiquing the responding officer trainees, the Facilitator should give positive feedback. The audience can often be used to point out inappropriate actions or statements of the trainees. In critiquing actions of trainees which have not been effective in response to the "EDP," the Facilitator might give suggestions for future use rather than negative criticism of present action or point out the potential negative consequences of present action, especially if the action might lead to harm to subject or others.

Conclusion

1. Remember Role Play experience is a learning process. It was developed for two specific reasons: a) to illustrate the behavior of an emotionally disturbed person and instruct police officer trainees in the management of those behaviors; and b) to allow the trainees to practice newly developed communication/assessment skills.

2. The Role Play Training method makes allowances for mistakes. It is better for the trainees to make errors of assessment in the classroom where they can be corrected than to pay a costly price for misjudgment in the streets. Keep in mind that if the experiences are not advancing the trainees' proficiency, it is not the fault of the trainee; it may be the process. Therefore, it becomes the responsibility of the trainers to adjust the role play so that the trainee has a good vehicle to test those newly developed skills, and the trainer has a good vehicle to impart information.

3. Both the facilitator and the trainer acting as the emotionally impaired person must master the knowledge of all the materials contained in the manual. The role play technique is an effective training method, particularly when experience is well planned, enacted, and managed by prepared skilled instructors.
## Summary of Components

<table>
<thead>
<tr>
<th>Components</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation</td>
<td>1. Become familiar with scripts</td>
</tr>
<tr>
<td></td>
<td>2. Rehearse</td>
</tr>
<tr>
<td></td>
<td>3. Assemble Props</td>
</tr>
<tr>
<td>Conducting the Role Play</td>
<td>1. Describe the role play process</td>
</tr>
<tr>
<td>Orientation</td>
<td>2. Describe the expectations of role players and audience.</td>
</tr>
<tr>
<td></td>
<td>3. Explain <em>Ground Rules.</em></td>
</tr>
<tr>
<td></td>
<td>a) Role plays will be conducted in a safe environment; there will be</td>
</tr>
<tr>
<td></td>
<td>no weapons present in the room during role plays.</td>
</tr>
<tr>
<td></td>
<td>b) Situations will not be &quot;black and white,&quot; but will deal with &quot;gray</td>
</tr>
<tr>
<td></td>
<td>areas.&quot;</td>
</tr>
<tr>
<td></td>
<td>c) Facilitator will be available to role players at all times.</td>
</tr>
<tr>
<td></td>
<td>d) Situations will be played as realistically as possible; vulgar</td>
</tr>
<tr>
<td></td>
<td>language, ethnic/racial, sexual slurs, etc. are likely.</td>
</tr>
<tr>
<td></td>
<td>e) Role plays focus on development of communication skills; they are</td>
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<tr>
<td></td>
<td>not designed as tactical exercises.</td>
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<td></td>
<td>f) Facilitator will step in if players decide to take tactical action.</td>
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<td></td>
<td>g) Any player may end role play at any time if necessary.</td>
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<td></td>
<td>h) Class is expected to be actively involved in debriefing.</td>
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<tr>
<td>Introduction</td>
<td>1. Describe the scene of specific role play.</td>
</tr>
<tr>
<td>Role Player 2 - The Facilitator</td>
<td>2. Describe the behavior of the “EDP” which resulted in call to police</td>
</tr>
<tr>
<td>The Scene</td>
<td>department.</td>
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<tr>
<td>Role Player 1 - The &quot;EDP&quot;</td>
<td>1. Engage, capture attention of the trainees.</td>
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<td>2. Cue training points.</td>
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<td>3. Validate appropriate responses.</td>
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<td>4. Guide action toward an appropriate resolution.</td>
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<tr>
<td>Role Player 2 - The Facilitator</td>
<td>5. Keep notes on the interactions of the role play and accomplishment of training points.</td>
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<td>6. Coach when necessary to discuss with role players what seems to be</td>
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<td>going wrong and how to adjust approach to the &quot;EDP.&quot;</td>
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<tr>
<td>Debriefing</td>
<td>1. Give support and validation to role players</td>
</tr>
<tr>
<td>Role Player 2 - with contributions from Role Player 1</td>
<td>a) ask them to talk about how they are feeling;</td>
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<tr>
<td></td>
<td>b) validate that anxiety, fear and anger are normal feelings.</td>
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<td>2. Evaluate role play</td>
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<td>a) explore what action would be taken after resolution</td>
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<td>b) review legal and procedural limitations</td>
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<td>c) review possible referral resources.</td>
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PART TWO

SENSITIZING POLICE OFFICERS TO PERSONS WITH DEVELOPMENTAL DISABILITIES

A Curriculum Guide for Law Enforcement Trainers

University of North Texas Department of Rehabilitation, Social Work and Addictions

Donald R. Louis Rosalva Resendiz

February, 1997
CHAPTER 12: INTRODUCTION TO DEVELOPMENTAL DISABILITIES

Overview

Police work is very complex in that it requires a constant and changing responsiveness to circumstances, and further, the community policing model is placing new and additional demands on police officers. Regardless of the model with which the officer is working, the police play a central role in our democratic society. The police are called upon to enforce our laws, to observe constitutional restraint upon the exercise of governmental power, to answer individual calls for help, and to respond to community demands for safety.

According to Jeremy Travis, Director of the National Institute of Justice, "of all governmental operations, the police function is the most intimate--the daily, varied encounters between police officers and individuals, ranging from routine to traumatic, represent the most visible and powerful interactions between the government and the public. If the police perform their role effectively, our society benefits immeasurably; if the police perform their role poorly, the damage to public confidence and democratic principles can be irreparable (p.1)."

America develops yardsticks for its major concerns. We measure everything from the productivity of factory workers to rates of infectious illness to the endurance of athletes. A wave of concern is elevating to consciousness the injustices, frequently and perhaps very innocently, dealt to persons with developmental disabilities that confront the criminal justice system. A lack of awareness regarding the nature of disabling conditions, the existence of services, the need for special programs for offenders with life-long disabilities and the inability to recognize behavior that signals a need for special evaluation of an accused have been found nationwide. This lack of awareness has contributed to persons with developmental disabilities suffering gross injustices, which far exceed the injustices, suffered by any other class of offenders. This training material is not designed to advocate for a dual standard, rather that of an increased understanding by police officers of the unique characteristics of persons with life-long disabilities might contribute to their experiencing equal justice.

The road from institutionalization to community inclusion for persons with any of the cluster of developmental disabilities (DD) has been long, complex and fraught with unforeseen difficulties. The policies of deinstitutionalization, first implemented over 25 years ago and designed to transfer the care of persons with developmental disabilities from large state institutions to local communities, have affected many public and private groups of society. A few groups have found themselves with a disproportionate amount of additional responsibilities not always with a concomitant allocation of resources. The various levels of law enforcement are reflective of this action as personnel were left untrained regarding the unique characteristics of persons with life-long disabling conditions.

One such problem is the percentage of persons with developmental disabilities confronting the criminal justice system which is frequently reported as approaching seven times the corresponding number in the general population. At the same time, most
authorities argue that those with life-long disabilities are no more likely to commit crimes than those without disabilities.

Community inclusion implies that persons with DD are both in and of the community. As citizens they are entitled to the same rights and privileges under the law as the non-disabled. Currently, in most states, criminal justice personnel receive adequate training on mental illness, yet virtually no training about the characteristics of persons with DD. This absence of training has led to undue hardships for the DD community in experiencing equal treatment within the criminal justice system.

Because of community inclusion, on any given shift, the possibilities that law enforcement officers may encounter persons with life-long disabilities is greater than it has ever been. Many police authorities report that as much as 80 percent of police calls and accompanying responses do not involve a criminal act. Thus normal policing activity will expose officers to encounters with persons exhibiting confused behavior, an inability to communicate or a variety of behaviors inappropriate to time and place. There may be many causes of behavior of which some are indeed illegal, however the majority of instances involve persons with impaired mental and physical abilities.

Many of the problems that surface for law enforcement officials are due to the officers' unfamiliarity with the real nature of these episodes. Police may interpret dazed behavior, inability to obey directives and a combative response to restraint as conscious actions. Police are likely to react with force and may try to arrest the person who perhaps is having a seizure (as an example). Such response is humiliating to all persons involved and may precipitate unwanted injury and lawsuits. In a few instances, the failure to recognize a developmental disability has had fatal outcomes.

The key to a more appropriate law enforcement response to the five percent of the population with life-long disabilities is training. Such training involves a basic understanding of the major categories and how to identify each, accompanied by appropriate communication strategies. This material is designed to give the law enforcement officer an additional tool when responding to a call involving a person with DD.

Law enforcement officers are likely to encounter people with DD in a variety of settings and circumstances. The aim of this material is not to suggest that every episode involving a person with DD is justified, which would be both incorrect and unrealistic. Rather the intent is to raise law enforcement officers' awareness of the possibility that the persons, are in fact persons first, and that they possess unique traits that require understanding.

Although implementation of a new approach (paradigm) cannot be accomplished overnight, planning efforts that ignore an emerging paradigm build obsolescence into future plans. Persons with disabilities are citizens, entitled to full protection, rights and privileges under the law. Consequently, the need for informed and sensitive police officers is self-evident.

"Sensitizing Law Enforcement Officers To Persons with Developmental Disabilities" is a comprehensive training program for police officers designed to increase the officer's awareness of the unique characteristics of persons with life-long disabilities. The goal of the material is to give officers a working knowledge and understanding on how to interact while in the line of duty with persons who are disabled. The background material gives a brief overview of the characteristics and ramifications of each of five categories of
HOW TO USE THIS MATERIAL

This material was developed so as to be self-contained, with this being the instructor's material and with a separate trainees guide for participants. At various interval in the material, a reference is given to a specific page in the learner's guide for participants to turn to for the completion of an activity. Individuals who train law enforcement officers to handle calls involving persons with developmental disabilities should possess a mixture of skills and information, along with specific knowledge about law enforcement and the criminal justice environment. In addition to being able to lead a discussion and encourage increased awareness, the trainer should display sensitivity to law enforcement officers training needs and personal biases.

The material was designed for one (1), eight(8) hour session of advanced law enforcement officer training in the state of Texas. It contains six major sections that are the result of state-wide fact finding research undertaken by the authors prior to the development of this material. While developmental disabilities are numerous by categories, the authors' findings from five community forums held in key Texas cities suggested that five major categories should be addressed. This material is organized by beginning with (1) an overview of DD, followed by sections on (2) mental retardation, (3) autism, (4) cerebral palsy, (5) epilepsy and (6) hearing impairments.

Confucius (551-479 B.C.), the Chinese philosopher gave words of wisdom that have stood the test of time in professional training. He said, what I hear I forget, what I see I understand, what I do I remember. This material contains elements of all three as it includes lecture material assisted with a generous number of transparencies to emphasize key points. In addition, it includes the use of three videos and a brief activity at the close of each of the six sessions.

Each section of this course is designed to meet the specific objectives of assisting with identification and communication with persons with developmental disabilities. The objectives are of two broad types. The first type refers to what officers should know about responding to persons with DD, and the second is to give them an opportunity to practice using the material just covered.

It is suggested, that the instructor use one of several possible methods to acquaint participants with local and regional resources. One method may possibly be the use of a handout containing a list of agencies such as the nearest MHMR office and agencies such as the local chapter of United Cerebral Palsy, the Autism Society, etc. Another suggestion could be the use of a speaker such as a representative of the local community-based MHMR agency making a brief presentation during one of the sessions focusing their remarks on resources available in that community for persons with developmental disabilities.

Evaluation of this session will consist of two parts. We are asking for you to administer a 25 item true-false test prior to the beginning of the session and the identical instrument again at the close. Ask the participants to place their initial in the upper right hand corner for ease of matching instruments for comparison purposes. This will give the authors a chance to examine the effectiveness of the material. In addition, we are asking that the second quiz be accompanied by a one page questionnaire whereby participants can
quickly and anonymously give their evaluation regarding the effectiveness of the session.

**METHOD OF PRESENTATION**

- Video
- Lecture/Discussion

**RESOURCES SUGGESTED**

**VIDEOS FOR THIS CHAPTER**

- **Making Contact: Communicating with Adults with Mental Retardation**
  Suncoast Media
  12551 Indian Rocks Road #15
  P.O. Box 990
  Largo, Florida 34649
  Telephone:
  Officer's Guide: Interacting with Disabled People
  Dayle McIntosh Center for the Disabled
  150 W. Cerritus, Bldg. 4
  Anaheim, CA 92805
  Contact Norm Savage, ADA Project Coordinator
  Telephone: 714-772-8285
  Costs: $49.95

- **Take Another Look: Police Response to Seizures and Epilepsy**
  Police Executive Research Forum
  2300 U Street, N.W., Suite 910
  Washington, D.C. 20037
  Telephone: 202-466-7820
  Fax: 202-466-7826
  Costs: $10.00 plus $3.75 for shipping.

**SUGGESTED GUEST SPEAKERS**

- Local community-based MHMR agency
- Goodwill Industries
- Housing Provider

**INSTRUCTION OBJECTIVES**

Students will:

- Demonstrate a basic knowledge about developmental disabilities and why this topic is important to policing activities.
• Understand the major classifications and identify persons with each of these life-long disabilities.
• Understand basic rules of communications
• Demonstrate knowledge of community resources that provide services to persons with DD.
CHAPTER 13: GENERAL TOPICS IN DEVELOPMENTAL DISABILITIES

PERFORMANCE OBJECTIVE

Given a subject with a developmental disability involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 6 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

ENABLING OBJECTIVES

- Demonstrate general knowledge of the unique factors of persons with any of the major categories of DD.
- Role play with another participant with a DD in a simulated situation with emphasis on identification by category.

*Suggested note to trainer:* Ask participants if any of them has ever had an experience encountering a person with a developmental disability. If someone has, ask them to tell of situation and how they knew the person had a developmental disability. What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:
As an officer, you arrive at a park in response to a call concerning the strange behavior of a young male. You encounter a male, approximately 30 years of age. Although the weather is quite warm, he is dressed in heavy clothes, an overcoat and a scarf. The man is following an older woman, asking her questions typical of those a child might ask. The woman is obviously bothered, and tries to brush him off, but he continues to asks questions, such as "have you seen my friend Bob?"

The officer observes the behavior, and questions the young man. His answers are simple, and stated in the manner of a child. His speech is slightly impaired. The young man explains, rather slowly, that he came to the park to play and has lost his friend. He also explains that he has been asking all the ladies in the park if they have seen his friend. You are asked to resolve the situation. Given the information from this class at this point, attempt to determine if a crime has been committed, identify if the person has a life-long disability. Try to communicate with the person, soliciting basic information, and determine if there is a need for additional community resources. How do you resolve the incident?

The Identification of a person with a developmental disability is not always easy. The majority of basic skills required hinge around discerning the classification of the disability (i.e., mental retardation, autism, cerebral palsy, epilepsy, hearing impaired) and the degree of the condition. The majority of efforts in identification will be explained as the material progresses through the specific disabling conditions. Extra emphasis will be placed on mental retardation as it is the largest category.
IDENTIFICATION OF A PERSON WITH DEVELOPMENTAL DISABILITIES

IDENTIFICATION TIPS-DD

Identification of a person with a developmental disability is not always easy, therefore some things for the officer to keep in mind include:

- Identification of a person with DD is most difficult when encountering someone who is mildly retarded.

- Persons with mild retardation are streetwise and are very clever at masking their limitations.

- Be familiar with the names of state schools, community based programs, special education programs, group homes, and respite programs in your area.

- Know local jargon relevant to group homes

- The person may not want their disability to be noticed.

- The person may be overwhelmed by police presence

- The person may be very upset at being detained and/or try to run away.

The officer should also observe for physical appearance:

- Is the person appropriately dressed for the season?

- Does the individual show any physical defect, that is, unusual physical structures?

- Does the individual appear uncomfortable with his/her body, or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?

- Does the individual have a slow reaction to such stimuli as questioning?

- Inquire about education level.

- Ask if the person was in special education classes or vocational education.

- Obtain information from the person while conversing about his or her family and childhood history.

- Are there obvious speech problems?

- Is the person attentive?

- Does the person exhibit an inability to use abstract reasoning?

- Observe for social behavior

- Is the person easily frustrated?

- Does the person avoid questions concerning a disability?
BACKGROUND INFORMATION
Before this session goes further, everyone needs to familiarize themselves with a working knowledge of what constitutes a disability as related to an impairment and a handicap.

IMPAIRMENT
Term used to define a deviation from normal, such as not being able to is the correct make a muscle move or not being able to control an unwanted movement. Impairment refers to a loss of physical or physiologic function at the organ level. Impairments exist in varying degrees and may or may not affect one's functioning.

DISABILITY
Term used to define a restriction in the ability to perform a normal daily activity that someone of the same age is able to perform. If the impairment is so severe as to inhibit the person's ability to function, then we have a disability.

HANDICAP
Term used to describe the condition of a person who, because of the disability, is unable to achieve a normal role in society appropriate to his or her age and environment.

Note: Obstructions in the pursuit of independence can arise when the person with a disability confronts public buildings that are not accessible to wheelchairs, or policies that limit participation. There are no handicapped persons, only handicapping conditions imposed by society. Stair steps are handicaps for persons in a wheelchair.

THE IMPACT OF CHRONIC CONDITIONS

AN IMPAIRMENT IS AT THE ORGAN LEVEL.
In most cases, during the course of this study we are talking about the central nervous system. When the impairment is severe enough that it impacts the person, we have a disability. When a person's disability is severe enough, the person with the disability impacts the family. Every family that has raised a child with a developmental disability is permanently changed. Society is impacted when services are needed.

DD DEFINED
A developmental disability is a severe chronic disability attributed to a mental or physical impairment or a combination of these factors. The onset occurs before the age of 22, and results in substantial functional limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.
In addition, a developmental disability reflects:

6. the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and,

7. in that such term, when applied to infants and young children means individuals from birth to age five, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

➢ A WAY OF UNDERSTANDING DD

8. A good way to understand a DD is to think of it as:
   • A condition that an individual may have had since birth or childhood,
   • Which during adulthood has prevented him or her from being fully independent, socially or vocationally,
   • And which continues on into old age.

9. Persons with life-long disabilities have experienced increased visibility in the community only in recent years. Multiple forces have converged to place emphasis on the needs of this subpopulation from the perspective of persons employed in the field of law enforcement.

The major underlying reason for police to be informed about DD is that for the first time in our nation's history, we have escalating and very significant numbers of persons with DD who are entering the public school systems. Multiple reasons are thought to be involved in this phenomenon that includes higher rates of births from teenage mothers, mothers involved in substance abuse during the prenatal period, and improper care during the early years. Because of high-tech medical intervention, which includes the control of respiratory infections, large numbers of developmentally disabled persons are living beyond middle age. Previously death came earlier, usually because of respiratory complications. In summary, the number of persons with DD is increasing rather significantly.

A second factor has evolved as the result of social research. In previous decades, large numbers of persons with developmental disabilities were institutionalized in state schools and/or large intermediate care facilities for the mentally retarded (ICF/MRs). The results of continued research have indicated that the grouping of persons with like disabilities contributes nothing to either the quality or quantity of their social exchanges. Social exchange, regardless of the size of the facility, occurs between staff and client, not client to client. Furthermore as providers attempted to quantify quality of life issues, it was found that those with the more severe disabling conditions needed and benefited the most from integration into the community.
The third factor and an emerging social problem that is a precipitate of the community inclusion model is the growing number of persons with DD involved with law enforcement agencies and/or the criminal justice system. Not only are their numbers an extreme exaggeration to their naturally occurring percentages in society at large, countless lives have been lost in confrontational occurrences because the criminal justice system is lacking appropriate training involving situations where persons with DD are at the focal point. Providers of services to persons with DD agree that persons with DD are no more prone to criminal behavior than their non-DD counterparts (Reid, 1987).

The term developmental disability first appeared in federal legislation in 1970 and included three categories of individuals that had previously been treated as distinct populations - those with mental retardation, cerebral palsy and epilepsy. By 1975, individuals with autism and dyslexia were included among the populations considered developmentally disabled (Gelman, 1986). In 1978 the definition shifted from one focused on distinct diagnostic classifications or labeled disabilities to a more inclusive description that centered on severe and chronic disabilities. The word severe is generally implies the need for assistance in three of the important areas of life as shown below. Chronic generally implies that a condition is long-term in nature.

The word development must be distinguished from growth. Growth refers to an increase in physical size. Development has multiple connotations with the primary reference in this case to the normal developmental period of life. Implied in this case is also the implication of an increased control the person has over the physical body and the thought processes. It is in this area that the word takes on additional meaning when the normal evolutionary process for an individual is impeded and/or lacking to a noticeable degree. While the sequence of development is the same for all children, the rate of development varies from one person to another. An example depicting lagging development with a motor skill is when a child must learn to sit before it learns to walk. This involves the discarding of primitive reflex and replacing it with the development of a voluntary movement. Persons with developmental disorders involving a motor skill experience a persistence of involuntary reflexes beyond the usual age.

- FOUR TYPES OF SKILLS

The developmental period involves gaining mastery of four major types of skills:

- Gross motor - such as walking, running, sitting
- Fine motor - such as picking up small objects
- Communication - capacities needed to understand others
- Social - necessary for interacting with others.

Development of these skills occurs simultaneously to prepare a person to meet physical, social, linguistic and emotional demands. Gross motor skills involve the use of large muscles in such activities as sitting, running, walking, and other activities. Fine motor or adaptive skills involve the use of small muscles such as in the fingers and hands, and include manipulative skills, such as those used for feeding and dressing, skills that are necessary to interact effectively with the environment.
Communication skills are the capacities needed to understand others and express oneself. Communication skills are both verbal and nonverbal and are used in understanding both simple and complex instructions. This area encompasses the development of receptive language, which is the ability to receive and process information, and to understand its meaning. Communication also includes expressive language or the ability to transmit information. Social skills are the skills necessary to interact with others. Adults with developmental disabilities, for a variety of causes, failed to master control of their lives because the development of these skills did not progress. A developmental disability refers to any disability appearing early in life that impedes on the child's development. It is important to remember that it is not the clinical diagnoses that is critical, rather one's functional ability.

Because (as shown above) of their severe and chronic impairments, individuals with DD are more vulnerable and less able to reach an independent level of existence as compared to their non-disabled peers. The four skills listed are sufficiently acquired during the early years, which is not the case for persons with DD. Families of persons with DD bear the major responsibility for providing or arranging for care and services. The extent to which persons with DD reach their full potential in education, independent living and employment reflects the persistence and resourcefulness of families in advocating on behalf of their family members with disabilities.

In the United States, there are approximately 40 million persons with disabilities that are significant enough to limit or restrict functioning to some degree. This figure represents 15 percent of the general population. The onset of a disabling condition can occur at any point, prior to or during the developmental years, throughout mid-life and in the retirement years. This material is about the unique characteristics of persons whose onset is prenatal or during the first 22 years of life. This is generally thought to be about five percent of the general population.

**CATEGORIES OF DEVELOPMENTAL DISABILITIES**

- **DD ENCOMPASSES A WIDE VARIETY OF CONDITIONS**
  - Mental retardation
  - Autism
  - Cerebral palsy
  - Epilepsy
  - Deafness
  - Blindness
  - Orthopedic impairments
  - Learning disabilities
  - Other neurological/sensory impairments

Prevalent developmental disabilities include mental retardation, autism, cerebral palsy, epilepsy, (thus the acronym MACE) and other neurological impairments.
Developmental disabilities encompass a variety of other conditions that include blindness, deafness, orthopedic impairments, learning disabilities and other neurological and sensory impairments. This training session will examine the unique characteristics of five categories most likely to be confronting the law enforcement officer: mental retardation, autism, cerebral palsy, epilepsy and hearing impaired. All of these conditions can manifest in varying degrees from very mild to extremely severe.

Certain ancient historical concepts of developmental disabilities have been preserved through paintings, sculptures, mosaics and the like. Nearly 4,000 years ago it was common to use dwarfs as entertainers in royal courts, a practice that lasted through the seventeenth century. Naturally, there is no clear record of how many such entertainers had overlapping disabling conditions but, given what is known about genetic influence on dwarfism, and dwarfism itself, it is reasonable to assume that some were at a minimum mentally retarded.

A societal shift in western thinking about persons with DD began to occur about 1700 as the result of viewing them through a scientific concept as opposed to a supernatural one. While well intentioned professionals had widely varying views about persons with DD, they were unanimous in their belief that they could best be served through segregated living arrangements. While an approach of divide and conquer seems archaic, by bringing the majority of the vast assortment of persons with DD into common living arrangements, specialists began to realize the vast differences that existed among those labeled mentally retarded.

Over the past 25 years, services to persons with DD have been in a state of flux. Since the 1970s, experts have been educated and trained to provide highly specialized services to individuals residing in segregated community facilities and/or working and pursuing activities in segregated community sites and programs. The community placement model was a reaction to the earlier custodial mode of treatment that eventually invited litigation (1960s and 1970s) in response to the deplorable standards of care existing in public institutions. And now, in the 1990s, experts recognize best practices as those that offer supports and assistance to participants within inclusive communities.

Inclusive community, or more simply put, the community membership paradigm, is not synonymous with community placement. Community placement was the logical outgrowth of the deinstitutionalization movement of the 1960s and was based on a developmental paradigm. The underlying assumption of this model was that all persons, regardless of their level of disability could learn and grow. Part of this earlier reasoning was that development took place in separate settings within a community that could not be accessed until skills were perfected. That is, specialized services such as sheltered workshops, group homes and rehabilitation services were established to prepare the participant for eventual integration into less restrictive environments. The basic orientation of specialized services was to move the person to a specialized environment where problems could be worked on and skills could be developed. The assumption was made that once people had achieved a higher level of functioning they could move on to a less restrictive setting, typically to a group home or other community facility. To reach a higher level of functioning, skills were taught without regard to the natural context in which those skills would be practiced.
Across time, leaders in the field of DD developed suspicions that separate and specialized settings may have become just another institutionalized system. Few individuals left the sheltered workplace for jobs in the integrated world and fewer yet were found in normalized social settings that included semi or independent housing.

The road from institutionalization to community inclusion for persons with any of the cluster of developmental disabilities (DD) has been long, complex and fraught with unforeseen difficulties. One such problem is the percentage of persons with DD confronting the criminal justice system which is frequently reported as approaching seven times the corresponding number in the general population. At the same time, most authorities argue that those with life-long disabilities are no more likely to commit crimes than the non-disabled. In summary, the majority of persons who were once institutionalized are now living in the community and receiving support as needed.

Community inclusion implies that persons with DD are both in and of the community. As citizens they are entitled to the same rights and privileges under the law as the non-disabled. Currently, in most states, criminal justice personnel receive adequate training on mental illness, yet virtually no training about the characteristics of persons with DD. This absence of training has led to undue hardships for the DD community in experiencing equal treatment within the criminal justice system.

The emerging paradigm, calling for functional development while in the community rather than as a precedent to community inclusion, is based on the assumption that persons with disabilities are more like than unlike the rest of the population. Therefore, work skills are acquired at a job in the community, living skills are developed in the individual's own residence and social skills are learned as the person interacts in social settings within the community. This model has a logical sequence as mainstreaming or community inclusion, and strongly suggests that, as a consequence, larger numbers of persons with DD will be confronting the criminal justice system.

Recently there has been a growing awareness of the discrimination that persons with life-long disabilities face and a recognition that these people have a right to be treated with equal respect and consideration by all members of society. Equal treatment, particularly from a legal aspect, has often been denied because they have not mastered basic communication skills, they are denied linguistic access to the law and its processes, that is, they cannot communicate successfully with those who represent the law.

The prevalence rate of persons in the general population varies by source, by country and by type of measurement. It is generally thought that, when cumulatively considering all types of DD, approximately 5 percent of the general population is involved. Authorities (too numerous to reference) seem to be in agreement that approximately three percent of the population have some degree of mental retardation. Further, most sources report that approximately 90 percent of those with mental retardation as their primary disabling condition test in the range of mild retardation. The primary contributor, in excess of 80 percent of the entire number with mental retardation, is environmental conditions, such as the living environment.
The exact number is also very nebulous as many cases are never reported and many persons have overlapping conditions. The number is also subject to differences depending on whether or not persons with learning difficulties are included. That category tends to be specific to educational environments. To qualify for Medicaid assistance in Texas, an individual must have an IQ of 69 or below (TPCDD, 1991). This is the generally accepted level, determined by standardized tests, to be the cut-off point with a score of 100 considered average.

In the past there has been a lack of awareness and sensitivity among the general public with respect to the words used to describe people with disabilities. Over the past 20 years, however, an increasing amount of attention has been paid to such language, and recently a great deal of attention has been given to issues of education, employment and public access for individuals with disabilities. Because of this evolving awareness and respect, it is no longer acceptable to refer to individuals by their disability, such as the spastic or the epileptic. The current acceptable terminology stresses the individual person first and then the disability second. Person first language acknowledges that there is more to the person than merely the disabling condition. Other terms that are now used and contribute to a more enlightened view is the usage of such terms as mentally challenged rather than mentally retarded.

The definitional issues for police officers need to be understood from another perspective. Our interest in this material is not only the developmentally disabled but the offender with DD. An offender is one who commits an act or offense which is against the law. The criminal justice system by definition must concern itself not only with the physical act or violation but also with the mental state of the alleged person who broke the law. Criminal actions are defined by legislatures to provide punishment for those who commit specific acts in the presence of certain underlying circumstances while possessing certain states of mind. The state of mind is an integral element of a criminal act. In order to be found guilty of a crime, all three elements must be present: the act, the underlying circumstances and that the accused acted knowingly. In other words, the accused must have acted purposely, knowingly, recklessly and negligently in order to be held accountable for an offense. It is for this reason that identification is a key factor in the processing of a person suspected of committing a crime that possibly has a life-long disability.

Once it has been determined that the accused person has a developmental disability, every effort must be made to determine whether the individual’s mental impairment(s) and functional limitations rule against his/her coming to trial. An individual whose mental condition is such that he/she lacks the capacity to understand the nature and object of the proceedings against him/her, or to consult with an attorney, and to assist in preparing his/her defense may not be subjected to a criminal trial. Conviction of an accused who is mentally incompetent, violates their due process of law. In addition, these persons are likely to be targets of victimization by other prisoners.

The number of persons with DD who commit crimes cannot be ascertained with much confidence. Obviously, it is impossible to know if a crime was committed by a person with DD unless the perpetrator is apprehended, tried and convicted. Frequently the apprehended person is not identified as having a life-long disability by the police, the jails, the courts or by his/her attorney. It is not until
the defendant is convicted and sentenced to prison that testing to identify the existence of DD is conducted.

Some authorities believe that the rates of mental retardation as a category are often overstated due to persons likely being frightened, hostile, non-cooperative, having emotional illnesses or symptoms of other conditions at the time they are being tested. Testing is usually done immediately after entering prison and the person has not stabilized or adapted to the new environment.

The following characteristics are known about federal and state prisoners with DD (DHHS, 1991).

- **CHARACTERISTICS OF PRISONERS WITH DD**
  - The majority are male
  - The majority are from minority groups. In Texas 8 out of 10 are either Black or Hispanic. This is probably due to economic considerations.
  - Many defendants come from broken or dysfunctional families and have little community support.
  - Often they develop low self-esteem from performing poorly in school, along with a low level of expectation from family members.
  - The majority have mild mental retardation.
  - Some carry a dual diagnosis of DD along with mental illness
  - Some inmates have additional disabling conditions.

The frequent claim that offenders with DD tend to commit serious crimes is misleading. The above data (overhead) is based on data from federal and state prisons which are likely to receive inmates who commit serious crimes. In reality, the overwhelming majority of offenses committed by these persons are misdemeanors, less serious felonies and public disturbances.

With regard to offenses committed by inmates with DD, crimes of burglary and breaking and entering are the categories that occur the most frequently (Santamour & West, 1982). Homicide ranks as the second highest category of offenses, yet at a far reduced rate compared to the non-disabled prison population. By far the majority of crimes committed are lesser offenses considered petty and generally do not lead to incarceration.

People with mild mental retardation tend to be followers, easily manipulated and often used by others with more intelligence and/or experience. As examples, they may act as lookouts, transport drugs or other contraband, carry a forged check into a bank or attempt to sell merchandise stolen by others. Studies show that persons with DD are not only more likely to be arrested, but also to be convicted and sentenced than are other offenders. Factors for the high conviction rate of persons with DD can be attributed to the primary contact with police officers. Persons with DD are usually the last persons to leave the scene of the crime and are most likely to take responsibility for a crime that they have not committed.

One possible reason that the percentage of persons with DD in prisons is out of proportion to the percentage in the non-prison population is due to probation
policies. Probation is more commonly granted to individuals with higher intelligence and greater educational achievement (Santamour & West, 1982). Persons with DD are generally undereducated and underskilled. Work histories are also a very important consideration, and these persons tend not to have a work history. Therefore, they tend to be considered as poor candidates for probation. Probation is arbitrarily denied on the basis of an unsubstantiated belief in the ability of the person with DD to handle probation. There have been no studies to confirm this falsehood.
CHAPTER 14: MENTAL RETARDATION

Chapter Objectives

➢ PERFORMANCE OBJECTIVE

Given a subject with mental retardation involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 12 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

➢ ENABLING OBJECTIVES:

• Demonstrate general knowledge of the unique factors of persons with mental retardation.

• Role play with another participant with mental retardation in a simulated situation with emphasis on identification and communication.

Suggested note to trainer: Ask participants if any of them have ever had an experience encountering a person with mental retardation. If someone has, ask that person to tell of the situation and how they knew the person had mental retardation? What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an on-duty officer, you are responding to a call at a shopping mall. The store manager of the toy store believes that a middle-aged man has just engaged in shop-lifting and is still in the store. You are told that the suspect has put a small piece of merchandise in his pocket. You approach the suspect, introduce yourself and ask initial questions. The suspect has difficulty answering your questions and begins crying at a low-intensity. You observe that he has a limited vocabulary suggesting that his condition is mental retardation. Proceed with the interview while utilizing some of the performance tasks that you just learned about. If you detect mental retardation, how will you resolve the incident.

Identification of a Person with Mental Retardation

Identification of a person with M-R is not always easy particularly when encountering someone with mild retardation. That is because the majority are in the mild range, therefore a higher degree of interaction between the police officer and the person is required in comparison to trying to determine mental illness. In the majority of cases persons with M-R cannot be identified by physical characteristics.
The identification is often delayed until after the trial and sentencing. This delay may prevent the prosecution, the defense, the judge and jury from appropriately considering the effects of mental retardation such as determining competence and criminal responsibility. Also, persons with mild retardation are streetwise and are very clever at masking their limitations. The following are some general areas to consider in the identification process:

- **PHYSICAL APPEARANCE**
  - Is the individual appropriately dressed for the season?
  - Does the individual show any physical defect, that is, unusual physical structures?
  - Does the individual appear uncomfortable with his or her body or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?
  - Does the individual have a slow reaction to such stimuli as questioning?

- **EDUCATIONAL HISTORY**
  - Check available records
  - When asking for identification--ask for cards issued by city transportation agencies as these ID’s sometimes disclose physical or mental impairments.
  - Obtain information from the person while conversing about his or her family and childhood history.
  - Is the individual in the proper school grade for his or her age? Two or more grades behind in school is evidence that this may be a retarded person.
  - Is the individual in a special education class or vocational class?

- **SPEECH/LANGUAGE PROBLEMS**
  - Does the person have any obvious speech defects?
  - Does the person understand the questions?
  - Are there any signs of deafness?
  - Is the person unable to provide appropriate answers?
  - Does the person offer parroted responses?
  - Does the person understand his/her Miranda rights? Is the person able to explain them in his/her own words?
  - Is the person attentive?
  - Does the person exhibit an inability to use abstract reasoning?
  - Does the person have a limited vocabulary or limited grammatical skills.
- Does the person have difficulty describing facts or details of the offense?

➤ OVERHEAD – SOCIAL BEHAVIORS

- Does the person associate with children or younger persons?
- Does the person seem to want to please?
- Does the person crowd personal space when interacting with others? Are they oblivious to their surroundings?
- Does the person behave in a manner that is inappropriate for his/her age? They often engage in a low degree of crying in a crisis situation. Also they tend to pickup cues from what someone else is doing and mirror the action.
- Is the person easily persuaded or influenced by others?
- Does the person have an advocate, who assumes responsibility or provides help to the person with mental retardation in certain situations? Note: Sometimes he or she may act solitary, but this does not imply unlikable or unfriendly behavior.
- Is the person easily frustrated? They can react aggressively as the result of their perception of fear, which is why officers should use a conciliatory posture. Persons with M-R read a great deal into posture.
- Does the person avoid questions concerning a disability (for example, questions concerning special education and vocational training), remain silent or take a long pause before answering?

➤ PERFORMANCE TASKS

Performance Tasks -- Try to keep the tasks within the context of the situation. Ask the person to:

- Identify himself/herself by name.
- Read and write (read a few sentences in their primary language out of a newspaper or magazine; read a street sign; write their first and last name, address, including the zip code and telephone number)
- Use the telephone.
- Identify his/her number in the telephone book.
- Describe the appearance of someone they know.
- Give directions to their home.
- Name the first four months of the year.
- Repeat five numbers backwards, do not explain backwards.
- Tell time on a regular watch or clock; usually they can not tell time to the minute, neither are they accurate in recalling time.
• Count to 100 by 10’s or 5’s.
• Define some words, i.e., sympathy, deceased, pharmacy, etc.
• Tell you the date, time, month, year and city.
• Make change. How many dimes are in a dollar? How many nickels in a dollar? etc.
• Does the person understand directions?
• Does he/she use public transportation?
• Does he/she have the ability or understand his or her rights upon arrest--that is, the Miranda warnings?

It is important that the officer be sensitive to the dignity of the person. Testing and asking information can be done without making the person aware that he/she is being tested. If the person is unable to do any of the above mentioned, the person will find a way to avoid doing the task (Santamour, 1989). The officer should be acutely aware that the person's failure to succeed in one of these tasks in front of an acquaintance (the professional or a friend) will cost him or her a considerable amount of self-respect. It may cause humiliation or could likely force them into a set of behaviors easily interpreted as a lack of motivation--or maybe even aggression towards authority or the system (Santamour, 1989).

➢ CRIMINAL HISTORY
• Check records and look for evidence that the person has been involved in criminal activity as a follower.
• Has the individual become involved in illegal activity to gain acceptance from others?
• Is the person noticeably older than the other persons involved? Was the individual with younger adolescents at the time of his or her arrest?
• Was the individual the initiator of criminal activity? Was the person a follower? Most often a person with a developmental disability is a follower, not a leader.
• Did the individual show a greater likelihood of confessing to the crime that he or she was charged with?
• Did the person remain at the scene of the crime while others ran? Did the person seem confused about whether he or she had been involved in something illegal?

➢ OFFICER MAKES A DETERMINATION OF M-R

If the officer determines that the person is retarded, what should be done?
• Notify as soon as possible the person's parents, legal guardians or those who provide care for the person.
• If the above is not possible, the officer should attempt to contact a mental retardation agency for assistance.

• If the crime was fairly minor, always try to reach a disposition not involving the criminal justice system. However, the parent/guardian/house counselor should be made aware of the incident and advised to guard against a similar occurrence.

SUMMARY

In general, persons with M-R will provide inferior responses and those responses will be a function of his/her level of retardation. While interviewing the person, the officer should be aware of the person’s reactions to the questions. Nonverbal behavior or body language often providers as much information as the answer itself. Avoiding questions regarding his/her background, such as special schooling or vocational training, large gaps in answers or even silence may all be an indication of retardation. Rephrasing the question once or twice might help get an answer. Obvious reluctance to discuss what might appear to be a simple matter, such as education, is a valuable clue in itself and should not require a constant attempt to help gain a satisfactory answer.

Mental Retardation Defined

MENTAL RETARDATION DEFINED

Mental retardation (M-R) refers to substantial limitations in present functioning. It is characterized by significantly below average intellectual functioning existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work (AAMR, 1992).

Mental retardation is further characterized as a fundamental difficulty in learning and performing certain daily life skills that involve the realms of conceptual, practical and social intelligence. These three areas are specifically affected in M-R whereas other personal capabilities such as health and temperament may not be. A score of 70 or below indicates below average intellectual functioning.

A less complex and less wordy definition of this the largest category of developmental disabilities is:

WORKING DEFINITION

• Significant below average intellectual functioning
• Deficits in adaptive behavioral functioning
• Manifests before the age of 18

The term intellectual functioning is determined by an intelligence quotient (I.Q.) obtained by scores from standardized measures (tests) of general intelligence.
The word quotient has long meant the number resulting from the division of one number by another. In this case quotient, or ratio, is mental age divided by chronological age times 100 (I.Q. = MA/CA x 100). Thus if a person's mental age corresponds to his/her chronological age, as determined by standardized tests, the ratio or quotient would be one (1) times 100. In this manner, an I.Q. score of 100 became the norm and the mid-point of the range between 90 and 110.

**BELOW AVERAGE INTELLECTUAL FUNCTIONING**

Classification of Intelligence

The graphic illustration places approximately 50 percent of all persons in the normal range which requires scores from 90 to 110. Immediately on either side of normal is another 15 percent with those in the range of 80-90 considered dull normal, and those from 110-120 are considered bright normal. The second range out from 100 reflects I.Q. scores from 70-80, labeled border line; superior scores ranging from 120-130. By totaling the percentages under the curve at this point we have 94 percent. The remaining six percent is equally divided: three percent at the low end which are retarded and three percent at the upper end which are very superior. This section is about those at the lower end on the bell shaped curve which show significant sub-average general intellectual functioning.

**PREVALENCE RATE OF M-R**

- **DIVISION OF 3% WITH M-R**

  For many decades it has generally been recognized that three (3) percent of the general population has an intelligence score that falls some degree below average. One of the important facts to keep in mind is that the rate of persons that are incarcerated is far out of proportion to their numbers in the general population. Reports vary from 10 percent to 75 percent with many professionals believing that as much as 30 percent of the prison population is M-R.

  Of the retarded, at least 85 to 90 percent are in the educable mild range with I.Q. scores in the range of 50-69 (about 2.5% of the general population). Of the remaining, about four-tenths of one percent (.4%) is in the range between 30-49 and labeled moderate. One tenth of one percent (.1%) is considered severe or below an IQ of 30. Because all individuals are unique and have different strengths as well as weaknesses, a diagnosis of mental retardation does not imply that all persons in a given range will exhibit equal functional capacities. These levels reflect the degree of difficulty a person has in learning.

- **FUNCTIONING POTENTIAL OF PERSONS WITH M-R**

  It is important to remember about those in the following ranges that they tend not to be violent or substance abusers, and that MR is not a communicable disease.
• Persons who are mildly/moderately retarded:
  ⇒ Differ from non-retarded persons only in their rate and degree of intellectual development.
  ⇒ Should have access to and participate in specialized and generic services in the community.
  ⇒ Can live satisfying and productive lives in the community
  ⇒ Usually lose their identity as retarded when employed and involved in community life.

• Persons who are severely retarded:
  ⇒ Have a substantially impaired ability to learn
  ⇒ Frequently have disabilities in addition to mental retardation.
  ⇒ Have poor judgment and may be subject to exploitation by others.

  Person in the latter category would likely require supervision at home or in employment. If you encounter a person who is severely or profoundly retarded, you should offer some level of protective assistance. Their needs are exactly the same as those of the non-retarded - to be loved, to be important, to be someone, to feel worthwhile, and to have a sense of worth and human dignity.

ADAPTIVE BEHAVIORAL FUNCTIONING

➢ The second criteria necessary in the determination of mental retardation is the presence of limitations in the area of adaptive behavioral functioning. Limitations of this type must exist concurrently with below average intellectual functioning and generally occur within the context of community environments typical of the person's age peers. In addition, these deficits generally are an indicator of the person's individualized needs for supports. Adaptive behavioral functioning refers to the behaviors that a person demonstrates in his or her effectiveness in adapting to the environment.

➢ The limitations in adaptive skills are more closely related to the intellectual limitation than to some other circumstances such as cultural diversity or sensory limitation. Evidence of these limitations is necessary because intellectual functioning alone is insufficient for a diagnosis of mental retardation. The AAMR's criteria states that a significant disability in two or more adaptive skill areas has to exist. The 10 areas of skills are as follows (AAMR, 1992):

➢ ADAPTIVE SKILLS
  • Communication - comprehending what has been said and the ability to express oneself verbally or non-verbally such as with gestures or through
writing. Conversations may appear mundane as much of what the person with M-R expresses is with language that is child-like which is a reflection of their developmental age.

- Self-Care - possesses skills such as eating, dressing, toilet care, grooming, practicing hygiene and other basic needs.
- Home Living - possesses skills such as cooking, budgeting, home care, housekeeping, house chores and contacts with neighbors.
- Social Skills - has use of such skills as fostering friendships, appropriate sexual behavior, typical social exchanges with others.
- Community Use - includes the appropriate use of community services, knowing how to travel in the community and return home.
- Self-Direction - includes being able to follow scheduled activities, learning about the environment where he/she lives, making choices, assertiveness and completing tasks.
- health and Safety - involves a basic understanding of a healthy lifestyle, doing prevention, seeking treatment, following safety rules and being responsible for their own health.
- Functional Academics - possesses the ability to apply the skills that he/she learns such as writing or the use of basic math.
- Leisure - involves doing recreational activities that are self-generated or part of a group.
- Work - can demonstrate the ability to hold a job, improve work related skills and interact with co-workers.

MANIFESTS BEFORE AGE 18

The third criteria of M-R is that the condition must manifest before the person is 18 years of age. This is a deviation from the criteria as set forth in the basic definition of a developmental disability. This age is used as it approximates the age when persons in American society typically assume adult roles as the result of completing basic public secondary education.

POLICE SITUATIONS

Police officers come in contact with persons with mental retardation in four different types of situations:

- Victim of a crime - Persons with M-R are easily taken advantage of which lends itself to being open to suggestions. He or She may be lured into a non-observable area and then robbed or beaten simply because they could not recognize the danger of the situation. Frequently these persons are subject to verbal, physical or sexual abuse. In addition, these persons frequently will not know when he/she has been victimized. It
may be necessary for an officer to explain to a victim with M-R what has happened in order to secure relevant information for a case.

- **Witness** - Persons with M-R can serve as effective witnesses, however, extra patience may be required. The officer should remember that a person with M-R may have a shorter attention span and have problems with abstract thinking.

- **Offender** - Common misconceptions would lead law enforcement personnel to believe that the population that is mentally retarded commits the majority of violent felony crimes. The reality is that the overwhelming majority of offenses committed by these persons are misdemeanors, less serious felonies and public disturbances. Studies show that not only are persons with M-R more likely to be arrested, but also to be convicted and sentenced more than other offenders. Estimates of those found guilty and sentenced run as high as 30 percent (Poelvoorde, 1991). Likewise, persons with M-R may very innocently be involved in a crime thinking that they are doing someone a favor such as transporting illegal substances.

It has been found that many delinquent acts committed by persons who are mentally retarded are due to their level of social and behavioral insight. Also, individuals with M-R are sometimes easily led and intimidated, and may have a desire to please the questioner, which makes them vulnerable when questioned by authorities anxious to resolve a crime.

When encountering a suspect with M-R one should explore every possibility of keeping the suspect out of the criminal justice system. As mentioned earlier, the officer and the entire criminal justice system by definition must concern itself not only with the physical act or violation but also with the mental state of the alleged person who broke the law. Criminal actions are defined by legislatures to provide punishment for those who commit specific acts in the presence of certain underlying circumstances while possessing certain states of mind. The state of mind is an integral element of a criminal act. In order to be found guilty of a crime, all three elements must be present: the act, the underlying circumstances and that the accused acted knowingly. In other words, the accused must have acted purposely, knowingly, recklessly and negligently in order to be held accountable for an offense.

Frequently the suspect may not understand his/her civil rights including the Miranda warning. This fundamental American right potentially poses particular problems when it is only partially comprehended or not understood at all. This is also important as the offender may be so frightened by the police that he/she may be fearful of invoking the protections that are identified, particularly if they are not well understood. In consequence, offenders with M-R may confess to crimes, or provide other information when it is not in their best interest to do so. In some cases it has been observed at the conference that persons with M-R confess to a crime even though they did not commit it (DHHS, 1991). Further, the information they provide is sometimes of doubtful accuracy, not because of an intent to deceive, but because of limited ability to observe, comprehend and express themselves. Since prosecution cases are often based on confessions and information given by accused persons, a failure to utilize the rights provided by the Miranda warning can place offenders with M-R at a severe disadvantage resulting in a miscarriage of justice.
• General police contacts - In all situations, it is extremely important for the officer to proceed in the following manner when encountering a person with M-R.
  ⇒ Make the person feel safe and comfortable in the environment.
  ⇒ Assure the person that you are a friend, and try to calm him/her if agitated.
  ⇒ Use a normal tone of voice, average speech and a non-threatening attitude; this will yield responses to your questions.
  ⇒ Use patience and proceed slowly to be sure the person understands your questions and his/her rights. This is particularly important as generally the police have no problems with persons with M-R and the typical encounter will require the police to be a helper rather than an apprehender.

COMMUNICATING WITH PERSONS WITH MR

VIDEO: Making Contact: Communicating with Adults with Mental Retardation.

➢ INSTRUCTOR NOTES:

This video was done in a medical-type (non-criminal justice) setting and participants should be so informed. The authors of this material believe that it makes some excellent points regarding communication with persons with M-R.

The following are the key points that are worthy of summarizing at the completion of this section:

• Leveling - the officer and the person at the same eye level assists in establishing trust.

• Eliminate as many distractions as possible

• Remove others that might be a distraction - this must be a direct conversation between the two of you.

• Use open-ended simple statements and do not supply answers.

• Provide feedback and be sincere as the person picks-up on this and will tend to respond in an open manner.

The person with M-R presents unique problems to the officer, especially with respect to communication. Part of the dilemma, particularly where an obvious crime has been committed brings the question of what takes precedence. Is the individual to be viewed as an offender with M-R; or a person with M-R who has committed a possible offense? This material takes the position that probably he/she should be viewed as a special offender. In addition, just as there are varying degrees of M-R, so are there varying degrees of communication problems. In some instances very little assistance will be needed.

It is not the intent of this material to detract from the fact that law enforcement personnel, by virtue of his/her responsibilities as prescribed by law has as their first priority that of the protection of the interests of society. Recognizing that there are various levels of competency, yet each act must be dealt with
individually. Regardless, that involves gathering information, much of which involves communication. This material seeks to develop a sensitivity to the communication demands of a situation where a person with M-R is involved. Verbal communication should be emphasized only after any confrontation is stabilized which is the officer's foremost concern. It is after stabilization occurs that a critical analysis can incorporate the concepts used here.

Communication has little value if the sender is the only one who understands what was said. Because what we speak and hear shapes how we think about the world and how we relate to it, our language can be thought of as either a battleground or a meeting place. In operational terms this means expanding and detailing the meanings that a victim, suspect or witness might need to make rather than restricting or controlling possible or expected meanings. Restriction and control of meaning can occur if you do not recognize when a person has not understood what you are saying. This can also occur by failing to recognize that a person, especially with M-R might need an individual style of help or support in order to supply the information you need.

In this context, the officer is cautioned to remember:

- Persons with M-R are first and foremost people.
- Persons with M-R are more like the officer than unlike them.
- They cannot be required to forego any rights or human considerations afforded to everyone else.
- Treat adults as adults, do not treat adults who have mental retardation as children. Give the same amount of respect to a person with M-R that you would give to any other person.
- They are subject to the same influences as the non-retarded.
- They are sensitive to other's speech and actions and will respond in the manner in which they are treated.
- They represent a wide range of descriptors and abilities.
- They should be approached in a positive manner, not be belittled.
- Do not assume that someone with a developmental disability is totally incapable of understanding or communicating.
- Persons with M-R do not like being called retarded or even have the word retardation used in reference to their disability. Use the phrase person with a disability.
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence.
- The person may be very upset at being detained and/or try to run away.
- The person may have difficulty describing facts or details of offense.
• Be aware of a retarded person's reluctance to discuss the matter.
• Be aware of a retarded person's attempts to please others.
• The person usually understands more than he/she can indicate.

➤ OFFICER'S ATTITUDE
• Use an average attitude.
• Use a non-threatening attitude.
• Be patient.
• Take time giving or asking for information.
• Use firm and calm persistence if the person fails to comply or acts aggressive.

The officer's success requires that they recognize that their contribution to the conversation is the key determinant. Persons with M-R will respond better if the officer remembers that their mental age is less than their chronological age, therefore persons with M-R have a much reduced capacity to understand anything abstract. The officer should break information needs into small chunks and use simpler language.

➤ OVERHEAD – TIPS WHEN COMMUNICATING
• When possible, arrange for a quiet and private setting.
  ⇒ This will help the person relax, enable the officer to interview the person, and reduce any embarrassment the person might feel in a more public setting.
  ⇒ Try to calm the person, make the person feel safe and comfortable in the environment, and assure the person that you are a friend.
  ⇒ Avoid any rapid-fire questions - this serves to intimidate or unnerve the person
• Speak directly to the person
  ⇒ Speak slowly and clearly.
  ⇒ Use simple language and vocabulary.
  ⇒ Keep sentences short.
  ⇒ Break complicated series of instructions or information into smaller parts.
  ⇒ If possible use visual aids, picture symbols, diagrams and actions to help convey meaning.
  ⇒ Use concrete terms. Abstract ideas may confuse the person with disability.
OVERHEAD – ADDITIONAL COMMUNICATION TIPS

- Repeat and rephrase questions once or twice.
- Do not badger the person, it might result in uncooperative behavior.
- Ask for concrete descriptions: colors, clothing, etc.
- Avoid confusing questions about reasons for behavior.
- Do not ask leading questions.
- Ask open-ended questions.
- Avoid yes and no questions.
- Be aware of the person's reactions to the questions.
- Listen carefully to the content of the answer.

Everyone has the right to be heard and responded to in a language they understand. It is a challenge of the entire criminal justice system to make that right a reality for people with M-R.

COMMUNITY Resources for Persons with MR

- Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed.

- Many communities will have a local chapter of the Association of Retarded Citizens (ARC). The address of the national office is as follows:

  The Arc
  500 East Border St., Suite 300
  Arlington, TX 79010
  1-817-261-6003
  1-800-433-5255
CHAPTER 15: AUTISM

CHAPTER OBJECTIVES

➢ PERFORMANCE OBJECTIVE:
Given a subject with autism involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 18 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

➢ ENABLING OBJECTIVES:
• Demonstrate general knowledge of the unique factors of persons with autism.
• Role play with another participant with autism in a simulated situation with emphasis on identification and communication.

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with autism. If someone has, ask them to tell of situation and how they knew the person had autism. What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:
It is a weekend morning and you, as an officer of duty, are asked to respond to a 911 call. Upon arriving at the address, you are met at the door by the attendant of a group home housing persons with developmental disabilities. The female attendant tells you that one of the respite residents (there only for an extended weekend), is behaving in a bizarre manner. She states that she only works part-time and that this young man has never been here before. She believes that the tantrum like mannerisms began when she tuned the radio to some hard-rock music. The music is blaring in the background, and it is further observed that there is a broken vase on the floor.

Based on what you have just learned, how would you attempt to assist the attendant? What category of developmental disability do you suspect this to be, and what contributed to the young man having a tantrum?
IDENTIFICATION OF PERSONS WITH AUTISM

General things for police officers to keep in mind as persons with autism exhibit some or all of these symptoms:

- Persons with autism may have sensory
- Persons with autism may have uneven patterns of intellectual functioning (70% of persons with autism have varying degrees of mental retardation).
- Persons with autism may engage in repetitive behavior.
- Persons with autism like a fixed routine
- Persons with autism may have marked restriction of activity and
- Persons with autism do not like to be touched.
- In criminal justice situations the person with autism:
  - May not understand his/her rights,
  - May have difficulty remembering facts or details of offenses,
  - May become anxious in new situations,
  - May not understand consequences of their actions.

Autism is a developmental disorder characterized by three closely related conditions: impaired social relating and reciprocity, abnormal language and communication development and a restricted behavioral repertoire that may include repetitive activities and routines (Stone & Ousley, 1996). Thus autism is a syndrome or a cluster of conditions. The condition is usually diagnosed before a child reaches three years of age.

CHARACTERISTICS OF AUTISM

**IMPAIRED SOCIAL BEHAVIOR**

- Lack of awareness of social rules
- Lack of awareness of or attention to others--staring past things, seemingly at someone else or staring into space or through things and a stand-offish manner
- Poor, unusual or lack of eye contact
- Inappropriate laughing or crying (used as form of releasing anxiety, fear, and tension)
- Flat facial response - emotional response does not match situation
- Trouble with transitions and interruptions
- Resists change in schedule or environment
- Ritualistic behaviors
- Slow to predict consequences
• No fear of real dangers
• Extreme distress for no discernable reason (e.g., crying tantrums)
• Difficulty mixing with others
• Inappropriate attachments to objects
• Deliberate soiling
• Uneven gross/fine motor skills
• Marked physical over-activity or passivity

➢ IMPAIRED LANGUAGE SKILLS
• May be non-verbal or have very limited verbal abilities
• May appear deaf; may not respond to verbal cues
• May repeat words or phrases in place of normal communications
• May have difficulty expressing needs; uses gestures or points
• Inability to understand what others are saying
• Lack of speech or impaired speech patterns
• Impaired pitch, stress, rate, volume or rhythm of speech
• Difficulty with abstract concepts and rational terms
• Indicate needs by gesture
• Generally do not initiate requests
• Pronoun reversals
• Parroting of responses, both literally or as a question
• Poor quality and quantity of receptive/expressive language

➢ AUTISM AND REPETITIVE ACTIVITIES
Persons with autism may have a preoccupation with:
• Matching, pairing and ordering objects
• Blinking compulsively
• Switching lights on and off
• Dropping things repetitively
• Jumping
• Rocking
• Rocking from one foot to another
- Hand-shaking
- Flicking objects
- Chin-tapping
- Head-banging
- Clapping
- Tearing paper
- Breaking glass
- Spinning things, spinning oneself or running in circles
- Fascination for colored and shiny objects

**Major Aspects**

Autism is the least understood of the major categories of DD. While research on this condition has over a 50 year history, much has yet to be learned. Persons with autism are subject to behavioral changes, and these typically represent the occasions when police are involved due to a non-understanding by others. Persons with autism have experienced countless injustices by the criminal justice system, of which many of these incidences have raised the level of awareness on the part of society for the need for police training on all the categories of DD.

The vast majority of research on persons with this condition has been conducted on/with children. Until recently, children with autism never grew up to be called adults with autism. Instead, they were called schizophrenic or mentally retarded, and were usually institutionalized. Why were adults with autism not called autistic? Until recently, there were not residential, training or employment opportunities for adults with autism, so the only way they could receive services was to be labeled something else. Once labeled, the easiest thing to do was to shut them away in institutions.

Now more services are available for adults with autism and as a result more people have finally begun to see adults with autism for who they are. They are people who usually require intensive, continuing training in order to lead fulfilling lives. The more they are capable of satisfying their own needs and wants, the happier they will be. Children with autism usually carry with them into adulthood the same behavior, preferences and demands they have had throughout life. This can be both good and bad as undesirable behavior does not end by entering adulthood. Many adults with autism retain their need for sameness and continue to throw temper tantrums. The good news is that adults with autism do not usually acquire new behavior problems, nor do they lose the progress they have made in controlling their behavior and in meeting their own needs (Holmes, 1989).

Although the diagnostic criteria for autism has become increasingly refined, accurate diagnosis can be complicated by several factors. First, there are no medical tests or biological markers, thus the sole determination is behavioral based. As there are no physiological tests at this time to determine whether a person has autism, the diagnosis of autism is given when an individual displays a number of characteristic behaviors.
Because of its low prevalence, few professionals receive little exposure to persons with autism in the course of their training and are unfamiliar with its behavioral expression.

The second problem arises due to the fact that characteristics and behavioral manifestations often vary as a function of age or developmental level. Diagnostic features prominent during the preschool years may not be the same as those seen in middle childhood. A third factor is that of overlapping conditions between autism and other forms of DD. Lastly, the body of knowledge about autism continues to expand and therefore many facts become outdated.

Many autistic infants are different from birth. Two common characteristics they may exhibit include arching their back away from their caregiver to avoid physical contact and failing to anticipate being picked up (i.e., becoming limp). As infants, they are often described as either passive or overly agitated babies. A passive baby refers to one who is quiet most of the time making little, if any, demands on his/her parents. An overly agitated baby refers to an infant who cries a great deal, sometimes non-stop, during his/her waking hours. During infancy, many begin to rock and/or bang their head against the crib; but this is not always the case.

In the first few years of life, some autistic toddlers reach developmental milestones, such as talking, crawling and walking, much earlier than the average child; whereas others are considerably delayed. Approximately one-third of autistic children develop normally until somewhere between 1 and 1/2 to 3 years of age; then autistic symptoms begin to emerge. These individuals are often referred to as having regressive autism. Some people in the field believe that vaccinations and exposure to a virus, or the onset of seizures may be responsible for this regression.

During childhood, autistic children may fall behind their same-aged peers in the areas of communication, social skills, and cognition. In addition, dysfunctional behaviors may start to appear, such as self-stimulatory behaviors (i.e., repetitive, non-goal directed behavior, such as rocking, hand-flapping), self-injury (e.g., hand-biting, head-banging), sleeping and eating problems, poor eye contact, insensitivity to pain, hyper- hypo-activity, and attention deficits.

One characteristic which is quite common in autism is the individual's "insistence on sameness" or "perseveration" behavior (continuation of something to an exceptional degree). Many persons become overly insistent on routines; if one is changed, even slightly, the child may become upset and tantrum. Some common examples are: drinking and/or eating the same food items at every meal, wearing certain clothing or insisting that others wear the same clothes and going to places away from the home using the same route. One possible reason for "insistence on sameness" may be the person's inability to understand and cope with novel situations.

Autistic individuals sometimes have difficulty with the transition to puberty. Approximately 20% have seizures for the first time during puberty which may be due to hormonal changes. In addition, many behavior problems can become more frequent and more severe during this period. However, others experience puberty with relative ease.

There is no adjective which can be used to describe every type of person with autism because there are many forms of this disorder. For example, some individuals are anti-
social, some are asocial and others are social. Some are aggressive toward themselves
and/or aggressive toward others. Approximately half have little or no language, some
repeat (or echo) words and/or phrases and others may have normal language skills.

In contrast to 20 years ago when many autistic individuals were institutionalized, there
are now many flexible living arrangements. Usually, only the most severe individuals
live in institutions. In adulthood, some people with autism live at home with their
parents; some live in residential facilities; some live semi-independently (such as in a
group home); and others live independently. There are autistic adults who graduate from
college and receive graduate degrees, and some develop adult relationships and may
marry. In the work environment, many autistic adults can be reliable and conscientious
workers. Unfortunately, these individuals may have difficulty getting a job. Since many
of them are socially awkward and may appear to be eccentric or different, and they often
have difficulty with the job interview.

Prevalence of Autism

Autism is a rare disorder, yet its prevalence rate makes it the third most common
developmental disorder. The most cited statistic is that autism occurs in 4.5 out of 10,000
live births (Stone & Ousley, 1996). This is based on large-scale surveys conducted in the
United States and England. However, other recent studies have found substantially
higher prevalence rates, ranging from 10 to 15 persons with autism per 10,000; this
suggests that autism may be more common than previously thought (Gillingham, 1997).
In addition, the estimate of children having autistic-like behaviors is 15 to 20 out of
10,000 (Van Bourgondien, 1987). Interestingly, estimates on the prevalence of autism
vary considerably depending on the country, ranging from 2 out of 10,000 in Germany to
as high as 16 out of 10,000 in Japan. Possible reasons for the discrepancy in prevalence
rates may be due to differing diagnostic criteria, genetic factors and/or environmental
influences.

Autism is four times more likely to affect males than females (Stone & Ousley, 1996).
Gender ratios seem to differ as a function of intellectual ratio, with a higher percentage of
females found at lower intellectual levels. This gender difference is not unique to autism
since many developmental disabilities have a greater male to female ratio.

Autism appears to be distributed equally among all social classes. Early work with this
disorder led researchers to believe that it appeared more often to families of upper social
status. That has since been disapproved as investigators began to realize that upper class
families were probably more likely to have the resources that enabled them to find
programs that involved diagnostics. Recent trends toward increased recognition of
autism and wider availability of public funding for services have led to greater access for
families at lower levels.

Intelligence and Autism

While the entire range of intelligence is possible for persons with autism, frequently
persons with autism may show an unevenness of development precipitating a display of
talent in certain limited areas such as music or mathematics, while being deficient in
areas related to living skills, including their ability to communicate and relate to others.
Most persons with the condition need structure, supervision and guidance in much of what they do.

Approximately 70 percent of all persons with autism function within the mentally retarded range. Persons of any age with autism do not test up to their abilities because these results are probably affected by the communications difficulties associated with the condition. Many develop seizures during adolescence and this tends to be those of IQ scores less than 70. It is rare to find seizures in persons with autism and a normal IQ. About 10% of autistic individuals have exceptional intellectual skills by most standards. These skills are often spatial in nature, such as special talents in music and art. Another common savant skill is mathematical ability in which some autistic individuals can multiply large numbers in their head within a short period of time; others can determine the day of the week when given a specific date in history or memorize complete airline schedules.

Many autistic individuals do not realize that others may have different thoughts, plans and perspectives than their own. For example, a person with autism may be asked to show a photograph of an object to another person. Rather than turning the picture around to face the other person, the person with autism, may instead, show the back of the photograph. In this example, the persons with autism can view the picture but does not realize that the other person has a different perspective or point of view.

Causes of Autism

Although there is no known unique cause of autism, there is growing evidence that autism can be caused by a variety of problems. There is some indication of a genetic influence in autism. For example, there is a greater likelihood that identical twins will have autism than fraternal twins. This is explained as with identical twins there is a 100 percent overlap in genes; whereas in fraternal twins, there is a 50% overlap in genes, the same overlap as in non-twin siblings. In a survey conducted in Utah, researchers identified 11 families in which the father had autism. Of the 11 families, there was a total of 44 offspring, 25 of whom were diagnosed as having autism. Other research has shown that depression and/or dyslexia are quite common in one or both sides of the family when autism is present.

There is also evidence that a virus can cause autism. There is an increased risk in having an autistic child after exposure to rubella during the first trimester of the pregnancy. Additionally, there is speculation that viruses associated with vaccinations, such as the rubella vaccine and the pertussis component of the DPT shot, may cause autism.

The cerebellum is a relatively large portion of the brain and is located near the brain stem. It is primarily responsible for motor movements, and damage to this area during the birth process can cause cerebral palsy, a disorder characterized by uncontrollable motor movements. There is also some recent evidence that the cerebellum is partially responsible for speech, learning, emotions and attention. Damage to this portion of the brain is one possible reason that persons with autism may experience differences with speech, learning, emotions and attention.

Although there is no scientific evidence at this time, there is growing concern that toxins and pollution in the environment can also lead to autism. There is a high prevalence of
autism in the small town of Leomenster, Massachusetts, where a factory manufacturing sunglasses was once located. Interestingly, the highest proportion of autism cases were found in the homes down-wind from the factory smokestacks.

**Physical Differences**

Researchers have located several brain abnormalities in individuals with autism; however, the reasons for these abnormalities is not known nor is the influence they have on behavior. These abnormalities are detected through postmortem studies. Many of the reported abnormalities are not consistent from one study to another. The most consistent finding in autistic populations has been increased or in some cases decreased levels of serotonin in their blood and cerebral spinal fluid (Stone & Ousley, 1996). Serotonin is thought to regulate a number of behavioral processes, including pain and sensory perception, motor function and learning and memory. It should be mentioned that other disorders, such as Down Syndrome, attention deficit/hyperactivity disorder and unipolar depression are also associated with abnormal levels of serotonin.

The scientific community tells us that the senses of the individual with autism are very acute. The human body has a biochemical means to deal with pain and these are called endorphins. The brain, in an attempt to block out over-stimulation produces added endorphins, which results in the blockage of not only the pain, but also the senses. Endorphins are created as the natural response of the body to counteract pain and anxiety. When in pain or under stress, individuals with autism use repetitive behaviors to produce endorphins. A lack of response to stimulation, demonstrated by those who have autism, can be tied directly to the amount of endorphins that they have produced through the use of repetitive behaviors (Gillingham, 1997). For the policeman, repetitive behavior should signal that the person is experiencing a sensory overload and has learned how to produce the endorphins as a defense measure to literally shut out the offensive stimuli from the stressful environment of the person with autism.

Some people with autism have excessive amounts of a type of yeast called candida albicans in their intestinal tract. This is a type of parasitic fungi that resembles a yeast. It is thought that high levels of candida albicans may be a contributing factor to many of their behavioral problems. One scenario is that when a person with autism develops a middle ear infection, the antibiotics that help fight the infection may destroy microbes that regulate the amount of yeast in the intestinal tract. As a result, the yeast grows rapidly and releases toxins in the blood; and these toxins may influence the functioning of the brain.

**Sensory Impairments**

Persons with autism:

- May act as deaf
- May have fear of sound
- May stare at lights
- May be insensitive to pain
• May dislike contact with textures and people
• May lick and/or smell things

Many autistic individuals seem to have an impairment in one or more of their senses. This impairment can involve the auditory, visual, tactile, taste, vestibular, olfactory (smell) and proprioceptive senses. These senses may be hypersensitive, hyposensitive or may result in the person experiencing interference such as in the case of tinnitus (a persistent ringing or buzzing in the ears). As a result, it may be difficult for individuals with autism to process incoming sensory information properly.

Sensory impairments may also make it difficult for the individual to withstand normal stimulation. For example, some autistic individuals are tactiley defensive and avoid all forms of body contact. Others, in contrast, have little or no tactile or pain sensitivity. Furthermore, some people with autism seem to crave deep pressure. Another example of sensory abnormalities is hypersensitive hearing. About 40% of individuals with autism experience discomfort when exposed to certain sounds or frequencies. These individuals often cover their ears and/or tantrum after hearing sounds such as a baby's cry or the sound of a motor. In contrast, some parents have suspected their child with autism of being deaf because they appeared unresponsive to sounds.

Gillingham (1997) believes that a broader understanding of the sensory processing of persons with autism lies at the root of a better knowledge base about the condition. The scientific community had long thought that nature limits the amount of stimuli coming in and prevents the brain from becoming overloaded with information. Thinking on this matter has recently changed as we now recognize that some persons are supersensitive. According to persons with autism, their disability is linked directly to the senses. While their eyes, ears, nose and skin can seem normal, it is now believed that when sensory messages reach the brain, they are not linked into an understandable picture of the outside world. They describe how the touch of another human being can be excruciating, smells can be overpowering, hearing can hurt, sight can be distorted and tastes may be too strong. In other words, their world can be a world of pain. The development of the autistic personality is, according to Gillingham, their method of coping with pain.

The receiving of faulty messages about the world around them leads to a lack of understanding of speech and gesture and hence a lack of ability to communicate. Because of the missing link in understanding, autistic persons appear to be withdrawn and seem to live in an isolated world of their own. Moreover, the frustration caused by the inability to communicate often leads to disturbed behavior.

Many autistic individuals also have a narrow or focused attention span; this has been termed stimulus over-selectivity. Basically, their attention is focused on only one, often irrelevant, aspect of an object. For example, they may focus on the color of a utensil, and ignore other aspects such as the shape. In this case, it may be difficult for a person with autism to discriminate between a fork and a spoon if he/she attends only to the color. Since attention is the first stage in processing information, failure to attend to the relevant aspects of an object or person may limit one's ability to learn about objects and people in one's environment.
The above principle is important to police officers and others who are trying to initiate a conversation with someone with autism. For most people, it takes a short period of time, less than a second or two, to redirect attention from one stimulus to another in the environment. In contrast, autistic individuals continue to attend to a stimulus even when prompted for redirection, and they may take three to five seconds or longer to shift their attention. It is thought that many persons with autism have difficulty directing their attention to changes in their surroundings, and by the time they do shift their attention, they lose information regarding context and content. An inability to shift attention in a timely manner may result in their not hearing the first sentence or two that someone else might say. For example, if a person with autism is focusing on an object of any kind and a police officer asks him/her a question, it may take a few seconds before he/she can redirect their attention and listen to the officer. As a result, the person has difficulty understanding the officer because he/she did not attend to the first few sentences. Therefore, it is considered a good practice to repeat the first two sentences of a conversation.

**Communicating With Persons with Autism**

As mentioned earlier, persons with autism tend to have extreme limitations with both expressive and receptive language. The police officer might consider the following tips when attempting to communicate with a person with autism.

- Do not use physical contact.
- Be patient.
- The person with autism may lack awareness of or attention to others. The person may have a stand-offish manner.
- A person with autism may be unable to make eye contact.
- Persons with autism may parrot responses of others.
- Use simple language, speak slowly and clearly.
- Use concrete terms and ideas.
- Repeat simple questions, allowing time (10-15 seconds) for a response.
- Proceed slowly and give praise and encouragement.
- Do not attempt to physically stop self-stimulating behavior.
- Talk indirectly, look away and act indifferent.
- Use symbols or objects when talking.
- When the person with autism is speaking, the autistic individual needs to know that he/she is being heard. How do you listen without antagonizing him/her? Standing calmly by, without looking intently at the person with autism. The officer should keep in mind that each individual with autism is unique and may act or react differently. Please contact a responsible person who is familiar with the individual, particularly when attempting to solicit important information.
Community Resources for Persons with Autism

Texas has 31 community-based MHMR centers with components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. In addition many communities will have a local chapter of the Autism Society of America (ASA). The address of the national office as well as other organizations are as follows:

Autism Society of America
7910 Woodmont Avenue, Suite 650
Bethesda, MD 20814
800-328-8576
301-675-0881
fax: 509-534-5245

The Arc
500 E. Border St. #300
Arlington, TX 79010
800-433-5255
817-261-6003
817-277-3491

Conclusion

Autism is a very complex disorder, and the needs of these individuals vary greatly. After 50 years of research, traditional and contemporary approaches are enabling us to understand and treat these individuals. It is also important to mention that professionals are beginning to realize that the symptoms of autism are treatable--there are many interventions that can make a significant difference.

The two treatments which have received the most empirical support are behavior modification and the use of vitamin B6 with magnesium supplements. Vitamin B6 taken with magnesium has been shown to increase general well-being, awareness and attention in approximately 45% of autistic children. There are also a number of recent reports about the benefits of another nutritional supplement, Dimethylglycine (DMG) also seems to help the person's general well-being, and there are many anecdotal reports of it enhancing communication skills.

Allergies and food sensitivities are beginning to receive much attention as possible contributors to autistic behaviors. Many families have observed rather dramatic changes after removing certain food items from their family member's diet. Researchers have recently detected the presence of abnormal peptides in the urine of autistic individuals. It is thought that these peptides may be due to the body's inability to breakdown certain proteins into amino acids; these proteins are gluten (e.g., wheat, barley, oats) and casein (found in human and cow's milk). Many parents have removed these substances from their family member's diet and have, in many cases, observed dramatic, positive changes in health and behavior.

The logo for the national parent support group, the Autism Society of America, is a picture of a child embedded in a puzzle. Most of the pieces of the puzzle are on the table, but we are still trying to figure out how they fit together. We must also keep in mind that these pieces may fit several different puzzles.
CHAPTER 16: CEREBRAL PALSY

Objectives

➢ PERFORMANCE OBJECTIVE:
  Given a subject with Cerebral Palsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 24 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

➢ ENABLING OBJECTIVES:
  • Demonstrate general knowledge of the unique factors of persons with cerebral palsy.
  • Role play with another participant with cerebral palsy in a simulated situation.

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with cerebral palsy. If someone has, ask them to tell of situation and how they knew the person had cerebral palsy? What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:
As an on-duty officer, you are responding to a call from a convenience store that has reported making a sale to a man who was staggering and had slurred speech. The store attendant informs you that he suspected that the person was intoxicated and should not be out in public. The attendant has observed the direction in which the man left the premises and you pursue.

A couple of blocks away you observe the individual and the store attendant's description of the man's walk appears very accurate. You approach, identify yourself and notice the slurred speech as well. What disabling condition might be present and how do you gather additional information regarding his physical and/or mental state?

Identifying Persons with Cerebral Palsy
It is usually easy to identify persons with CP through observable physical manifestations, chief of which is gait disturbance. These persons can have normal intelligence. Physical manifestations can be limited to certain areas of the body; i.e., upper body, lower body, right side, left side, one arm or all. CP can be present in varying degrees. Persons with CP have problems in processing information in terms of where they (and their limbs) are physically and where they perceive themselves to be; therefore, there may be some unusual posturing. Some persons with CP have genius intelligence, yet only with recent innovations is this factor detected.
IDENTIFICATION OF PERSONS WITH CEREBRAL PALSY

A person with CP may have the following characteristics:

- Stiff and jerky movements
- Unsteady and shaky
- Poor balance
- Trouble holding themselves in an upright, steady position
- Random, involuntary movements
- Experience seizures
- Muscle imbalance in one of their eyes (lazy eye)

STUDENT ACTIVITY

Bend your arm to move your hand up to touch your nose. To do that you must shorten, or increase the tone in the muscle in the front of the upper part of your arm (biceps muscle) while you lengthen, or decrease the tone in the back of the upper part of your arm (triceps muscle). To move your arm smoothly without jerks and without hitting yourself in the nose, the tone in muscles used to make that movement must change in a way that is just right -- an even change to tighten one while loosening the other. Persons with CP are not able to change their muscle tone in a smooth and even way, so their movements may be jerky or wobbly.

WHAT IS CEREBRAL PALSY?

Cerebral Palsy (CP) is a functional disorder caused by damage to the brain during pregnancy, delivery or shortly after birth. Sometimes injuries to a baby's brain happens while the baby is still in the mother's womb (before birth). The injury might be caused by an injection or by an accident in which the mother is hurt. If a mother has a medical problem such as high blood pressure or diabetes, this can also cause problems with the baby. There may be problems during birth, such as the baby not getting enough oxygen, or a difficult delivery in which the baby's brain is injured. Problems after birth may happen when a baby is born too soon (premature delivery) and his/her body is not ready to live outside the mother's womb. Even babies born at the right time can have infections, or bleeding in their brain which causes a brain injury because the brain is still developing after birth.

The words cerebral palsy are used to describe a medical condition that affects control of the muscles. Cerebral means brain or anything in the head, and palsy means a disorder of movement or posture. Palsy also refers to anything wrong with control of the muscles or joints in the body. If someone has cerebral palsy it means that because of an injury to their brain (that is the cerebral part) that they are not able to use some of the muscles in their body in the normal way (that's the palsy part). Persons with CP may not be able to walk, talk, eat, or participate in other activities in the same ways that non-disabled persons do.
Cerebral Palsy is the term used to describe the motor impairment resulting from brain damage. Cerebral Palsy is caused by damage to the brain with the damage varying in location and extent. CP is a non-progressive disorder of motion and posture due to a brain insult or injury during the period of early brain growth (prenatal up to 5 years).

No event is an absolute predictor of CP. Most sources report that a minimum of 50% of the cases result from trauma during birth. In addition, the major source of trauma appears to be severe asphyxia (a lack of sufficient oxygen to the brain). What is not clear is whether asphyxia causes cerebral palsy or that asphyxia is a symptom of an otherwise sick baby with other neurological problems.

The risk of CP is drastically increased for babies born with very low birth weights. Premature babies are at a much higher risk for developing cerebral palsy than full-term babies, and the risk increases as the birth-weight decreases. Babies weighing less than three pounds are 25 times more likely to develop cerebral palsy than infants who are born at full term weighing more than five pounds.

Progress in medical science regarding the care of babies with low birth weight is contributing to more babies surviving with CP. One proven test for determining CP is when a premature baby does not cry within five minutes following birth. Babies who have congenital malformations in systems such as the heart, kidneys, or bones are also more likely to develop CP, because they also have malformations in the brain. A new born that has seizures also has an increased risk of developing CP.

CP is a static, non-progressive disorder of movement and posture due to injuries of the brain sustained during the early developmental period. The term stable non-progressive neurologic disorder is sometimes used for this for this disorder (Blackman, 1987). CP is not temporary and it does not get worse. CP is not a single disorder but a group of non-progressive disorders, with multiple causes and manifestations, that usually result in some degree of permanent impairment of motor function.

Cerebral Palsy can affect different parts of the body, and can be manifested by a wide variety of movement problems. It can result in restricted movement or extraneous, uncontrolled movements. Spasticity, which refers to the inability of a muscle to relax occurs in about 60% of all cases of CP. Spasticity results in reduced movement due to an increased resistance of fast stretching muscles that give way. The distribution of affected body regions can vary with the most common including the trunk and all four extremities with the legs more affected than the arms. Most estimates of all persons with CP indicate that 35% to 45% experience seizures (Miller & Bachrach, 1995). The involuntary movements of dyskinesia are made worse as a result of heightened emotional states.

Individuals with CP frequently manifest nutritional deficiencies because of difficulties in swallowing. In addition, many of those affected have extra caloric needs. Approximately 1 in 8 have hearing deficits. Many persons with CP have normal intelligence, yet appear to be retarded. It is common for persons to have better receptive (understanding) than expressive (speech) language skills.
Because CP is a condition caused by damage to the central nervous system, many of the complications of CP are neurological. Persons of all ages with CP may also have orthopedic problems, that is problems with the spine, bones, joints, muscles or other parts of the skeletal system. CP may manifest as a combination of impairments involving multiple body systems. Persons with CP may also have problems that are secondary to neurological and orthopedic conditions. An example of a secondary effect of CP is poor nutrition caused by difficulty in swallowing. For some persons with CP, one of these kinds of problems may dominate and the CP will be a relatively minor issue. For example, some persons with CP may be able to walk and have few physical limitations, yet manifest some degree of mental retardation.

Prevalence Rate of CP

- **GENERAL INCIDENCE OF CP**

  The generally accepted incidence of CP is 5 per 2000 persons and this seems to remain constant in the United States (Miller & Bachrach, 1995). Life expectancy is normal and the estimated living American population, using the above formula, with CP is about 650,000.

- **FACTS ABOUT**

  - CP is not a disease, it is not inherited, it is not contagious, it does not get worse, and there is no cure.
  
  - About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition and premature delivery.
  
  - About 40% of cases are caused by lack of oxygen or in injury during birth or shortly after.
  
  - About 30% of the causes are unknown.
  
  - Occurs to some degree in about 2.5 out of 1,000 live births.

The most important thing to remember is that cerebral palsy is not contagious and you do not develop CP later in life. It is caused by an injury to the brain near the time of birth. Cerebral palsy is generally classified according to the type of movement problem. Motor ability and coordination vary greatly from one person affected to another, and there are very few statements that hold true for all persons with CP. The word for the dominant type of movement or muscle coordination problem is often combined with the word for the component that seems to be most problematic for the person with CP. Thus generalizations about CP can only have meaning within the context of the following subgroups.

Types of Cerebral Palsy

- Spasticity - tight limb muscles
• Athetosis - involves purposeless movement
• Rigidity - severe form of spasticity, usually quadriplegic (involving arms and legs).
• Cerebral Ataxia - lack of balance
• Mixed - muscle tone differences

Persons with CP have damage to the area of their brain that controls muscle tone. Depending on where their brain injury is and how big it is, their muscle tone may be too tight, too loose or a combination of the two. Muscle tone is what lets us keep our bodies in a certain position like sitting with our heads up to look at your instructor in this class. Changes in muscle tone let us move.

➢ SPASTIC CEREBRAL PALSY
Spasticity refers to the inability of a muscle to relax. If muscle tone is too high or too tight, the term spastic is used to describe the type of cerebral palsy. Persons with spastic CP have stiff and jerky movements because their muscles are too tight. They often have a hard time moving from one position to another or letting go of something in their hand. This is the most common type of CP as most sources believe that a minimum of 60% of all people with CP have spastic CP (Miller & Bachrach, 1995).

➢ ATAXIC CEREBRAL PALSY
Low muscle tone and poor coordination of movements is described as ataxic (a-tax-ick) CP. Persons with CP look very unsteady and shaky. They have a lot of shakiness, similar to a tremor you might have seen in very old persons, especially when they are trying to do something like write or turn a page or cut with scissors. They also often have very poor balance and may be very unsteady when they walk. Because of the shaky movements and problems coordinating their muscles, persons affected may take longer to finish a task that involves skills such as writing.

➢ ATHETOID CEREBRAL PALSY
The term athetoid is used to describe the type of CP when muscle tone is mixed - sometimes to high and sometimes too low. Therefore these individuals lack the ability to control the movement of a muscle. Persons affected have trouble holding themselves in an upright, steady position for sitting or walking, and often show lots of movement of their face, arms and upper body that they do not mean to make (random, involuntary movements). These movements are usually big. It takes an extra amount of work and concentration for many persons with this type of CP to get their hand to a certain spot like to scratch their nose or reach for a cup. Because of their mixed tone and trouble keeping a position, they may not be able to hold onto things such as a toothbrush, fork or pencil. Athetoid CP occurs in about 10 percent of all cases of CP, thus is the least common type (Miller & Bachrach, 1995).
RIGIDITY
Persons with this level of CP are generally quadriplegic which implies that all four extremities as well as trunk and neck muscles are impaired. These individuals have a heightened level of spasticity. The term rigidity is generally synonymous with stiffness. Some persons with CP become very stiff, especially in the joints. Spasticity is generally due to the muscles being very tight and then suddenly relaxing. When the stiffness does not suddenly relax but slowly stretches out, with the feeling of bending a lead pipe, then the term used is rigidity.

MIXED CP
When muscle tone is too low in some muscles and too high in other muscles, the type of CP is called mixed.

Conditions Frequently Accompanying Cerebral Palsy

PRIMARY CONDITIONS
Because CP is a condition caused by damage to the central nervous system, many of the complications of CP are neurological. Persons with CP may also have orthopedic problems that affect the spine, bones, joints, muscles or other parts of the skeletal system. In addition, they may also have problems that are considered "secondary" to the neurological and orthopedic problems. One example of a secondary effect of CP is poor nutrition caused by the person's difficulty in swallowing. Other neurological problems associated with CP include:

NEUROLOGICAL PROBLEMS ASSOCIATED WITH CP
- seizures and epilepsy
- mental retardation
- learning disabilities
- attention deficit-hyperactivity disorder
- hydrocephalus (enlargement of fluid-filled spaces surrounding the brain)
- behavior problems
- visual impairments
- hearing loss
- speech impairment
- swallowing difficulties

All of the above conditions have implications for the law enforcement official assisting/investigating a scene involving a person with CP. As mentioned earlier, slightly less than one-half may experience seizures. A seizure (also called a convulsion) occurs when bursts of disorganized electrical energy interfere with normal brain functioning. Electrical bursts of this sort can occur in different parts of the brain and can result in different kinds of seizures. The most common kind of seizure for the person with CP is the grand mal seizure. This is a generalized type of seizure involving the entire body. The officer needs to remember that this
may involve a loss of consciousness, alternating rigidity and relaxation of muscles and a period of drowsiness or disorientation. Regardless of the disposal of the situation, the person must continue to receive the medication that assists with the control of the seizures.

Persons with CP may have intelligence within the entire range of possibilities. They do tend to experience difficulty with speech, partly because of the possibility of impaired hearing, and have difficulty in writing and problem solving that involves a concentrated focus. Much of what non-disabled persons perceive is the result of being able to freely move around objects and see all dimensions. Persons with CP generally are lacking in mobility skills and thus their perceptual skills may be not as well developed as their non-disabled counterparts (Alexander & Bauer, 1988).

In the discussion of spastic CP we talked about the inability of muscles to relax. Nearly one-half of the persons with spastic CP have a muscle imbalance in one of their eyes resulting in what is commonly called cross-eye. In addition, the absence of adequate oxygen during birth tends to impair vision. As many as 80 percent of the persons with CP suffer from a lazy eye.

Community Resources for Persons with Cerebral Palsy

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. In addition many communities will have a local chapter of the United Cerebral Palsy Association. The address of the national office as well as other organizations are as follows:

United Cerebral Palsy
1522 K Street NW, Suite 1112
Washington, DC  20005
1-800-872-5827

National Association of Developmental Disabilities Councils
1234 Massachusetts Ave. NW, Suite 103
Washington, DC  20005
1-202-346-1234

The Arc
500 East Border St., Suite 300
Arlington, TX  79010
1-817-261-6003  1-800-433-5255

Epilepsy Foundation
4351 Garden City Drive
Landover, MD  20785
1-800-332-1000
United Cerebral Palsy's mission is (1) to promote and provide the mechanisms for independent growth, self determination and community inclusion for persons with cerebral palsy and other persons with disabilities and their families, and (2) to promote community awareness of cerebral palsy and other disabilities.

There are 155 United Cerebral Palsy affiliates located throughout the country sharing the common goal of providing direct services and advocacy for individuals with cerebral palsy and other disabilities.

Program services for children often include infant and early childhood development programs for children ranging in age from 0-3 years. These programs include center-based, home-based and, as needed, hospital-based services. Some chapters assist families in securing day care in their communities. Also, many chapters maintain a registry of qualified respite providers to assist families in choosing short term in-home respite care.

Program services for adults generally include adult personal development and training sessions. A new emphasis is to create more opportunities for community inclusion of the participants through small group activities. Some local chapters feature community integrated employment programs, designed to assist individuals with CP and related conditions to obtain employment in the mainstream workforce.

Case management services are available at many locations to all program participants and individuals from the community. Individuals not attending agency programs are offered case management assistance in locating generic services and specific agency assistance. Speakers are available to present a number of topics related to cerebral palsy and other disabilities.
CHAPTER 17: EPILEPSY

Objectives

➢ PERFORMANCE OBJECTIVE:

GIVEN A SUBJECT WITH Epilepsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 30 in the Trainee's Guide. Include such factors as general information, identification, communication, and community resources.

➢ ENABLING OBJECTIVES:

• Demonstrate your general knowledge of the unique factors of persons with epilepsy.
• Role play with another participant with epilepsy in a simulated situation.

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with epilepsy. If someone has, ask them to tell of situation and how they knew the person had autism. What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an officer, you have arrested a man on suspicion of burglary and he is riding in the back of your police cruiser on the way to the police station. Suddenly, he lets out a hoarse cry, stiffens and begins to jerk his body rhythmically. You tell him to stop but he does not respond. You arrive at the station and he is slumped over and uncooperative. What do you suspect his disabling condition is and how should you respond?

Identifying Persons with Epilepsy

In general, people with epilepsy:

• are indistinguishable from people who do not have epilepsy unless a seizure is taking place or has just taken place.
• are generally as intelligent, perceptive and articulate as any other member of the public, although occurrence of a seizure will mask these attributes until the person is fully recovered.
• are employed and maintain the same kind of social and familial relationships as other people.
• are unable to interact with other people or to respond appropriately to the environment during a seizure. They often cannot follow directions, converse with
others and are generally out of touch with reality until the episode ends and normal brain activity returns.

However, some people with epilepsy may have other physical disabilities including mental retardation, cerebral palsy, autism or mental illness. Additionally, persons may experience social problems such as poverty, homelessness, drug addiction or alcoholism. Because these problems may interfere with consistent access to seizure-preventing medicines, this population may be more likely to have seizures than other people with epilepsy and to have them in settings or circumstances that will lead to police attention.

VIDEO: Take Another Look - Police Response to Seizures and Epilepsy.

What is Epilepsy

Epilepsy is a word derived from the Greek term epilepsia which means to seize (Hermann, Desai, & Green, 1988). Epilepsy is one of the oldest known disorders and was studied and discussed in some detail by Hippocrates (the Father of Medicine) over 2,000 years ago. Physicians of that era were fascinated by the mysteries of epilepsy, its many causes and manifestations. Although the condition is studied today using very scientific procedures, much of the mystery remains.

In addition to these medical mysteries, epilepsy has long been surrounded by social confusion and stigmatization. The term seizure dates back in history as during the middle ages when epileptics were believed to be seized by the devil and were despised and abused. On the other hand, the Romans displayed care for persons with epilepsy as they believed that epileptics were possessed by Gods. The condition is a disorder of the brain with the major characteristic being seizures. Epilepsy is not a disease, nor is it contagious. It is the symptom of a brain dysfunction with the malfunctioning due to an electrical outburst within the cells. These recurrent discharges affect the normal operation of the nervous system. The result of this electrical storm within the brain is a seizure.

The American Heritage Dictionary defines epilepsy as any of various neurological disorders characterized by sudden, recurring attacks of motor, sensory or psychic malfunction with or without loss of consciousness or convulsive seizures. Epilepsy is marked by disturbed electrical rhythms of the central nervous system. These attacks are typically manifested with a clouding of consciousness.

Epilepsy is a neurological condition that from time to time produces brief disturbances in the normal electrical functions of the brain. Normal brain function is made possible by millions of tiny electrical charges passing between nerve cells in the brain and to all parts of the body. When someone has epilepsy, this normal pattern may be interrupted by intermittent bursts of electrical energy that are much more intense than usual. They may affect a person's consciousness, bodily movements or sensations for a short time.

These physical changes are called epileptic seizures. That is why epilepsy is sometimes called a seizure disorder. The unusual bursts of energy may occur in just one area of the brain (partial seizures), or may affect nerve cells throughout the brain (generalized seizures). Normal brain function cannot return until the electrical bursts subside. Conditions in the brain that produce these episodes may have been present since birth, or
they may develop later in life due to injury, infections, structural abnormalities in the brain, exposure to toxic agents or for reasons that are still not well understood. Many illnesses or severe injuries can affect the brain enough to produce a single seizure. When seizures continue to occur for unknown reasons or because of an underlying problem that cannot be corrected, the condition is known as epilepsy. Epilepsy affects people of all ages, all nations and all races. Epilepsy can also occur in animals, including dogs, cats, rabbits and mice.

The Difference Between Seizures and Epilepsy

Seizures are a symptom of epilepsy. Epilepsy is the underlying tendency of the brain to produce sudden bursts of electrical energy that disrupt other brain functions. Epileptic seizures are the result of electrical discharges in one or more areas of the brain. These discharges can be monitored and recorded using an E.E.G. machine, allowing doctors to locate the area of the brain causing the seizures. Having a single seizure does not necessarily mean a person has epilepsy. High fever, severe head injury, lack of oxygen--a number of factors can affect the brain enough to cause a single seizure. Epilepsy, on the other hand, is an underlying condition (or permanent brain injury) that affects the delicate systems which govern how electrical energy behaves in the brain, making it susceptible to recurring seizures.

The seizure is a reaction of the body to the abnormal electrical outbursts within the brain. Not all seizures are the result of epilepsy. Seizures can result from low blood sugar, infection, and fever, without a person having the condition. When seizures recur, when they are unpredictable and without apparent medical cause, it may be epilepsy. Seizures that result in motor disturbances are labeled convulsions. Seizures may involve disturbances in mental or physical areas of the body or both.

The Causes Epilepsy

In about seven out of ten people with epilepsy, no cause can be found. Among the rest, the cause may be any one of a number of things that can make a difference in the way the brain works. For example, head injuries or lack of oxygen during birth may damage the delicate electrical system in the brain. Other causes include brain tumors, genetic conditions (such as tuberous sclerosis), lead poisoning, problems in development of the brain before birth and infections like meningitis or encephalitis. Epilepsy is often thought of as a condition of childhood, but it can develop at any time of life. About 30 percent of the 125,000 new cases every year begin in childhood, particularly in early childhood and around the time of adolescence. Another period of relatively high incidence is in people over the age of 65.

Most occurrences of epilepsy are without a known cause. A more limited number can be traced to a direct cause such as a lack of oxygen at birth, infectious diseases, poisons, strokes, head injuries, genetic factors, drug use, chromosomal abnormalities and health problems during pregnancy. In the majority of cases there is no direct reason why a person may have epilepsy.
How Epilepsy Diagnosed?

The doctor's main tool in diagnosing epilepsy is a careful medical history with as much information as possible about what the seizures looked like and what happened just before they began. A second major tool is an electroencephalograph (EEG). This is a machine that records brain waves picked up by tiny wires taped to the head. Electrical signals from brain cells are recorded as wavy lines by the machine. Brain waves during or between seizures may show special patterns which help the doctor decide whether or not someone has epilepsy. Imaging methods such as CT (computerized tomography) or MRI (magnetic resonance imaging) scans may be used to search for any growths, scars or other physical conditions in the brain that may be causing the seizures. In a few research centers, positron emission tomography (PET) imaging is used to identify areas of the brain which are producing seizures.

How is Epilepsy Treated?

Epilepsy may be treated with drugs, surgery or a special diet. Of these treatments, drug therapy is by far the most common, and is usually the first to be tried. A number of medications are currently used in the treatment of epilepsy. These medications control different types of seizures. People who have more than one type of seizure may have to take more than one kind of drug, although doctors try to control seizures with one drug if possible. A seizure preventing drug (also known as an anti-epileptic or anti-convulsant drug) won't work properly until it reaches a certain level in the body, and that level has to be maintained. It is important to follow the doctor's instructions very carefully as to when and how much medication should be taken. The goal is to keep the blood level high enough to prevent seizures, but not so high that it causes excessive sleepiness or other unpleasant side effects.

While medical treatment through medication is the mainstay, side effects are common. An ideal drug would be one that prevents or stops all seizures, does not sedate the person, is free of side effects and has no cumulative side effects. As such a drug does not exist, physicians balance gains obtained by using a particular drug against its side effects. The entire spectrum of side effects is possible including trouble with balance and walking when blood levels of some common drugs are excessively high. Other side effects include making the skin itch, noticeable smell in perspiration and breath and involuntary eye movements.

How can People Guard Against Seizures?

A person with epilepsy can help control his or her seizures by taking the prescribed medication regularly, maintaining regular sleep cycles, avoiding unusual stress and working closely with his or her physician. Regular medical evaluation and follow-up visits are also important. However, seizures may occur even when someone is doing everything he or she is supposed to.

Additional Facts on Epilepsy

- There are over 2.6 million Americans with epilepsy.
• There are about 125,000 new cases of epilepsy that occur each year.
• Most individuals with epilepsy can be helped with medications.
• There are over twenty kinds of seizures associated with epilepsy.
• One of the most significant problems associated with epilepsy is people's attitudes.
• Everyone maintains a certain degree of susceptibility to seizures
• There are over 300,000 students with epilepsy in schools in the U.S.

Prevalence Rate of Epilepsy

The prevalence of epilepsy varies by source with some figures ranging as high as three percent. At a minimum it is found in approximately 1 out of every 100 persons (Michael, 1995). One reason that this figure varies is because of the stigma and prejudice associated with this disorder. The same source cites the fact that one out of every 10 persons will have at least a single seizure at some point in their life and for 80 percent of those it will be their only seizure. Persons with isolated seizures are not classified as having epilepsy. The rates of epilepsy are higher in males than in females. The frequency among individuals of Afro-American heritage is higher than for traditional American whites. Males have a higher tendency to receive genetic traits, yet the reasons for persons of color to have elevated rates are thought to be many, including poorer prenatal care.

Seizure threshold refers to the susceptibility of a person to have seizures. A low threshold indicates that a person would be more apt to experience a seizure. There are a number of factors which could affect a person's threshold such as heredity, photosensitivity (flashing lights), extreme fatigue, stress, hormonal changes and growth periods and missed medications.

The intelligence range for persons with epilepsy, as measured by IQ tests is the same as the general population (Michael, 1995). Some sources report a slight reduction in intelligence scores, but this is generally attributed to medication. Seizures generally do not affect one's intelligence, unless the seizures occur often and are quite severe. One of the most commonly reported cognitive deficits in individuals with epilepsy has been memory. Memory, however, can be influenced by a number of factors, such as the type of seizure, duration, origin, frequency and medications.

Epilepsy, as a disabling condition is considered to be a major developmental disability. By occurring at higher rates, epilepsy is related to other specific disabilities. Although there are numbers of other conditions related to epilepsy, primary concern here is given to mental retardation, autism, cerebral palsy, multiple disabilities, multiple sclerosis and traumatic brain injury.

Types of Seizures

Many types of seizures exist with most sources generally using two major categories that are further subdivided into nine seizure classifications. The categories and classifications are used as guidelines to determine the severity of a person's epilepsy (Hermann, Desai, & Whitman, 1988). Knowledge of the common characteristics of a seizure classification
helps to anticipate the victim's actions during the seizure. The nine seizure classifications are:

- **SIEZURE CLASSIFICATIONS**
  - Tonic-Clonic (grand mal)
  - Absence (petit mal)
  - Myoclonic: Partial Seizures
  - Simple-Partial Seizures (consciousness not impaired)
  - With motor signs (Jacksonian)
  - With somatosensory and special sensory signs
  - With automatic signs
  - With psychic symptoms
  - Complex-Partial Seizures (consciousness impaired)
  - Simple-Partial--Impaired consciousness
  - Secondarily Generalized (partial onset evolving to generalized tonic-clonic seizures)

- **TWO MAIN CATEGORIES**
  
  There are two main categories of seizures: generalized and partial. It is important for the police officer to remember that behavior is out of control for persons experiencing seizures of either category. Generalized Seizures are those that affect the whole brain at once.

  Generalized Seizures.
  
  - Tonic-Clonic Seizures - also known as grand mal Seizures are the most common type experienced by persons of all ages (when including children) and characterized by stiffening of the entire body, followed by jerking muscle contractions. These seizures are associated in most people's minds with the words convulsion or fits. The individual may lose consciousness and bladder control during this seizure. There are 4 stages of Tonic-Clonic seizures:
    - Aura: Signs warning the individual or others that a seizure is about to occur. Some persons may notice their aura in time enough to get to a safe area for their seizure. For others, the aura would occur immediately before the seizure starts. Some persons affected are overcome by fear when the aura occurs and scream for help. The aura is the panic felt before the seizure. Other signs may include a bad taste in the mouth, ringing in the ears, strange smell, flashing of lights or tingling sensation to parts of their body. Within seconds, the individual loses consciousness, falls, and becomes very stiff (tonic phase). A few seconds later there is jerking of the limbs (clonic phase), the eyeballs roll up, the individual has frothing at the mouth and may bite his or her
tongue. In about a minute the jerking stops and the person falls asleep for 1 to 3 hours. This is the post-ictal phase in which the person gradually returns to consciousness in which mental confusion, stupor, slurred speech and weakness may occur. This phase potentially can be dangerous as the person may engage in limited actions without being aware of what they are doing. The tonic-clonic seizure may leave the subject exhausted, with a headache, and with whatever wounds they would receive during the seizure such as bites in the cheek and tongue, body bruises, etc.

Suggested first aid for such a seizure includes laying the individual flat on the ground, turning the head to one side and waiting for a minute or two. The seizure will generally stop in this time. During the seizure, the person is unaware of what is going on. After the seizure is over, the individual will generally be confused, will not recall what was said during the seizure, nor will he or she remember what happened during the seizure. Most persons who have these seizures tend to have only one at a time.

It is an extreme medical emergency when there are a flurry of seizures (Hermann, et al., 1988, p.248). Prolonged general seizures known as status epilepticus, also known as seizure status, is characterized by multiple seizures occurring simultaneously without a break in between the seizures or one seizure after another without a recovery stage between them. It is extremely dangerous to the individual suffering the seizures, because of the prolonged repetitive pattern of electrical stimulation to the brain. The most common factors that precipitate seizure status include sudden withdrawal of seizure-control medications, fever and infections. This form of seizure can lead to decreasing levels of mental functions, increased amount of neurological impairments or even death. Fortunately, this type of seizure is uncommon. This information is important to police officers in emphasizing the point that the person with epilepsy must continually receive their medication as prescribed.

- Absence Seizure - also known as petite mal seizures. These seizures are very short and sometimes are difficult to notice. An absence is a brief stare that lasts for about 10 seconds, during which the person has fluttering of the eyelids and/or lip smacking. The individual loses consciousness or goes blank for a few seconds. These seizures are prevalent in childhood, although they may occur in adults. Several absence seizures may occur within a 24 hour period. Absence seizures are within the category of generalized because they initially involve both hemispheres of the brain, thereby resulting in impairment of consciousness.

- Myoclonic Seizure - consists of one or more clonic-type jerks while still conscious. These seizures last for about one minute. The person is aware of everything around himself/herself, but has no control over the sudden massive muscle jerks or clusters of jerking movements. Muscle spasms which accompany this type are potentially strong enough to throw a person to the ground.
- Clonic Seizure - as mentioned above, it is characterized by the jerking, involuntary muscle contractions that are present in the latter stages of the tonic-clonic seizure. With these seizures there is no extension of the limbs, rather very rapid myoclonic activity with motions usually of rather small amplitude and very fast. Clonic seizures may involve the entire body and there is usually a loss of consciousness.

- Tonic Seizure - as mentioned above, it is characterized by an extension of the extremities with rigid stretching of the body. The tonic seizure is most common in children and adolescents. The seizure frequently begins with the sound of crying, yet there are essentially no risks. The attack can be severe and often a violent distortion of the head, face and limbs. The head and eyes may deviate, facial muscles contract and posturing of the limbs is prominent.

- Characterized by a sudden loss of muscle tone, causing the individual to slumber drop to the floor. Individuals suffering from this type of seizure may be required to wear safety gear, such as a posy vest and bike safety helmet.

Responding to Persons During a Seizure Episode

ENSURING OFFICER SAFETY

How can officer safety be ensured in situations involving seizures due to epilepsy or other causes?

Officers and criminal justice system personnel should follow standard safety precautions when approaching an unknown situation; however, where there is a possibility that a seizure is the cause of the behavior that is observed, they should:

- stay calm and assert authority to those in the surrounding area
- address the individual in a non-threatening tone to assess level of awareness and response
- look for a medical identification bracelet or necklace stating "epilepsy" or "seizure disorder"
- ask witnesses/bystanders what happened, and whether the individual has had similar episodes in the past or is known to have epilepsy
- guide individual away from hazards and away from crowds when possible, while speaking in a calming, reassuring tone
- remember that the most likely danger in dealing with someone having a seizure is that he/she will strike out aggressively in response to physical restrain.

SYMPTOMS SEEN DURING OR FOLLOWING A GENERALIZED SEIZURE

- A cry at the onset caused by air being forced out of the lungs by contracting muscles
• Falling to the ground, stiffening of the body
• Rhythmic muscle contractions of the whole body, which gradually slow and then stop
• Temporary cessation of breathing and possible development of bluish tinge to the skin
• Slow return to consciousness, accompanied by noisy breathing
• Post seizure confusion, fatigue, temporary inability to respond
• Possible belligerence and irritability following the seizure

➤ ACTIONS TO TAKE DURING A GENERALIZED SEIZURE

During the seizure the person may fall, become stiff and make jerking movements. The person's complexion may become pale or bluish.

• DO help the person lie down and put something soft under the head.
• DO remove any eyeglasses and loosen any tight clothes.
• DO clear the area of sharp or hard objects.
• DO NOT force anything into the person's mouth.
• DO NOT try to restrain the person as you cannot stop the seizure.

➤ ACTIONS TO TAKE AFTER THE GENERALIZED SEIZURE

• DO turn the person to one side to allow saliva to drain from the mouth.
• DO arrange for someone to stay nearby until the person is fully awake.
• DO NOT offer the person any fluid or drink.

➤ PARTIAL SEIZURES

Partial seizures involve only a part of the brain. They may or may not impair consciousness. Those seizures where consciousness is not impaired throughout the seizure are called simple partial seizures. Seizures that involve an impairment of consciousness are called complex partial seizures.

• Simple-Partial Seizure - is a form of seizure that starts at one extremity of the body, such as an arm or leg, and progressively moves upward to other areas on that side of the body, as more neurons are affected. A Tonic-Clonic seizure may follow the seizure. One type of simple-partial seizure is named the Jacksonian seizure. Jacksonian seizures begin with twitching in one area of the body and may progress in an orderly manner up the extremity and to another area with the potential of one-half of the body displaying clonic activity.

• Complex-Partial Seizure - appears as irrational behavior. A person may uncontrollably twitch their arm or leg, smack their lips, engage in chewing,
grimacing, spitting, mumbling, picking at things, rubbing parts of the body (usually the nose) or wander aimlessly. Only a portion of the brain is involved in the seizure. The seizure usually last only a few seconds. The individual is usually conscious during this seizure. Complex partial seizures are the single most common type of seizure experienced by adults.

- Secondarily Generalized Seizure - refers to tonic-clonic seizures that result when from the spread of a partial seizure (originating in one area of the brain). These are partial seizures with secondary generalizations. While the manifestations of this type will appear the same as the generalized, they are mentioned only in that different medications are effective for each category.

**SYMPTOMS DURING OR FOLLOWING A PARTIAL SEIZURE**
- Starts with a blank stare, followed by chewing or twitching movements of the mouth or face
- Communication becomes blocked or disordered
- May mumble, look dazed, unaware of surroundings and sometimes understand spoken work but be unable to respond
- Actions appear clumsy, not directed, may wander without regard to location or barriers in path, and may make repeated movements with part of the body or fumble with clothing
- Actual seizure lasts a couple of minutes, confusion remains for up to half an hour afterwards
- Less common symptoms may be screaming, crying, moaning, laughing, apparent fear, disrobing, unnatural movements of arms or legs

**ACTIONS TO TAKE DURING A PARTIAL SEIZURE**
- DO try to remove harmful objects from the person's pathway or coax the person away from them.
- DO NOT try to stop or restrain the person.
- DO NOT agitate the person.
- DO NOT approach the person if you are alone and the person appears to be angry or aggressive. This is very unusual.

After the seizure: The person may be confused or disoriented after regaining consciousness and should not be left alone until fully alert.

**SEIZURES AND THE NEED FOR MEDICAL ATTENTION**
- If the person does not start breathing within 1 minute after the seizure ends (begin mouth-to-mouth resuscitation)
- If a generalized tonic-clonic seizure lasts more than 2 minutes.
• If the person has one seizure right after another.
• If the person is injured.
• If the person requests an ambulance.

**Differences Between Mental Illness and a Seizure**

Mental illness tends to be a constant problem, or changes relatively slowly. People with epilepsy will experience a sudden change from normal to impaired. People who are mentally ill will be able to interact with the officer on some level. During a generalized or complex partial seizure meaningful interaction with an officer, or with anyone else is unlikely. Speech, comprehension and information processing are all affected by seizure activity in the brain.

**Differences Between Intoxication and a Seizure**

Intoxication has a slow, observable onset. Seizures arise abruptly from a normal state. Intoxicated people will have a strong smell of alcohol present while someone having a seizure may or may not have had an alcoholic drink prior to the seizure. Acknowledgement is also made that seizures can also occur in alcoholic persons. When this is the case, the person should be managed in the same manner by attempting to protect them from injury, and not forcibly apply restraint. Police interactions with an intoxicated person, while impaired by slurred speech, inappropriate behavior and a staggering gait, can take place on some level. Interaction is usually not possible with someone who is having a seizure until the seizure is over. The police should observe for other identification as most persons who have a history of seizures will wear a medical ID bracelet.

**Police Involvement**

No one chooses to have a seizure, and seizures can strike any person at any time, and without warning. There are no common characteristics of persons with epileptic seizures other than the seizures themselves. This condition can affect the well off, the middle class, and those living on the fringes of society. Where the seizure occurs as well as what it looks like may have an effect on the police's response. The police officer, in approaching a person with seizure-related behavior must respond to the seizure regardless of the circumstances in which it occurred.

To have this condition means that from time to time one's ability to control one's actions and one's link to the surrounding reality is temporarily lost. Control is important to everyone; losing it is humiliating. No member of the community who values his or her reputation wants to appear unable to control his or her movements in a public place. Yet this kind of experience, and the resulting embarrassment, is similar to some seizure episodes. No one need be concerned about being violently attacked by a person who suffers from epilepsy simply because they have seizures. If a person is violent, they should be dealt with in the same manner as a violent person who does not have seizures.

The role of the police officer in the majority of occasions involving persons with epilepsy will be that of a helper rather than an enforcer. Therefore, it is important that officers...
respond with dignity to calls involving persons with life-long disabling conditions. Most behavior involving a seizure-induced behavior is not disruptive. Because of the fact that most calls will be requiring a helping response, it is recommended to guide the victim of the seizure away from hazardous situations (when the person is mobile). Because there is no way to stop a seizure, the best response is the least response and you should engage in as little physical contact as possible. Ensuring and preserving individual rights are important functions in professional police work.

The most fundamental problem in identifying persons with epilepsy is the fact that too often the symptoms are mistaken for daydreaming or deliberate wrongdoing. If people with epilepsy commit a crime they should be treated the same as any body else. Particular problems arise when people with epilepsy are arrested because of a misinterpretation of what takes place during or immediately after a seizure. They may be unjustifiably arrested for disorderly conduct, drunkenness, creating a public disturbance, or being under the influence of drugs.

The police officer and all other personnel in the criminal justice system need to keep in mind that the person, regardless of whether a crime has been committed, must maintain their medication schedule. If a person with epilepsy is arrested and placed in custody, they can easily be deprived of his/her anti-epileptic medications resulting in further seizures. This discrimination is largely based on a failure to be informed rather than malice, nonetheless missing the medication can be harmful to the person.

Where and When do Encounters Occur?

Seizures can occur anywhere. Many occur at home in settings that would not lead to police interaction. Seizures are more likely to come to the attention of law enforcement when they happen in public facilities such as restaurants, stores, recreation centers, banks, in custody, during questioning, in police cruisers, at the site of an accident or other stressful event, and frequently at homeless shelters.

Encounters can take place at any time during police shifts. Seizures caused by alcoholism or illegal drug use may be more likely to occur during the evening hours. The weekends and holidays are peak periods for seizures because persons have exhausted their medication.

Community Resources for Persons with Epilepsy

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. The seasoned officer will know that in most instances involving a seizure no referral to an agency is needed. Officers are cautioned that for prolonged seizures or if injury occurs that the person should be transported to a hospital emergency room.
In addition many communities will have a local chapter of the Epilepsy Foundation of America, Association for Retarded Citizens, Mental Health Association or other appropriate social service agencies. The address of the national office as well is as follows:

The Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785-2267
Local Phone: (301) 459-3700
Toll Free: (800) EFA-1000
Fax: (301) 577-2684

Summary of Key Points

• Don't Panic. The first thing to remember is to remain calm during the episode.
• Keep the seizure victim safe during the seizure.
• Time the seizure. How long did the seizure last? Keeping a record of the length of the seizure, along with recording the characteristics of the seizure, allows the individual and medical staff to check for any changes in the seizure behavior.
• Remove any sharp objects or furniture within reach of the individual.
• Place a pillow under the person's head.
• Stay with the seizure victim. Make sure that the individual comes out of the seizure safely. The person could sustain a serious injury from trauma, or stop breathing.
CHAPTER 18: HEARING IMPAIRMENTS

Objectives

➢ PERFORMANCE OBJECTIVE:

Given a subject with a hearing impairment involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 36 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

➢ ENABLING OBJECTIVES:

1. Demonstrate your general knowledge of the unique factors of persons with hearing impairments.
2. Role play with another participant with hearing impairments in a simulated situation.

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with a hearing impairment. If someone has, ask them to tell of situation and how they knew the person had a hearing impairment. What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an officer, you respond to a call involving a two-car accident. The drivers were the only passengers in either car and neither were seriously injured. As you arrive, the drivers are accusing each other of being at fault. You inquire if there were witnesses to the accident. It appears that a pedestrian did see the accident and each give a similar description of the person who walked away.

You complete your work at the accident scene and proceed in the direction in which the witness left the scene. You make a routine stop at a popular donut shop and notice a young man that fits the description of the alleged witness of the car accident. You introduce yourself to the person and he appears to be reading your lips and not being very responsive to your questioning. What clue do you have to his disabling condition? Try to communicate with the person, soliciting basic information regarding the car accident.

Identifying the Hearing Impaired

Identifying Persons Who are Hearing Impaired

• The person appears alert but fails to respond to any sounds.
• The person points to the ears, or to the ear and mouth, and might also shake their head.
• The person speaks in a flat or harsh, unintelligible monotone voice.
In the case of a traffic check, the officer should keep his/her eyes on the person's hands and be aware that the person might be reaching for a pen and pad to write.

**Background: Hearing Impairments**

A reoccurring theme in the study of life-long disabilities is that attitudes about them can be traced back to ancient and medieval times. Curiosity about persons labeled deaf and dumb from birth is at the core of ancient inquiries about DD. For centuries, not only the public but eminent scientists of the day held the deaf to be fools who were incapable of learning and possessed of evil.

Man's need to communicate with his fellow man is possibly his greatest uniquely human need. The sense of hearing, the primary means by which infants develop language and speech, serves as the basis of human communication, with its attendant social and intellectual interaction throughout a person's life. Impairment of hearing, whether it be congenital deafness, acquired loss through illness or the gradual loss of hearing in later years, results not only in the primary disability of impaired communication but also the companion disability of the social stigma imposed on the hearing impaired by hearing people.

Only recently were some of the misconceptions gradually eliminated; but many remain as some continue to use the terms deaf and dumb and deaf-mute. Fortunately, the past two decades have been marked by a remarkable explosion of medical and technological advances in fields that offer assistance to persons with hearing loss, and by the enlightened interest in the educational and sociological betterment of persons with hearing loss.

**Review Definitions**

Definitions of Impairment ----

- Impairment: A loss of physical or mental functioning at the organ level.
- Disability: When the effect of the impairment is severe enough to inhibit functioning.
- Handicap: Obstructions imposed by society that inhibit the pursuit of independence.

Early in the first section we set forth definitions of impairment and disability, as well as development. Again, development refers to the period of life when persons are acquiring basic skills. While there are over 40 million persons in the United States with significant hearing impairment, approximately two-thirds of that number represent hearing loss associated with advanced age. This material is about developmental disabilities, or persons who are hearing impaired from birth or the developmental period. The disabilities and handicaps resulting from impaired vision and hearing are often compared as there is no doubt that blindness rates the highest degree of pity and sympathy. Yet, while blindness cuts people off from objects, deafness cuts people off from people. The result is social isolation.
Defining Deafness & Hearing Impairment

The word deaf is commonly applied to both partial and complete inability to hear. The term hard of hearing is used with a broad stroke of the linguistic brush and frequently alludes to both profound losses that can qualify as legal deafness and to moderate or even mild losses. One can be deaf through inability to hear amplified pure-tone signals above a certain volume or without reference to hearing capacity. A person is considered deaf when they cannot hear enough to recognize sounds or word combinations even when they are amplified. Generally, persons are considered hard of hearing when capable of only partial recognition of the spoken language or if conversation must be close and unusually clear to be understood.

One very important functional difference between the deaf and hard of hearing is that deaf implies the absence of sound. The person who is deaf can rarely follow speech and knows of that limitation. The person who is hard of hearing thinks they can recognize speech with the result frequently being a misunderstanding of what was said. The results may be good for laughter, but also may be yield miscommunication, an inaccurate appearance of sagging intelligence or indifference.

The human ear is very unique. It packs into a space smaller than a lime an electronics system with capabilities approximating as many wires as the telephone system of a city with a population of 300,000, and in many ways is more versatile and reliable than a telephone system. Ears can spot the location of sound, even if it is distant or behind us, despite the fact that we cannot move our ears as animals do. Ears collect and decipher whispers, sounds of gunfire or help us distinguish one musical note from another.

What Causes Hearing Loss?

Hearing loss can be inherited (genetic), congenital (acquired in the womb) or acquired after birth. The most common form of hereditary loss results in a blockage of the oval window that restricts passage of sound from the middle ear to the inner ear. Other less common hereditary forms are predisposition to auditory nerve degeneration and anatomical malformations. Hereditary deafness is believed to be responsible for approximately one-half of all childhood deafness (Stein, 1988). Persons born with Down syndrome frequently have hearing loss attributable to genetic factors.

Congenital deafness is caused by blood-group incompatibilities of the mother and the fetus and viral infections contracted by the mother during pregnancy. A baby is most likely to be born with hearing problems if the mother suffers an infection during the first three months of pregnancy as all the components of the ear are completely developed during this brief period.

Acquired hearing loss can result from a variety of causes including childhood diseases such as measles and mumps, and assorted viral infections that can cause inflammation of the inner ear. Hearing loss can also be acquired from such day-to-day items such as industrial gases, nicotine or excessive use of aspirin. Excessive noise over a prolonged period can also impact negatively on hearing.
Types of Hearing Disorders

The physiological complexity of the hearing mechanism may be thought of as a device converting sound waves into mechanical energy, then into fluid energy, and finally into electrical energy in the form of nerve impulses. This unique feat is accomplished by the three main parts of the ear: (a) the outer and middle ear mechanism; (b) the inner ear; and (c) the central auditory system of the central nervous system.

A hearing disorder involving the outer or middle ear mechanism, the mechanical portion of the system, results in what is termed a conductive hearing loss. This type of loss is similar to the volume on the radio being set very low with little or no distortion of sound. Conductive hearing loss results from a blockage or breakdown in the canal, eardrum, or middle ear bones. Hearing tests on people with conductive deafness show the inner ear or nerve function to be normal but the air conduction to be reduced. Persons with conductive hearing loss usually speak very softly because sound generated by their own voice appears louder owing to direct conduction through the skull into the inner ear. Conductive hearing loss can often be cured by surgery or improved through the use of a hearing aid.

The second major category of disorders involves the inner ear. When the inner ear is affected a sensory deafness results, and if the nerve of hearing is involved then a neural hearing loss occurs. Usually these two groups are lumped together under the term sensorineural (Rosenthal, 1987). Sensorineural hearing loss cannot be cured by surgery or helped by the use of a hearing aid. This type is often likened to a radio with the dial not being properly tuned.

Amplification of sound for these persons over amplifies the often normal low frequencies in an effort to improve the high frequency loss and results in a noisy jumble. Another characteristic of sensorineural deafness is that it is quite common for the sound, when amplified to become painful. This type of loss can cause one to be irritated by the raspy, fuzzy qualities of any sound (Freeland, 1989). Persons affected often mistake words like fifty for sixty or twenty for thirty. Because these persons often become irritated, they frequently "switch off" their concentration.

Another frequently used classification system is:

- Pre-lingual/early onset deafness
  - Refers to persons who were born deaf or became deaf in early childhood.
  - People in this category use sign language as their primary means of communication.

- Post-lingual deafness
  - Persons who belong to this group lose their hearing later in life after learning language.
  - Persons under this category lose their hearing for various reasons.
One of these reasons may be age. Many of these people are known as hard of hearing. For this group, it is difficult to generalize the primary means of communication. Many will NOT know sign language, many will have comprehensible speech and most will be unable to lip-read.

Prevalence of Hearing Impairments

Hearing loss is frequently described as the nation's number one disabling condition as it affects more Americans than cancer, heart disease, tuberculosis, blindness, multiple sclerosis, venereal disease and kidney disease combined (Stein, 1988). Approximately 50 percent of persons age 75 plus have a significant degree of hearing loss (Stein, 1988). Hearing impairment, when treated as a developmental disability occurs at the rate of approximately six per 1,000 persons or six-tenths of one percent (.6%). The rates increase as age categories increase. The prevalence rate when all age categories are combined is 7.64 percent.

Additional Disabling Conditions

- GENERAL INFORMATION

Additional disabling conditions or secondary problems are estimated to occur in about one-third of persons with severe hearing impairments (Stein, 1988). Conditions that are most frequently reported are mental retardation, perceptual disorders, emotional and behavioral problems and visual impairment. As mentioned earlier, up to 50 percent of persons with Down syndrome have hearing loss attributable to one of the two major types. Little research has been conducted on adults with hearing impairments and emotional disturbances. Studies on older youth as reported by Stein (1988) indicate that up to one-third have some degree of emotional disturbance. The two most common factors thought to contribute to persons with hearing impairments having emotional problems are: (1) inadequate language development and thus no effective way to communicate and (2) the failure of others to fully understand their condition.

The only persons who truly understand the problems faced by deaf persons are other persons who are deaf. Therefore, deaf people are unusual as a disability group in that among themselves they are not disabled. For this reason, they frequently become a culture unto themselves. The deaf community can appear very much like a minority group as they are held together by common experiences (specialized training, share a common way of communicating, jokes, etc.) Mature persons that are hearing impaired suffer disorders of mental health and mental retardation in proportions similar to the incidence rates within the general population of mature adults. They do appear to have a low tolerance for emotionally demanding situations. Some of the more common symptoms of disturbance for deaf youth are as follows:
HEARING LOSS AND EMOTIONAL DISTURBANCES

- chronic depression
- low frustration tolerance
- over-dependence and compliance
- lack of flexibility
- few social contacts
- unusual withdrawal
- attention-getting behavior
- nervous habits
- inappropriate laughter or silliness
- aggressiveness and potential danger to others

The reaction of the deaf individual to the police officer and society in general is a function of their hearing capacity and educational background. The police officer has no way of knowing these things in their initial contact with the person with a hearing impairment therefore should consider these basic facts:

BASIC FACTS

- The personalities of persons who are deaf are as unique as the mainstream of society - They are more like you than unlike you.
- The common bond among deaf people is their hearing disability - Deafness is more than just a loss of hearing.
- The real handicap of deafness is being cut off from normal means of acquiring and transmitting language - Communication loss
- This affects a deaf person's sophistication about his/her world and results in personal, social, educational and occupational obstacles. Deaf persons try to cope through auxiliary means of communication such as sign language, lip reading, reading and writing.

Types of Communication

- Lip-reading - is the least reliable method of communication. Lip-reading is about 30% effective in understanding what is being said.
- Reading & writing notes - is an effective means of communication, but you must be patient. A deaf person's grammar might be hard to understand.
- Sign language - is the preferred mode of communication. Ask a nearby friend or family to assist in interpreting. If none is available, have the dispatcher find an interpreter.
As in any situation involving the victim of a crime, one of the police officer's first priorities is to obtain a description of the suspect. With a deaf victim, it is essential to decide on the method of communication immediately. Lip-reading is the least reliable of the three communication methods. Only about 30 percent of what is said can be lip-read. If the person is able to lip-read, make sure there is adequate light, so the person can see your lips. The officer should look directly at the person when speaking. Be aware that a moustache or using chewing gum makes it more difficult for an individual to read your lips.

Writing notes is often an effective means of communication. The officer should note that the grammar of persons who are deaf is often hard to understand. Writing notes will require patience on the officer's part.

Sign language is the preferred method of communication. This requires the presence of an interpreter. Often there is a family member or friend with these skills that can provide assistance. The police dispatcher should maintain a list of interpreters available in your area.

**Police Encounters**

- Victim of a crime
- Witness to a crime
- Motor vehicle accident
- Traffic checks
- Rights of a deaf suspect

- **THE HEARING IMPAIRED AS A WITNESS.**

  A deaf witness to a crime or an incident may be more helpful than his or her counterpart. Deaf persons may observe more than a hearing person viewing the same event as they are more dependent on visual cues in understanding their environment.

- **MOTOR VEHICLE ACCIDENT INVOLVING A PERSON WITH A HEARING IMPAIRMENT.**

  The police officer may be called to the scene of an accident involving a person with a hearing impairment. (The transparencies labeled identification might alert the officer to the fact that the person has a hearing impairment.)

- **TRAFFIC CHECKS AND PERSONS WITH HEARING IMPAIRMENTS.**

  The police officer's trained response in approaching a traffic violator is to exercise caution and maintain personal safety. In situations involving a driver with a hearing impairment, it is a normal reaction for the person to instantly reach for a pen and pad located in his/her pocket or glove compartment. Drivers who are deaf are taught that when stopped by the police that they should place their hands
on the steering wheel; however, in the anxiety of the moment, the person might fail to remember this procedure.

THE RIGHTS OF A DEAF SUSPECT.

The police officer, when dealing with a deaf suspect should exercise caution so as to not intentionally violate his/her civil rights. Many cases involving deaf suspects have been incorrectly handled in the past, resulting in inadmissible evidence. Persons with hearing impairments have a legal right to a professional interpreter. Family members and friends are not professionals. The officer should never attempt to question a person who is hearing impaired without an interpreter. A written Miranda may not be sufficient. The Miranda warning is written at an eighth grade level, while the average deaf person reads at a fifth or sixth grade level. Suspects also have the right to make a telephone call using a telecommunication device for the deaf (TDD).

Communication Tips

Communicating with a deaf person . . .

• Decide on the method of communication immediately (lip-reading, writing notes or sign language)
  ⇒ If lip-reading is chosen, make sure there is adequate light, look directly at the person, and be aware that a moustache or chewing gum makes lip-reading difficult.
  ⇒ If writing is chosen, remember that a deaf person's grammar is different and might be hard to understand.
  ⇒ If sign language is used, find an interpreter

• Be patient.

• Face the deaf person when you speak

• Listen to both sides of the story--deaf persons have noted that police officers tend to ignore them.

Community Resources for Persons with Hearing Impairments

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. The seasoned officer will know that in most instances involving a person with a hearing impairment, no referral to an agency is needed. Officers may consider this agency as a location for a sign language interpreter.

In addition, many communities will have a Deaf Action Center, with other appropriate resources being the Association for Retarded Citizens, Mental Health Association or
other appropriate social service agencies. The address of the Texas Commission for the Deaf and Hard of Hearing is:

Texas Commission for the Deaf and Hard of Hearing
4800 N. Lamar Boulevard, Suite 310
Austin, TX 75756
telephone 512-451-8494
fax 512-451-9316

Summary

• Every hearing impaired person copes with his or her communication loss in a different way.

• Persons with hearing impairment can be mistaken for persons who are senile, mentally ill or mentally retarded. This problem of identification occurs because people with hearing are unaware of deaf people's communication difficulties. This problem is further compounded by people who are hearing impaired that are unable to ask for better communication.

• It is a state law in Texas that deaf persons be provided with a qualified interpreter involving any governmental procedure (Code of Civil Procedure 1965, (d), Art. 38.31). Under state law, these services are paid for by the governmental body involved in the case.

• You, not the interpreter, are the one talking to the deaf person.
CHAPTER 19: REFERENCES

Cox, Judith, Boland Leo, Morschauer Pamela; McCormick Co.: “Police Mental Health Training Program”; New York State 1990.
Dvostin, Joel, "I am Not a Gall Bladder, You Pompous Fool" OMH News Volume 3, #6 August, 1993.


